WELCOME TO

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

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WELCOME TO SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

Dear Member,

Southwest Michigan Behavioral Health (SWMBH) is the Prepaid Inpatient Health Plan (PIHP) as well as the Regional Coordinating Agency for southwest Michigan. We provide behavioral health/substance use services and supports to persons who meet criteria. As the manager of benefits, SWMBH will make sure that services are given to you based on your needs and goals and are within the guidelines set by the State of Michigan. SWMBH makes sure that you and your family members are treated with dignity and respect at all times.

SWMBH also makes sure that you have a say in how and what is provided to you throughout the time you are receiving services in ways that you can understand. This includes people who are deaf, have a hard time hearing, those who are not able to read, and for those who do not use English as their chosen language.

We want you to be satisfied with your services. If you have any questions, please call SWMBH Member Services toll-free at 1-800-676-5814.

You can also visit our website for more information (www.swmbh.org). Please call Member Services at 1-800-676-5814 if you need a printed copy of any website information including the provider directory.

The SWMBH Member Handbook is reviewed once a year. If there are changes to the handbook we will notify you through newsletters and other mailings.
The SMWBH regional Member Services office provides support and oversight to all the member services activities and can provide assistance to any member of the region. The SWMBH office can connect your call to any of our local CMH offices or any network provider agency to assist you as necessary.

Please contact:	**Member Services Specialist**
Address:	5250 Lovers Lane, Suite 200, Portage, MI 49002
Telephone:	Toll Free at 1-800-676-5814 or 711 MRC
Hours:	Monday-Friday 8 a.m. to 6 p.m. excluding Legal Holidays
Website:	www.SWMBH.org

As noted, our typical hours of operation for our Member Services office are 8 a.m. to 6 p.m. Monday-Friday. However, if you need to make contact with a member services representative outside of those hours, please leave a confidential voice message stating your name and phone number where you can be reached. If you add the best time to reach you, we will do our best to accommodate your request. Whenever you leave a message for a member services representative, it is the expectation of SWMBH that your call will be returned during the next business day. If you are looking for information, you may find what you are looking for on the SWMBH website at www.SWMBH.org.

If you are experiencing an emergency/crisis please call 911 or our crisis line at 1-800-675-7148, 24 hours a day, 7 days a week. You can also go directly to your local hospital.

Section 1
Southwest Michigan Behavioral Health Member Handbook

This handbook tells you about your coverage under Southwest Michigan Behavioral Health. It explains behavioral health, intellectual/developmental disabilities, and substance use disorder coverage as well as your rights and resources. You will also receive a handbook from your Integrated Care Organization (ICO) - Aetna or Meridian health plan. Your Aetna or Meridian handbook provide similar information but describe medical treatment services and coverage.
This is an important legal document. Please keep it in a safe place.

This plan is offered by Southwest Michigan Behavioral Health. When this Member Handbook says "we," "us," or "our," it means Southwest Michigan Behavioral Health.

You can speak with someone about getting this information in other languages. Call 1-800-676-5814. The call is free.

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5814-676 مقرلاب لصتا
يناجم لاصتالا.

Puede hablar con una persona para recibir esta información en itris idiomas. Llame al 1-800-676-5814. La llamada es gratuita.

You can ask for this handbook in other formats, such as large print. Call 1-800-676-5814 or 711 MRC any time Monday – Friday 8 a.m. – 6 p.m.

Disclaimers
SWMBH contracts with your ICO- Aetna or Meridian to provide both Medicare and Michigan Medicaid benefits to members for behavioral health services.
Benefits and provider networks may change from time to time throughout the year and on January 1 of each year. Please contact Southwest Michigan Behavioral Health for more details.

1.1 What are Medicare and Michigan Medicaid?

Medicare
Medicare is the federal health insurance program for:
- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Michigan Medicaid
Michigan Medicaid is a program run by the federal government and the State of Michigan that helps people with limited incomes and resources pay for long term supports, services, and medical costs. It also covers extra services and drugs not covered by Medicare.

Each state has its own Medicaid program. This means that each state decides what counts as income and resources and who qualifies for Medicaid. They also decide what services are covered by Medicaid and the cost for those services. States can decide how to run their own Medicaid programs, as long as they follow the federal rules.

You can get Medicare and Michigan Medicaid services through Southwest Michigan Behavioral Health as long as:

- you are eligible to participate
- we choose to offer the plan, and
- Medicare and the State of Michigan approve the plan.

Even if SWMBH stops operating in the future, your eligibility for Medicare and Michigan Medicaid services would not be affected.

1.2 What are the Advantages of MI Health Link Program?

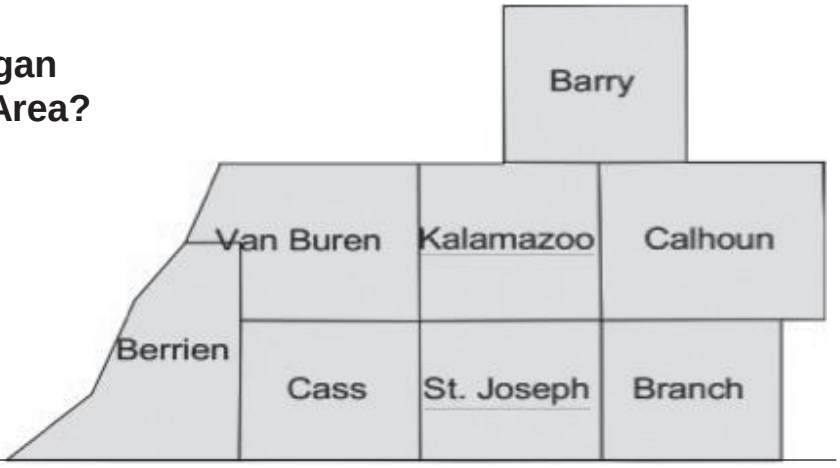
You will now get all your covered Medicare and Michigan Medicaid behavioral health services from SWMBH and your ICO- Aetna or Meridian, including prescription drugs. You do not pay extra to join this health plan.

SWMBH and your ICO- Aetna or Meridian- will help make your Medicare and Michigan Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will not pay a deductible or copayment when you get services from a provider or pharmacy in your ICO- Aetna or Meridian's provider network
- You will have your own Care Coordinator/Care who will ask you about your health care needs and choices and will work with you to create a personal care plan based on your goals
- Your Care Coordinator will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve
- You will be able to address both medical as well as behavioral health issues at the same time

1.3 What is Southwest Michigan Behavioral Health's Service Area?

- Barry County
- Berrien County
- Branch County
- Calhoun County
- Cass County
- Kalamazoo County
- St. Joseph County
- Van Buren



If you have questions, please call Southwest Michigan Behavioral Health at 1-800-676-5814, 8 a.m. – 6 p.m. Monday – Friday. The call is free. For more information, visit www.swmbh.org.

Only people who live in our service area can receive services from SWMBH.

If you move outside of our service area, you cannot stay with SWMBH.

1.4 What to Expect When You First Join MI Health Link Program

You will receive a Level I Assessment within the first 45 days of joining the MI Health Link Program. If a potential need for behavioral health services is identified based on the Level I assessment, you will receive a Level II Assessment from SWMBH within 15 days.

If Southwest Michigan Behavioral Health is new for you, you can keep receiving behavioral health services and seeing the doctors and other providers you go to currently for at least 90 days from your enrollment start date. If you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through SWMBH, you will be able to receive services and see the doctors and providers you go to currently for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time period if your current provider is not part of SWMBH's provider network. A network provider is a provider who works with the ICO- Aetna or Meridian.

1.5 What is a Care Plan?

A care plan is the plan for those supports and services you need and how you will get them.
After your Level I Assessment, your care team will meet with you to talk about what health services, including behavioral health services, you need and want. Together, you and your care team will make a care plan.

Every year, and when the health services you need and want change, your care team will work with you to update your care plan.

1.6 What is a Person Centered Plan?

The process used to design your individual plan of mental health supports, service, or treatment is called "Person-Centered Planning (PCP)." PCP is your right protected by the Michigan Mental Health Code. The document created is called an Individual Plan of Service (IPOS). If you are receiving services for a substance use disorder, your IPOS may be titled Individual Treatment Plan.
The process begins when you determine whom, beside yourself, you would like at the person-centered planning meetings, such as family members or friends and what staff you would like to attend. You will also decide when and where the person-centered planning meetings will be held. Finally, you will decide what assistance you might need to help you participate in and understand the meetings.

During person-centered planning, you will be asked what are your hopes and dreams. You will be helped to develop goals or outcomes you want to achieve. The people attending this meeting will help you decide what supports, services, or treatment you need, who you would like to provide this service, how often you need the service, and where it will be provided. You have the right, under federal and state laws, to a choice of providers.

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

What if I cannot get the services I asked for?
If your provider cannot provide you with a specific service to best meet your needs, another service or support can be discussed and explored during this time.
Are there limits on Person-Centered Planning?
The services offered by your provider are set by best practice guidelines. From the services available, you will be offered a variety of service choices. However, there may be limits on some of your choices:

- Your choices must not do harm to you or someone else
- Your choices must not be illegal

1.7 Does Southwest Michigan Behavioral Health have a Premium?

No. You will have no premiums or copays under the MI Health Link program.

1.8 About the Member Handbook

This Member Handbook is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal or challenge our action. For information about how to appeal, see section 8.6, or call 1-800-MEDICARE (1-800-633-4227).

The contract is in effect for the months you are enrolled in SWMBH between January 1, 2016 and December 31, 2016.

1.9 What Other Information Will You Get?

Under your Integrated Care Organization (ICO), you will have one card for your Medicare and Michigan Medicaid services, including long term supports, services, and prescriptions. You must show this card when you get any services or prescriptions.

If your card is damaged, lost, or stolen, call your ICO Member Services right away and they will send you a new card. You can also contact SWMBH and we will assist you with contacting your ICO- Aetna or Meridian.

As long as you are enrolled in the MI Health Link plan you do not need to use your red, white, and blue Medicare card or your Michigan Medicaid card to get services. Keep those cards in a safe place in case you need them later.

1.10 What makes you eligible for Southwest Michigan Behavioral Health MI Health Link Services?

You are eligible for our plan as long as:

- you live in our service area, and
- you are 21 years of age or older
- you have Medicare Part A, Part B, and Part D, and
- you are eligible for full Michigan Medicaid benefits, and
- you are not enrolled in hospice, and
- you are not enrolled in the MI Choice waiver program or the Program of All-inclusive Care for the Elderly (PACE). If you are enrolled in either of these programs, you need to dis-enroll before enrolling in the MI Health Link program through SWMBH

Provider Directory

The Provider Directory lists the providers in the SWMBH network. This directory will provide you such information as; specialty, location(s), hospital affiliations, languages spoken and whether or not they are accepting new members. While you are a member of SWMBH you must use network providers to get covered services. There are some exceptions when you first join our plan (see *What to Expect When you First Join MI Health Link Program* above). You can request a Provider Directory by calling Member Services at 1-800-676-5814. You can also see the Provider Directory at www.swmbh.org or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

What are "network providers"?

Network providers are doctors, therapists, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers, and others who provide goods and services that you get through Medicare or Michigan Medicaid. Network providers have agreed to accept payment from our plan for covered services as payment in full.

1.11 How We Keep Your Record Up-to-Date

You can keep your record up-to-date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing home or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Member Services at 1-800-676-5814.

1.12 Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected.

Privacy of Mental Health and Substance Use Disorder Information

The agencies authorizing and/or providing services to you must follow laws and requirements about confidentiality and privacy. These laws and other requirements include:

- Michigan Mental Health Code for Mental Health Services
- Rule 42 of the Central Federal Register (42 CFR Part 2) for Substance Abuse Services
- Health Insurance Portability and Accountability Act (HIPAA)

Confidentiality. You have the right to have information about your mental health treatment kept private. You also have the right to look at your own clinical records and add a formal statement about them if there is something with which you do not agree. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law. If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services.

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

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

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of a privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in the Notice of Privacy Practices and give you a copy of it
- You may ask for a Notice of Privacy Practices from where you receive services
- We will not use or share your information other than as described in the Notice of Privacy Practices unless you tell us we can in writing
- If you change your mind about the use or sharing of your information, you also need to put it in writing. You may change your mind at any time

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

If you have questions regarding Privacy or Compliance issues please call the SWMBH Program Integrity Office at (800) 783-0914.

Section 2
Important Contact Information

2.1 How to Contact the Southwest Michigan Behavioral Health General Line

Members receiving services through Aetna or Meridian, the ICO, and SWMBH, the PIHP, will continue to receive them according to their plan of care/PCP. Your ICO- Aetna or Meridian will provide the personal care services previously provided by the Department of Health and Human Services (DHHS) Home Help program. Other medically necessary behavioral health, intellectual/developmental disability, and substance use disorder services, including psychotherapy or counseling (individual, family, and group) when indicated, are available and coordinated through Aetna/Meridian and the PIHP.

Southwest Michigan Behavioral Health General Information Line

» **CALL**	1-800-676-0423 This call is free. Monday – Friday 8 a.m. – 5 p.m. We have free interpreter services for people who do not speak English.
» **TTY**	711 MRC This call is free. 24 hours a day/7 days a week
» **FAX**	1-269-883-6670
» **WRITE**	5250 Lovers Lane, Suite 200 Portage, MI 49002
» **WEBSITE**	www.swmbh.org

Aetna General Information Line

» **CALL**	1-855-676-5772 This call is free. Monday – Friday 8 a.m. – 5 p.m. We have free interpreter services for people who do not speak English.
» **TTY**	711 MRC This call is free. 24 hours a day/7 days a week
» **FAX**	1-855-854-3245
» **WRITE**	Aetna Better Health 1333 Gratiot Avenue, Suite 400 Detroit, MI 48207
» **WEBSITE**	www.aetnabetterhealth.com/michigan

Meridian General Information Line

» **CALL**	1-855-323-4578 This call is free. Monday – Friday 8 a.m. – 5 p.m. We have free interpreter services for people who do not speak English.
» **TTY**	711 MRC This call is free. 24 hours a day/7 days a week
» **FAX**	1-844-253-0182
» **WRITE**	Meridian Health Plan 777 Woodward Avenue, Suite 600 Detroit, MI 48226
» **WEBSITE**	www.medicaremeridian.com

Contact the General Information Line about:

- Questions about services
- Where and how to get an assessment
- Where to go to get services
- A list of other community resources
- Questions about claims or billing

2.2 How to Contact Southwest Michigan Behavioral Health Member Services

» **CALL**	1-800-676-5814 This call is free. Monday – Friday 8 a.m. - 6 p.m. We have free interpreter services for people who do not speak English.
» **TTY**	711 MRC This call is free. 24 hours a day/7 days a week
» **FAX**	1-269-441-1234
» **WRITE**	Southwest Michigan Behavioral Health Member Services 5250 Lovers Lane, Suite 200 Portage, MI 49002
» **WEBSITE**	www.swmbh.org

Contact Member Services about:

- Questions about the PIHP
- Questions about benefits, services, or express a complaint
- Coverage decisions about your health care [To learn more about coverage decisions, see section 8.6]
- Appeals about your treatment or care [To learn more about making an appeal, see section 8.11]
- Complaints about your treatment or care [To learn more about making a complaint see section 2.4]

2.3 How to Contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP).
MMAP is not connected with any insurance company or health plan.

» **CALL**	1-800-803-7174 This call is free.
» **TTY**	711 MRC This call is free. 24 hours a day/7 days a week
» **WRITE**	6105 St Joe Hwy #204 Lansing Charter Township, MI 48917
» **EMAIL**	info@mmapinc.org
» **WEBSITE**	mmapinc.org

Contact MMAP about:

Questions about your Medicare and Medicaid health insurance

MMAP counselors can:

- help you understand your rights,
- help you understand drug coverage, such as prescription and over-the-counter drugs,
- help you understand your plan choices,
- answer your questions about changing to a new plan,
- help you make complaints about your health care or treatment, and
- help you straighten out problems with your bills.

2.4 How to Contact the Quality Improvement Organization (QIO)

Our state uses an organization called KEPRO for quality improvement. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with our plan.

» **CALL**	1-855-408-8557 This call is free. Monday through Friday 9 a.m. to 5 p.m. Saturdays, Sundays, and Holidays 11 a.m. to 3 p.m.
» **TTY**	1-855-843-4776 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
» **WRITE**	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
» **EMAIL**	KEPRO.Communications@hcqis.org
» **WEBSITE**	http://www.keproqio.com

Contact KEPRO about:

Questions about your health care

- You have a problem with the quality of care,
- You think your hospital stay is ending too soon, or
- You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

2.5 How to Contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older or some people under the age of 65 with disabilities and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

» **CALL**	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
» **TTY**	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
» **WEBSITE**	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting “Help & Resources” and then clicking on “Phone numbers & websites.” The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Find health & drug plans.” If you don’t have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

2.6 How to Contact Michigan Medicaid

Michigan Medicaid helps with medical and long term supports and service costs for people with limited incomes and resources.

You are enrolled in Medicare and in Michigan Medicaid. If you have questions about the help you get from Michigan Medicaid, call the Beneficiary Help Line.

» **CALL**	1-800-642-3195 This call is free. Monday through Friday 8 a.m. to 7 p.m.
» **TTY**	1-866-501-5656 or 711 MRC This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
» **WRITE**	PO Box 30479 Lansing, MI 48909-7979

Michigan Medicaid eligibility is determined by the local Department of Health and Human Services (DHHS). If you have questions about your Michigan Medicaid eligibility or yearly renewal, contact your DHHS Specialist. For general questions about DHHS assistance programs, call 1-855-275-6424 between 8 a.m. and 5 p.m. Monday through Friday.

2.7 How to Contact the MI Health Link Ombudsman Program

The MI Health Link Ombudsman program helps empower beneficiaries and support their engagement in resolving problems with their health care, behavioral health care, and long-term services and supports. MHLO will also investigate and work to resolve beneficiary problems with Plans, and identify trends and emerging issues with the MI Health Link Program.

» **CALL**	1-888-746-6456 or 1-888-746-MHLO This call is free. Monday through Friday 8 a.m. to 5 p.m.
» **TTY**	711 MRC This call is free. 24 hours a day/7 days a week
» **EMAIL**	HELP@mhlo.org
» **WEBSITE**	http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html This is the official website for the MI Health Link Project. The MI Health Link Ombudsman Program will have a link on this webpage.

Section 3
Accessing Services
3.1 Emergent, Urgent, and the Behavioral Health Crisis Line
If you are experiencing a behavioral health, life or death emergency, please call 9-1-1 or go to the nearest hospital.
Emergency Services
A "mental health emergency" is when a person is experiencing symptoms and behaviors:

- that can reasonably be expected in the near future to lead him/her to harm self or another;
- or because of his/her inability to meet his/her basic needs he/she is at risk of harm;
- or the person's judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future.

You have the right to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care.

If you have a mental health emergency you should seek help right away. You can call the SWMBH access line listed in Accessing Services section, or you can go to any hospital that offers emergency care.

> **Please note:** If you utilize a hospital emergency room, there may be health care services provided to you as part of the hospital treatment that you receive. Depending on your insurance status, you may receive a bill and may be responsible for paying the charges for some other medical services provided by the hospital. These services may not be part of the SWMBH emergency services you receive. Member Services can assist with questions about such bills.

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

Getting urgently needed care
Urgently needed care is care you get for a sudden onset or change of symptoms or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.
In most situations, we will cover urgently needed care only if:

- you get this care from a network provider, and
- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

- Our plan does not cover urgently needed care or any other care that you get outside the United States.

Contact the Behavioral Health Crisis Line for any of the following reasons:

- Suicidal thoughts
- Information on mental health/illness
- Substance abuse/addiction
- To help a friend or loved one
- Relationship problems
- Abuse/violence
- Economic problems causing anxiety/depression
- Loneliness
- Family problems

» CALL TO ACCESS ALL SERVICES (including emergency services)	1-800-675-7148 This call is free. Emergency services 24 hours a day/7 days a week Monday – Friday 8 a.m. – 8 p.m. We have free interpreter services for people who do not speak English.
» TTY	711 MRC This call is free. 24 hours a day/7 days a week
» FAX	1-269-441-1234
» WRITE	5250 Lovers Lane, Suite 200 Portage, MI 49002
» WEBSITE	www.swmbh.org

3.2 Accessing Services

If you are seeking behavioral health, intellectual/developmental disabilities, or substance use disorder services please contact SWMBH at the number above. Michigan has a managed care delivery system for mental health and substance use/abuse services.

The State of Michigan Department of Health and Human Services (MDHHS) sets rules and regulations that we follow regarding who is eligible for services funded by federal and state funds. This includes the types of Medicare and Michigan Medicaid mental health and/or substance use/abuse services that are funded through SWMBH network and the eligibility criteria used to determine if someone qualifies for services.

MI Health Link beneficiaries are entitled to obtain services that are medically necessary. When decisions are being made about your services they will be based only on appropriateness of care and service and existence of coverage. SWMBH and your ICO- Aetna or Meridian may refer people who are not part of our mandated service eligibility groups to other community agencies to receive services.

When you call to inquire about services provided by the SWMBH network, we can provide you with any necessary information about mental health and/or substance abuse services. You will speak with clinical staff qualified to assist you with how to access our services. We will conduct an eligibility screening or assessment to determine what services you may qualify for.

Section 4
Using Southwest Michigan Behavioral Health Benefits, Services and Providers

4.1 About "Services", "Covered Services", "Providers", and "Network Providers"

Services are health care, long term supports and services, supplies, behavioral health, prescription and over-the-counter drugs, equipment, and other services.

Covered services are any of these services that SWMBH pays for. Covered services are listed in the Benefits Chart in section 6.4.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long term supports and services.

Network providers are providers who work with SWMBH. These providers have agreed to accept our payment as full payment. Network providers bill us directly for the care they give you. When you see a network provider you will pay nothing for covered services.

4.2 Rules for Getting Your Services Covered by Southwest Michigan Behavioral Health

SWMBH covers all behavioral health and related home and community based services covered by Medicare and Michigan Medicaid.
SWMBH will generally pay for supports and services you get if you follow the rules.
To be covered:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in section 6.4 of this handbook).
- The care must be **medically necessary**. Medically necessary means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. Medical necessity is closely monitored and regulated by specific criteria. If you would like to review this criteria, please find it listed on SWMBH's website (www.SWMBH.org), or contact Customer Services (800-890-3712) for more details. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with SWMBH. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what emergency or urgently needed care means, see section 3.1.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. You will need to obtain prior authorization with SWMBH before utilizing your out of network provider. In this situation, we will cover the care as if you got it from a network provider or at no cost to you. To learn about getting approval to see an out-of-network provider, see section 4.4.

When you first join the plan, you can keep receiving services and seeing the doctors and other providers you go to now for at least 180 days from your enrollment start date. Your care coordinator will work with you to choose new providers and arrange services within this time period.

4.3 Your Care Coordinator

What is a Care Coordinator?

A Care Coordinator is someone who will assist you with coordinating your care with not only behavioral health services but also with your Aetna or Meridian Care Coordinator and Primary Care Physician. Your Care Coordinator collaborates with you and the ICO- Aetna or Meridian to assure all necessary supports and services are provided to enable you to achieve your desired outcomes.

Contacting Your Care Coordinator

You will receive a Care Coordinator once you have started treatment/services with SWMBH. You will have a Care Coordinator you will be able to utilize to assist you with coordinating all your behavioral health and medical needs. You can contact your Care Coordinator at the contact information in section 2.

Contact your Care Coordinator about:

- Questions about your treatment or care
- Questions about getting behavioral health or substance use disorder services
- Questions about any other supports and services you need

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Personal Care Services
- Home health care

Requesting a Change in Care Coordinator

You can request a change in Care Coordinator through the Member Services department. See section 2.2 for contact information.

4.4 Accessing Care from In-Network or Out-of-Network Providers

In- Network

You may choose a provider of your choice to provide your care. We can assist you with choosing a provider from our Provider Directory that may meet your needs.

You may request to change your provider for any reason, at any time. Also, it's possible that your provider of choice might leave our plan's network. We can help you find a new provider. Just call SWMBH Member Services at 1-800-676-5814 to request a change in provider.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we will try to give you uninterrupted access to qualified providers
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider
- We will help you select a new qualified provider to continue managing your service needs
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please contact Member Services at 1-800-676-5814.

Out of Network

There may be times in which there are no providers in the SWMBH network that are able to provide you with a service that you need. If there is a service that is a covered Medicare or Michigan Medicaid benefit and it is medically necessary for you, SWMBH and your ICO- Aetna or Meridian will work with you to find a provider out of our network to provide the service. This will be at no cost to you.
If you feel that your needs require services from an out of network provider, please contact the SWMBH Member Service representative as noted in section 2.1 of this handbook.

Please note: If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Michigan Medicaid. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you receive. Providers must tell you if they are not eligible to participate in Medicare.

4.5 How to Participate in a Self-Determined Arrangement

What are arrangements that support self-determination?

- Self-determination is an option available to enrollees receiving services through the MI Health Link Home and Community Based Services waiver program. It is a process that allows you to design and exercise control over your own life. This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget." If you choose to do so, you would also have control over the hiring and management of providers.

Who can receive arrangements that support self-determination?

- Arrangements that support self-determination are available for enrollees who receive services through the home and community-based services waiver program called MI Health Link HCBS.

How to get help in employing providers?

- You may work with your care coordinator to get help employing providers.

4.6 How to Get Transportation

Please contact Aetna or Meridian (at the contact information in section 2) or SWMBH Member Services department at 1-800-676-5814 for more information on transportation assistance.

4.7 What Should You Do if You Are Billed?

If a provider sends you a bill instead of sending it SWMBH, you should not pay the bill yourself. If you do, we may not be able to pay you back. If you have paid for your covered services or if you have gotten a bill for covered medical services, see section 7 to learn what to do.

What should you do if services are not covered by our plan?

SWMBH covers all services:

- that are medically necessary, and
- that are listed in the plan's Benefits Chart (see section 6.4), and
- that you get by following plan rules

If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any behavioral health service or care you have the right to ask us. If we say we will not pay for your services you have the right to appeal our decision.

Section 8 explains what to do if you want the plan to cover a treatment or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. Medicare has limetime limits for services. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

4.8 Are Services Covered When You Are In A Clinical Research Study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare or SWMBH approves the study. If you are part of a study that Medicare or SWMBH has not approved, **you will have to pay any costs for being in the study.**

Once Medicare or SWMBH approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers.

You <u>do</u> need to tell us before you start participating in a clinical research study.

Here's why:

- We can tell you if the clinical research study is Medicare-approved
- We can tell you what services you will get from clinical research study providers instead of from our plan

If you plan to be in a clinical research study, you or your Care Coordinator should contact Member Services.

When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure that is part of the research study
- Treatment of any side effects and complications of the new care

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

4.9 How are your Services Covered if you are in a Religious Non-Medical Institution/Provider?

What is a religious non-medical health care institution?

A *religious non-medical health care institution* is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is any care that is not voluntary and is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare
- Our plan's coverage of services is limited to non-religious aspects of care
- Our plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions
- If you get services from this institution that are provided to you in a facility, the following applies:
  - » You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care

» You must get approval from our plan before you are admitted to the facility or your stay will not be covered

All Medicare Inpatient Hospital coverage limitations apply, see section 6.4 for the benefits chart.

Section 5
Rights and Responsibilities

Below, you will find your rights and responsibilities as a member. We must honor your rights.

5.1 You Have Rights

1. **You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.**
2. **You have the right to be treated with respect and recognition of your dignity and right to privacy.**
3. **You have the right to participate with practitioners in making decisions about your health care.**
4. **You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.**
5. **You have the right to voice complains or appeals about the organizations or the care it provides.**
6. **You have the right to make recommendations regarding the organization's member rights and responsibilities policy.**
7. **You have the responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.**
8. **You have the responsibility to follow plans and instructions for care that you have agreed to with your practitioners.**
9. **You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.**

You have the right to get information in a way that meets your needs

We must tell you about the PIHP benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan. Members have a right to make recommendations to SWMBH's Members' Rights and Responsibilities policy. If you have further questions or want a more comprehensive look at SWMBH's policy, please contact Member Services to request Policy 13.12: MI Health Link Enrollee Rights and Responsibilities.
To get information in a way that you can understand, call Member Services at 1-800-676-5814.
If you are a person who is deaf or hard of hearing, you can utilize the Michigan Relay Center (MRC) to reach Aetna or Meridian, SWMBH, or service provider. Please call 7-1-1 and ask MRC to connect you to the number you are trying to reach. More information about MRC is available at www.michiganrelay.com.
Your service providing agency may also have TDD or TTY equipment available if you would prefer

to contact the agencies directly. Please let us know your preferred contact method.
If you need a sign language interpreter, contact Member Services 1-800-676-5814 as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.
If you do not speak English, if English is not your primary language, or if you need any other language accommodations with materials or information provided to you, contact Member Services office at 1-800-676-5814 so that arrangements can be made for an interpreter or assistance can be arranged for you. Language interpreters are available at no cost to you.
We work with a variety of providers and agencies to offer interpretation and translation services. All critical documents will be provided in Spanish; however, if our written materials are not available in your language, we will provide verbal translation of the materials in a language you understand. Some of our materials may be available in Braille, large print, or audiotape.
If you are having trouble getting information from the PIHP because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You may also file a complaint with Michigan Medicaid. Please see section 8.26 for more information.

10. We must treat you with dignity and respect at all times

The PIHP must obey laws that protect you from discrimination or unfair treatment. We do not discriminate against members because of any of the following:

- ☐ Race
- ☐ Ethnicity
- ☐ National origin
- ☐ Religion
- ☐ Sex
- ☐ Sexual orientation
- ☐ Age
- ☐ Cognitive ability
- ☐ Behavior
- ☐ Mental or physical disability
- ☐ Health status
- ☐ Receipt of health care
- ☐ Use of services
- ☐ Claims experience
- ☐ Appeals
- ☐ Medical history
- ☐ Genetic information
- ☐ Evidence of insurability
- ☐ Geographic location within the service area

Under the PIHP, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.
We cannot deny services to you or punish you for exercising your rights.
For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697). You can also call the Michigan Department of Civil Rights at 1-800-482-3604. If you wish to file a complaint with the Michigan Department of Civil Rights please call 1-313-456-3700 or the toll free number listed previously.
If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

11. You have the right to physical accessibility to SWMBH and provider buildings

In accordance with federal and state laws, all buildings and programs of SWMBH are required to be physically accessible to individuals with all qualifying disabilities.

- Any individual who receives emotional, visual, or mobility support from a qualified/trained and identified service animal such as a dog will be given access, along with the service animal, to all buildings and programs of SWMBH. If you need more information or if you have questions about accessibility or service/support animals, contact Member Services.
- If you need to request an accommodation on behalf of yourself or a family member or a friend, you can contact Member Services. You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

12. We must ensure that you get timely access to services

As a member:

- You have the right to choose a provider in the network. A *network provider* is a provider who works with the PIHP. You also have the right to change your provider within the PIHP
  - Call Member Services or access the SWMBH website for the *Provider Directory* to learn which providers are accepting new patients.
- We do not require you to get referrals
- You have the right to get covered services from network providers within a reasonable amount of time
- You have the right to get emergency services or care that is urgently needed without prior approval
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see section 4.4
- Section 8.10 tells what you can do if you think you are not getting your services within a reasonable amount of time
- Section 8.7 also tells what you can do if we have denied coverage for your services and you do not agree with our decision

13. We must protect your personal health information

We protect your personal health information as required by federal and state laws. See section 1.12 for further information

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first*. Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on our quality of care.
    - We are required to give Medicare and Michigan Medicaid your health information. If Medicare or Michigan Medicaid releases your information for research or other uses, it will be done according to Federal and State laws.

14. You have a right to see your medical records (see section 1.12)

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a reasonable fee for making a copy of your medical records.
- You have the right to amend or correct information in your medical records. The correction will become part of your record.
- You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Program Integrity at (800)-783-0914.

15. The PIHP must provide you information about the PIHP, its network providers, and your covered services

As a PIHP member, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have. To get an interpreter, call us at 1-800-676-5814. This is a free service. *You have the right to get information in a way that meets your needs* for all accommodations of oral or written materials needs.

If you want any of the following, call Member Services:

- Information about MI Health Link
- Information about the PIHP, including:
    - Financial information
    - The number of grievances made by members
    - The number of appeals made by members

- Information about our network providers including:
  - How to choose or change primary providers
  - The qualifications of our network providers
  - How we pay the providers in our network

For a list of providers in the PIHP's network, see the *Provider Directory*. To obtain a copy of the Provider Directory or more detailed information about our providers call Member Services, or visit our website at www.swmbh.org

- Information about covered services and about rules you must follow, including:
  - Services covered by the PIHP
  - Limits to your coverage
  - Rules you must follow to get covered services
- Information about why something is not covered and what you can do about it, including:
  - Asking us to put in writing why something is not covered
  - Asking us to change a decision we made
  - Asking us to pay for a bill you have received

16. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. If a network provider tries to charge you for covered services, please call Member Services at 1-800-676-5814.

17. You have the right to leave your ICO- Aetna or Meridian at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave our plan, you will still be in the Medicare and Michigan Medicaid programs. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. If there is another MI Health Link plan in your service area, you may also change to a different MI Health Link plan and continue to receive the coordinated Medicare and Michigan Medicaid benefits. You can get your Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.

18. You have the right to make decisions about your treatment

You have the right to know your treatment options and make decisions about your care

You have the right to get full information from your providers and other health care professionals when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

- **Know your choices.** You have the right to be told about all the forms of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another provider before deciding on treatment.

- **You can say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from services. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You can ask us to cover a service that was denied or is usually not covered.** Section 8.6 tells how to ask the plan for a coverage decision.

19. You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you
- Give your provider written instructions about how you want them to handle your health care if you become unable to make decisions for yourself

The legal document that you can use to give your directions is called an *advance directive*. There are different types of advance directives and different names for them. Examples are a psychiatric advance directive and a durable power of attorney for health care.

Medical Advance Directive

This is also referred to as Durable Power of Attorney for Health Care. An advance directive is a tool for you to use to tell people of your wishes for your care. Some of the decisions you can make include: living wills, do not resuscitate (DNR) orders, or decisions about tissue or organ donation.

Psychiatric Advance Directive

Adults have the right, under Michigan law, to a "psychiatric advance directive." A psychiatric advance directive is a tool for making decisions before a crisis in which you may become unable to make a decision about the kind of treatment you want and the kind of treatment you do not want. This lets other people, including family, friends, and service providers, know what you want when you cannot speak for yourself. If you are interested in creating an advance directive, we can help you understand what it is and also help you to get these documents. Directives do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself. SWMBH does not have any moral objections and will not create any limitations to implementing an advance directive; however, there may be providers in our network who do. Please talk to your provider about their policies on advance directives.

All Advance Directive decisions are voluntary. If you do create an advance directive, you should give copies to:

- All providers caring for you;
- People you have named as a Medical or Mental Health Patient Advocate; and
- Family members or trusted friends who could help your doctors and behavioral health providers make choices for you if you cannot make those choices.

If you do not believe you have received appropriate information regarding Psychiatric Advance Directives from the SWMBH network, please contact the member services office to file a grievance.

Now is a good time to write down your advance directives because you can make your wishes known while you are healthy. Your doctor's office has an advance directive you fill out to tell your doctor what you want done. Your advance directive often includes a do-not-resuscitate order. Some people do this after talking to their doctor about their health status. It gives written notice to health care workers who may be treating you should you stop breathing or your heart stops. Your doctor can help you with this if you are interested.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Michigan Medicaid may also have advance directive forms. Forms can also be found on SWMBH's website: www.swmbh.org
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your provider. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

In Michigan, your advance directive has a binding effect on doctors and hospitals. However, if you believe that a doctor or a hospital did not follow the instructions in your advance directive, you may file a complaint with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services at 1-800-882-6006.

20. You have the right to make complaints and to ask us to reconsider decisions we have made

Section 8 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is not about discrimination for the reasons listed in section 5—you can get help in these ways:

- You can **call Member Services**
- You can **call the State Health Insurance Assistance Program (SHIP)**. In Michigan, the SHIP is called the Medicare/Medicaid Assistance Program (MMAP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP).

- MMAP is not connected with any insurance company or health plan
  - Call: 1-800-803-7174 This call is free.
  - Write: 6105 St Joe Hwy #204 Lansing Charter Township, MI 48917
  - Email: info@mmapinc.org
  - Website: http://mmapinc.org/
- You can call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can **call the MI Health Link Ombudsman program** 1-888-746-6456, Monday-Friday 8 a.m. to 5 p.m.

There are several ways to get more information about your rights:

- You can **call Member Services**
- You can **call MMAP.** See above for contact information
- You can **contact Medicare:**
  - You can visit the Medicare website to read or download "Medicare Rights & Protections." Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can **call the MI Health Link Ombudsman program** 1-888-746-6456, Monday-Friday 8 a.m. to 5 p.m.

5.2 You Have Responsibilities

As a member of the PIHP, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

1. Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.

- For details about your covered services, see section 6.4 and 6.5. Those sections tell you what is covered, what is not covered, what rules you need to follow, and what you pay.

2. Tell us about any other health coverage you have.

Please call Member Services to let us know.

- We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits*.
- For more information about coordination of benefits, see section 6.

3. **Tell your providers that you are enrolled in the MI Health Link.**
   - Show your plan ID card whenever you get services.

4. **Help your health care providers give you the best care.**
   - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
     - Make sure your providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, illicit drugs, vitamins, and supplements.
   - If you have any questions, be sure to ask. Your providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

5. **Be considerate.** We expect all our members to respect the rights of other members. We also expect you to act with respect in your providers' offices.

6. **Pay what you owe.** As a plan member, you are responsible for these payments:
   - Medicare Part A and Medicare Part B premiums. For most SWMBH members, Michigan Medicaid pays for your Part A premium and for your Part B premium.
   - If you get any services that are not covered by the PIHP, you must pay the full cost.
   - If you disagree with our decision to not cover a service, you can make an appeal. Please see section 8.7 to learn how to make an appeal.

7. **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
   - If you move *outside* of our plan service area, you cannot be a member of the PIHP. Section 1.3 tells you about our service area. We can help you figure out whether you are moving outside our service area.
   - If you move *within* our service area, we still need to know. We need to keep your membership record up to date and know how to contact you.

Call Member Services for help if you have questions or concerns.

Section 6
Southwest Michigan Behavioral Health Benefits and Covered Services

6.1 Understanding Your Covered Benefits

This section tells you what services SWMBH pays for. You can also learn about services that are not covered. This section also explains limits on some services.

You pay nothing for your covered services as long as you follow the plan's rules. See section 4.2 for details about the plan's rules. The only exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Human Services.
Depending on eligibility criteria, some items, supplies, supports, and services may be offered through SWMBH or the ICO- Aetna or Meridian. To ensure SWMBH and the ICO-Aetna or Meridian are not paying for the same items, supplies, supports or services, your Care Coordinator can help you get what you need from either SWMBH or the ICO. Services from the PIHP have different eligibility or medical necessity criteria.

If you need help understanding what services are covered, call your Care Coordinator and/or Member Services at 1-800-676-5814.

6.2 Southwest Michigan Behavioral Health Does Not Allow Providers to Charge You

We do not allow SWMBH providers to bill you for services. We pay our providers directly and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from an in-network provider. If you do, see section 7.

6.3 About the Benefits Chart

This benefits chart tells you which services SWMBH pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below. The only exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Health and Human Services.

- *Your Medicare and Michigan Medicaid covered services must be provided according to the rules set by Medicare and Michigan Medicaid.*
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- You get your care from a network provider. A network provider is a provider who works with the ICO. In most cases, the plan will not pay for care you get from an out-of-network provider. Section 4.4 has more information about using in-network and out-of-network providers.

Some of the services listed in the Benefits Chart are covered only if your doctor or other in-network provider gets approval from us first. This is called prior authorization. All services, except emergency services, will need prior authorization requested either from you or your provider.

Covered services that need a prescription from a doctor are marked in the Benefits Chart by an asterisk.

Please see your Aetna or Meridian Member Handbook for a complete list of Pharmacy Benefits, Drug List and ICO covered services.

All services, except emergency services, are subject to prior authorization by either you or your provider.

6.4 Benefit Chart

Mental Health- Medicare	What you must pay
Psychiatric diagnostic interviews	$0
Individual psychotherapy	$0
Inpatient behavioral health care The plan will pay for behavioral health care services that require a hospital stay.	$0
Interactive psychotherapy	$0
Family psychotherapy (with member present and the primary purpose is treatment of the individual's condition)	$0
Family psychotherapy (without the member present, is medically reasonable and necessary, and the primary purpose is treatment of the individuals condition)	$0
Group psychotherapy	$0

Mental Health- Medicare	What you must pay
Partial hospitalization services *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.	$0
Psychoanalysis	$0
Pharmacologic management	$0
Electroconvulsive therapy (ECT)	$0
Diagnostic psychological and neuropsychological tests	$0
Hypnotherapy	$0
Narcosynthesis	$0
Biofeedback therapy	$0
Individualized activity therapy (as part of a Partial Hospitalization Program (PHP) and that is not primarily recreational or diversionary.)	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
Assertive Community Treatment Provides basic services and supports essential for people with serious mental illness to maintain independence in the community. An ACT team will provide mental health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and Participate in social, educational and vocational activities. ACT may be provided daily for individuals who participate.	$0
Assessment Is conducted to determine a person's level of functioning and mental health and/or substance use/ abuse treatment needs. Assessments may include a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments. Physical health assessments are not part of this PIHP service.	$0
****Assistive Technology** Includes adaptive devices and supplies that are not covered under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.	$0
Behavior Treatment Review If a person's illness or disability involves behaviors that they or others who work with them want to change, their individual plan of services may include a plan that talks about the behavior. This plan is often called a "behavior treatment plan." The behavior management plan is developed during person-centered planning and then is approved and reviewed regularly by a team of specialists to make sure that it is effective and dignified and continues to meet the person's needs.	$0
Clubhouse Programs Are programs where members (customers) and staff work side by side to operate the clubhouse and to encourage participation in the greater community. Clubhouse programs focus on fostering recovery, competency, and social supports, as well as vocational skills and opportunities.	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
Community Inpatient Services Are hospital services used to stabilize a mental health condition in the event of a significant change in symptoms, or in a mental health emergency. Community hospital services are provided in licensed psychiatric hospitals and in licensed psychiatric units of general hospitals.	$0
Community Living Supports (CLS) Are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community. Community Living Supports may also help families who have children with special needs (such as developmental disabilities or serious emotional disturbance).	$0
Crisis Interventions Are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on mental health and well-being.	$0
Crisis Residential Services Are short-term alternatives to inpatient hospitalization provided in a licensed residential setting.	$0
****Enhanced Pharmacy** Includes doctor-ordered nonprescription or over-the-counter items (such as vitamins or cough syrup) necessary to manage your health condition(s) when your Medicaid Health Plan does not cover these items.	$0
****Environmental Modifications** Are physical changes to a person's home, car, or work environment that are of direct medical or remedial benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities. Note that all other sources of funding must be explored first, before using Medicaid funds for environmental modifications.	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
Family Support and Training Provides family-focused assistance to family members relating to and caring for a relative with serious mental illness, serious emotional disturbance, or developmental disabilities. "Family Skills Training" is education and training for families who live with and/or care for a family member who is eligible for the Children's Waiver Program.	$0
Fiscal Intermediary Services Help individuals manage their service and supports budget and pay providers if they are using a "self-determination" approach.	$0
Health Services Include assessment, treatment, and professional monitoring of health conditions that are related to or impacted by a person's mental health condition. A person's primary doctor will treat any other health conditions they may have.	$0
Home-based Services for Children and Families Are provided in the family home or in another community setting. Services are designed individually for each family, and can include things like mental health therapy, crisis intervention, service coordination, or other supports to the family.	$0
Housing Assistance Is assistance with short-term, transitional, or one-time-only expenses in an individual's own home that his/her resources and other community resources could not cover.	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
Intensive Crisis Stabilization Is another short-term alternative to inpatient hospitalization. Intensive crisis stabilization services are structured treatment and support activities provided by a mental health crisis team in the person's home or in another community setting.	$0
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Provide 24-hour intensive supervision, health and rehabilitative services, and basic needs to persons with developmental disabilities.	$0
Medication Administration Is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or topical medication.	$0
Medication Review Is the evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing their medicines.	$0
Mental Health Therapy and Counseling for Adults, Children and Families Includes therapy or counseling designed to help improve functioning and relationships with other people.	$0
Nursing Home Mental Health Assessment and Monitoring Includes a review of a nursing home resident's need for and response to mental health treatment, along with consultations with nursing home staff.	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
****Occupational Therapy** Includes the evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day and treatments to help increase these abilities.	$0
Partial Hospital Services Include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – participants go home at night.	$0
Peer-Delivered and Peer Specialist Services Peer-delivered services such as drop-in centers are entirely run by customers of mental health services. They offer help with food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer mentors help people with developmental disabilities.	$0
Personal Care in Specialized Services Assists an adult with mental illness or developmental disabilities with activities of daily living, self-care and basic needs, while they are living in a specialized residential setting in the community.	$0
****Physical Therapy** Includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.	$0
Prevention Service Models *(Such as Infant Mental Health, School Success, etc.)* Use both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public mental health system.	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
Respite Care Services Provide short-term relief to the unpaid primary caregivers of people eligible for specialty services. Respite provides temporary alternative care, either in the family home, or in another community setting chosen by the family.	$0
Skill-Building Assistance Includes supports, services, and training to help a person participate actively at school, work, volunteer, or community settings, or to learn social skills they may need to support themselves or to get around in the community.	$0
****Speech and Language Therapy** Includes the evaluation by a speech therapist of a person's ability to use and understand language and communicate with others or to manage swallowing or related conditions, and treatments to help enhance speech, communication, or swallowing.	$0
Supports Coordination or Targeted Case Management A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals and to help find the services and providers inside and outside the local community mental health services program that will help achieve the goals. A supports coordinator or case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.	$0
****Physical Therapy** Includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.	$0
Supported/Integrated Employment Services Provide initial and ongoing supports, services and training, usually provided at the job site, to help adults who are eligible for mental health services find and keep paid employment in the community.	$0

Mental Health- Medicaid ****requires a doctor prescription**	**What you must pay**
Transportation May be provided to and from a member's home for non-medical Medicaid-covered services. Please talk with your supports coordinator about this.	$0
Treatment Planning Assists the person and those of his/her choosing in the development and periodic review of the individual plan of services.	$0
Wrap Around Services for Children and Adolescents Children with serious emotional disturbance and their families that include treatment and supports necessary to maintain the child in the family home.	$0

Substance Use Disorder- Medicare	**What you must pay**
Outpatient substance use disorder services We will pay for treatment services that are provided in the outpatient department of a hospital if you, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or if you require treatment but do not require the level of services provided in the inpatient hospital setting.	$0
Psychotherapy	$0
Patient education regarding diagnosis and treatment	$0
Prescription drugs administered during a hospital stay or injected at a doctor's office • this may include Methadone if provided in a hospital setting but not an outpatient clinic	$0

Substance Use Disorder- Medicare	What you must pay
Outpatient prescription drugs covered under Part D except Methadone for the treatment of substance use disorder.	$0
Structured Assessment and Brief Intervention (SBIRT) Assessment to quickly determine the severity of substance use and identify the appropriate level of treatment. Brief intervention or advice focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.	$0

Substance Use Disorder- Medicaid	What you must pay
Access Management Access Consists of those responsibilities, associated with determining administrative and clinical eligibility, managing resources (including demand, capacity, and access), ensuring compliance with various funding eligibility and service requirements, and assuring associated quality of care. Activities to carry out these responsibilities include appropriate referral and linkage to other community resources.	$0
Compliance Monitoring For the purpose of identifying abstinence or relapse when it is part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing).	$0
Crisis Intervention A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if the intervention is not provided.	$0

Substance Use Disorder- Medicaid	What you must pay
Detoxification/Withdrawal Monitoring For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.	$0
Early Intervention Includes stage-based interventions for individual with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.	$0
Family Therapy Face to face counseling with the beneficiary and the significant other and/or traditional or nontraditional family members.	$0
Group Therapy Face to face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities.	$0
Individual Treatment Planning The beneficiary must be directly involved with developing the plan that must include Recovery Support Preparation/Relapse Prevention Activities.	$0
Individual Therapy Face to face counseling services with the beneficiary.	$0
Intensive Outpatient (IOP) Is a service that provides more frequent and longer counseling sessions each week and may include day or evening programs.	$0
Outpatient Treatment Includes therapy/counseling for the individual, and family and group therapy in an office setting.	$0

Substance Use Disorder- Medicaid	What you must pay
Peer Recovery and Recovery Support To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social, emotional and/or educational supportive services to help prevent relapse and promote recovery.	$0
Pharmacological and Alternative Therapies This may include Methadone treatment or other medication assisted treatment. Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, methadone stabilizes the individual so that other components of the recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills as the individual moves toward a substance-free lifestyle. Such service is monitored by a doctor as well as nursing services and lab tests.	$0
Referral/Linking/Coordinating of Services For the purpose of ensuring the follow-through with identified providers, to the address other needs identified as part of the assessment and/or to establish the beneficiary with another provider and/or level of care.	$0
Residential Treatment Is intensive therapeutic services which include overnight stays in a staffed licensed facility.	$0
Sub-Acute Detoxification Is medical care in a residential setting for people who are withdrawing from alcohol or other drugs.	$0

Substance Use Disorder- Medicaid	What you must pay
Substance Abuse Prevention Services A set of services and activities designed to: educate and empower individuals, develop systems, reduce access to minors, change conditions, create personal attributes and promote attitudes. The purpose of these services and activities is to promote healthy behaviors, delay the age of first use, reduce consumption and support recovery. SA Prevention services are provided in a variety of settings through education (school, community), media, community-based activities/collaborations, advocacy for change in institutional/ community practices, referral to other health services and through other activities leading to development of skills in critical domains of life.	$0
Targeted Case Management A Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals and to help find the services and providers inside and outside substance abuse services program that will help achieve their goals. A case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.	$0
Women's Specialty Services and Supports Include enhanced supports for pregnant women or women caring for dependent children to assist them in obtaining treatment for substance use disorders and attending physical health appointments.	$0

Home and Community Based Waiver Services - Medicare	What you must pay
Adult Day Program The plan covers structured day activities at a program of direct care and supervision if you qualify. This service provides personal attention and promotes social, physical, and emotional well-being.	$0
Assistive Technology The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include: • van lifts • hand controls • computerized voice system • communication boards • voice activated door locks • power door mechanisms • specialized alarm or intercom • assistive dialing device	$0
Chore Services The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include: • heavy household chores (washing floors, windows, and walls) • tacking loose rugs and tiles • moving heavy items of furniture • mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks.	$0
Environmental Modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include: • installing ramps and grab bars • widening of doorways • modifying bathroom facilities • installing specialized electric systems that are necessary to accommodate medical equipment and supplies	$0

Home and Community Based Waiver Services - Medicare	What you must pay
Expanded Community Living Supports To get this service, you MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, and guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself.	$0
Fiscal Intermediary Services The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community based services authorized in your plan of care. You have the authority to hire the caregiver of your choice.	$0
Home delivered meals The plan covers up to two prepared meals per day brought to your home if you qualify.	$0
Non-medical transportation The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify.	$0
Preventive Nursing Services The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may receive other nursing services during the nurse visit to your home. These services are not provided on a continuous basis.	$0

Home and Community Based Waiver Services - Medicare	What you must pay
Private Duty Nursing (PDN) The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service.	$0
Respite Care Services You may receive respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.	$0

Home and Community Based Waiver Services - Medicaid	What you must pay
Community Living Supports (CLS) Facilitates an individual's independence, productivity, and promotes inclusion and participation in the community.	$0
Enhanced Medical Equipment and Supplies Includes devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances.	$0
Goods and Services Is a non-staff service that replaces the assistance that staff would be hired to provide. This service, used in conjunctions with a self-determination arrangement, provides assistance to increase independence, facilitate productivity, or promote community inclusion.	$0
Out-of-home Non-Vocational Supports and Services Is assistance to gain, retain or improve in self-help, socialization or adaptive skills.	$0
Personal Emergency Response devices Help a person maintain independence and safety in their own home or in a community setting. These are devices that are used to call for help in an emergency.	$0
Prevocational Services Include supports, services, and training to prepare a person for paid employment or community volunteer work.	$0
Private Duty Nursing Is individualized nursing service provided in the home, as necessary to meet specialized health needs	$0

6.5 Services Not Covered by Southwest Michigan Behavioral Health

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not pay for these benefits.

The list below describes some services and items that are not covered by SWMBH under any conditions and some that are excluded by SWMBH only in some cases.

SWMBH will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Michigan Medicaid will not pay for them either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see section 8.7.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Member Handbook*, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Michigan Medicaid, unless these services are listed by our plan as covered services
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See section 4.8 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community
- Private duty nurses except for those that qualify for this waiver service
- Acupuncture
- Naturopath services (the use of natural or alternative treatments)
- Hospice services: If you choose to enroll in a hospice program, you will be dis-enrolled from SWMBH and receive all of your medical care and services through Original Medicare and Original (fee-for-service) Michigan Medicaid
- Non-emergency services provided to veterans in Veterans Affairs (VA) facilities
- Environmental intervention
- Geriatric day programs
- Individual psychophysiological therapy that incorporates biofeedback training (any modality)
- Marriage counseling
- Pastoral counseling
- Report preparation
- Interpretation or explanation of results or data
- Transportation and meals
- Telephone services

Section 7
Asking Southwest Michigan Behavioral Health To Pay A Bill You Received For Covered Services

7.1 When you can ask SWMBH to pay for your services

You should not get a bill for in-network services. Our network providers must bill the plan for your services and drugs already received. An in-network provider is a provider who works with SWMBH. If you get a bill for health care or drugs, send the bill to us. To send us a bill, see section 7.2.

- If the services are covered, we will pay the provider directly.
- You should never pay a bill without first contacting SWMBH or your ICO-Aetna or Meridian.
- If the services are not covered, we will tell you.
    - Contact Member Services or your Care Coordinator if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may be billed but need to contact SWMBH first:

1. **When you get emergency or urgently needed health care from an out-of-network provider, you should ask the provider to bill SWMBH.**
    - If you pay the full amount when you get the care, please contact SWMBH as soon as possible.
    - You may get a bill from the provider asking for payment that you think you do not owe. Contact SWMBH regarding the bill.
        - If the provider should be paid, we will pay the provider directly.
        - If you have already paid for the service, please contact SWMBH to discuss options.

2. **When an in-network provider sends you a bill**
    Network providers must always bill SWMBH.
    - Whenever you get a bill from a network provider, contact or send SWMBH the bill. We will contact the provider directly and take care of the problem.
    - If you have already paid a bill from a network provider, please contact SWMBH to discuss options.

When you send SWMBH a request for payment, we will review your request and decide whether the service should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service. If we deny your request for payment, you can appeal our decision.

- To learn how to make an appeal, see section 7.4.

7.2 How and Where to Send Your Request for Payment

Please contact us if you do receive a bill from a provider for services. If you have already paid for or made payment on the bill for the service, please contact SWMBH Claims Department for options. You can ask your Care Coordinator for help.

Mail your request for payment, together with any bills or receipts, to this address:

Southwest Michigan Behavioral Health
Claims Department
5250 Lovers Lane, Suite 200
Portage, MI 49002

You must submit your claim to us within 180 days of the date you received the service or bill.

7.3 We Will Make A Coverage Decision

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your service is covered by the plan. We will also decide the amount, if any, you have to pay for the service.

- We will let you know if we need more information from you.
  - If we decide that the service is covered and you followed all the rules for getting it, SWMBH will pay for it.
  - If you have already paid for the service, please contact SWMBH to discuss options.
  - If you have not paid for the service, please contact SWMBH to discuss options.
- Section 4.2 explains the rules for getting your services covered.
- If we decide not to pay for the service, SWMBH will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

To learn more about coverage decisions, see section 4.

7.4 You Can Make An Appeal

If you think SWMBH made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

- The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see section 8.6.
  - If you want to make an appeal about getting paid back for a health care service, go to section 8.13.

Section 8
What To Do If You Have A Problem Or Complaint (Coverage Decisions, Appeals, Complaints)

8.1 If you are facing a problem with your behavioral health or long term supports and services

You should receive the behavioral health care, drugs, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your individual plan of service. You should try to work with your providers and SWMBH first. If you are still having a problem with your care or our plan, you will be able to call the MI Health Link Ombudsman at 1-888-746-6456. To find out about the MI Health Link Ombudsman, visit www.swmbh.org or call Toll Free at 1-800-676-5814 or 711 MRC. This section will explain the different options you have for different problems and complaints.

8.2 What to do if you have a problem

This section will tell you what to do if you have a problem with your plan or with your services or payment. These processes have been approved by Medicare and Medicaid. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

8.3 What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination" or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

8.4 Where to Call for Help

Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the MI Health Link Ombudsman

If you need help getting answers to your questions or understanding what to do to handle your problem, you can call the MI Health Link Ombudsman. The MI Health Link Ombudsman is not connected with us or with any insurance company. They can help you understand which process to use. To find out about the MI Health Link Ombudsman, you can call MI Health Link Ombudsman directly at 1-888-746-6456, visit www.swmbh.org or Toll Free at 1-800-676-5814 or 711 MRC. The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). In Michigan the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP counselors can answer your questions and help you understand what to do to handle your problem. MMAP is not connected with us or with any insurance company or health plan. MMAP has trained counselors and their services are free. The MMAP phone number is 1-800-803-7174. You can also find information on MMAP's website at http://mmapinc.org.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Getting help from Medicaid

You can also call Medicaid for help with problems. Call the Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656), open Monday through Friday from 8:00 a.m. to 7:00 p.m.

8.5 Which process to use to help with your problem

Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care, behavioral health care, long term supports and services, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care, behavioral health care, long term supports and services, or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go to the next part of this section, Section 8.6, "Coverage decisions and appeals."	**No.** My problem is not about benefits or coverage. Skip ahead to Section 8.21 at the end of this section: "How to make a complaint."

8.6 Coverage decisions and appeals

Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your behavioral health services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.
If you or your providers are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before you get the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is not medically necessary for you. If you or your provider disagree with our decision, you can appeal.

8.7 Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- You can talk to your Care Coordinator at 1-800-676-0423.
- You can call us at Member Services at 1-800-676-5814 or 711 MRC.
- Talk to your doctor or provider. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Call the MI Health Link Ombudsman for free help. The MI Health Link Ombudsman can help you with questions about or problems with MI Health Link or our plan. The MI Health Link Ombudsman is an independent program, and is not connected with this plan. MI Health Link Ombudsman can be reached at 1-888-746-6456, Monday-Friday 8 a.m. to 5 p.m.
- Call the Michigan Medicare/Medicaid Assistance Program (MMAP) for free help. MMAP is an independent organization. It is not connected with this plan. The phone number is 1-800-803-7174.
- Talk to a friend or family member and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal. Your designated representative will have the same rights as you do in asking for a coverage decision or making an appeal.
- If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.swmbh.org. The form will give the person permission to act for you. You must give us a copy of the signed form. You do not need to submit this form for your doctor or other provider to act as your representative.

- You also have the right to ask a lawyer to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you choose to have a lawyer, you must pay for those legal services. However, some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
- However, you do not need a lawyer to ask for any kind of coverage decision or to make an appeal.

8.8 Which section will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow.

- Section 8.9 gives you information if you have problems about services or items. For example, use this section if:
  - You are not getting behavioral health care or other supports and services that you want and you believe that this care is covered by our plan.
  - We did not approve services, items, or drugs that your provider wants to give you and you believe that this care should be covered and is medically necessary.
  - You received medical care or other supports and services that you think should be covered, but we are not paying for this care.
  - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.

NOTE: If the coverage that will be stopped is for medical hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to refer to your Aetna or Meridian handbooks for more information.

- Section 8.14 gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.

If you're not sure which section you should be using, please call your Care Coordinator at 1-800-676-0423 or Member Services at 1-800-676-5814 or 711 MRC. You can also get help or information from the MI Health Link Ombudsman. For information about the MI Health Link Ombudsman please call 1-888-746-6456, visit www.swmbh.org or call Toll Free at 1-800-676-5814 or 711 MRC.

8.9 Problems about behavioral health services and items

When to use this section

This section is about what to do if you have problems with your benefits for your behavioral health care or other supports and services.
This section tells what you can do if you are in any of the five following situations:

1. **You think the plan covers a behavioral health service or other supports and services that you need but are not getting.**

   What you can do: You can ask the plan to make a coverage decision. Go to Section 8.10 for information on asking for a coverage decision.

2. **The plan did not approve care your provider wants to give you and you think it should have.**

   What you can do: You can appeal the plan's decision to not approve the care. Go to Section 8.6 and 8.7 for information on making an appeal.

3. **You received services or items that you think the plan covers, but the plan will not pay.**

   What you can do: You can appeal the plan's decision not to pay. Go to Section 8.6 for information on making an appeal.

4. **Your coverage for a certain service is being reduced or stopped and you disagree with our decision.**

   What you can do: You can appeal the plan's decision to reduce or stop the service.

NOTE: If the coverage that will be stopped is for hospital care, read section 8.14 to find out more.

In all cases where we tell you that behavioral health care you have been getting will be stopped, use the information in Section 8.7 as your guide for what to do.

8.10 Asking for a coverage decision

How to ask for a coverage decision to get behavioral health care

To ask for a coverage decision, call, write, or fax us, or ask your representative or provider to ask us for a decision.

- You can call us at: 1-800-676-0423 or 711 MRC
- You can fax us at: 269-441-1234
- You can to write us at: Southwest Michigan Behavioral Health
  Utilization Management
  5250 Lovers Lane, Suite 200
  Portage, MI 49002

➔ **Please note:** Your Integrated Care Organization (ICO) will make coverage decisions for medical care, long term supports and services, and drug coverage. Contact your ICO for more information. See section 2 for that contact information.

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you, your representative, or your provider asked. If we don't give you our decision within 14 calendar days, you can appeal.

Sometimes we need more time and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

> ***The legal term** for "fast coverage decision" is **"expedited determination."***

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you, your representative, or your provider should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 72 hours**.

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-800-676-0423 or 269-441-1234. For the details on how to contact us, go to Section 2.1.
- You can also have your provider or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision *only* if you are asking about coverage for services or items *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for behavioral health care or an item you have already received.)
- You can get a fast coverage decision only if the standard 14 calendar day deadline could *cause serious harm to your health or hurt your ability to function*.

If your provider says that you need a fast coverage decision, we will automatically give you one.
If you ask for a fast coverage decision, without your provider's support, we will decide if you get a fast coverage decision.

- If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline instead.

- This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see section 8.21.)

How will I find out the plan's answer about my coverage decision?

We will send you a letter telling you whether or not we approved coverage.

If the coverage decision is *Yes*, when will I get the service or item?

You will be approved (pre-authorized) to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is *No*, we will send you a letter telling you our reasons for saying *No*.

- If we say no, you have the right to ask us to reconsider – and change – this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.

- If you decide to make an appeal, it means you are going on to the Internal Appeals Process (see Section 8.11 below). You also have the right to ask for a Fair Hearing if the coverage decision was for a service or item that could be covered by Medicaid (see Section 8.12).

➔ **Please note:** SWMBH does not specifically reward practitioners or other individuals for issuing denials of coverage and financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

8.11 Appeal for Behavioral Health covered services and items

What is an appeal?

An *appeal* is a formal way of asking us to review a coverage decision (denial) or any adverse action that we took. If you or your provider disagrees with our decision, you can appeal.

➔ **Please note:** Your Integrated Care Organization (ICO) will make coverage decisions for medical care, long term supports and services and drug coverage. Contact your ICO for more information. See section 2 for that contact information.

What is an adverse action?

An adverse action is an action, or lack of action, by SWMBH that you can appeal. This includes:

- We denied or limited a service your provider requested;
- We reduced, suspended, or ended coverage that was already approved;
- We did not pay for an item or service that you think is covered;
- We did not resolve your service authorization request within the required timeframes;
- You could not get a covered service from a provider in our network within a reasonable amount of time; or
- We did not act within the timeframes for reviewing a coverage decision and giving you a decision.

What is an Internal Appeal?

An Internal Appeal (also called a Level 1 Appeal) is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing and tell you what you can do next if you disagree with the decision.

You can ask for a "standard appeal" or a "fast appeal."

➔ **Please note:** If your problem is about a Medicaid service or item, you can also file a request for a Fair Hearing with the Michigan Administrative Hearing System (MAHS) before, during, after, or instead of the Internal Appeal to SWMBH. You must ask for a Fair Hearing within 90 days from the date on the letter that told you the service was denied, reduced, or stopped. For more information on the Medicaid Fair Hearings process, see Section 8.12.

How do I make an Internal Appeal?

- To start your appeal, you, your representative, or your provider must contact us. You can call us at 1-800-676-5814. For additional details on how to reach us for appeals, see section 8.7.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  - o You can submit a request to the following address:
    Southwest Michigan Behavioral Health
    Member Services
    5250 Lovers Lane, Suite 200
    Portage, MI 49002
  - o You may also ask for an appeal by calling us at 1-800-676-5814.

The legal term** for "fast appeal" is **"expedited reconsideration."

Can someone else make the appeal for me?
Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or www.swmbh.org.

If the appeal comes from someone besides you or your provider, we must receive the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an Internal Appeal?
You must ask for an Internal Appeal within 60 calendar days from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you were in the hospital, or we gave you the wrong information about the deadline for requesting an appeal.

➔ **Please note:** If you are appealing because you were told that a service you are getting will be changed or stopped, you must ask for your appeal within 10 calendar days or prior to the date of action if you want your benefits for that service to continue while the appeal is pending. Read *"Will my benefits continue during Internal Appeals"* below for more information.

Can I get a copy of my case file?
Yes. Ask us for a copy.

Please contact SWMBH for more information on requesting a copy of your file.

Can my provider give you more information about my appeal?
Yes. Both you and your provider may give us more information to support your appeal.

How will the plan make the appeal decision?
We take a careful look at all of the information about your request for coverage of behavioral health care or other supports and services. Then, we check to see if we were following all the rules when we said No to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your provider for it.

When will I hear about a "standard" Internal Appeal decision?
We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your condition requires us to.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- If we do not give you an answer to your appeal within 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, go to Section 8.12.

If our answer is *Yes* to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal.

If our answer is *No* to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we automatically sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, go to Section 8.12.

What happens if I ask for a fast appeal?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get your appeal. We will give you our answer sooner if your condition requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If we do not give you an answer within 72 hours or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, go to Section 8.12.

If our answer is *Yes* to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

If our answer is *No* to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, go to Section 8.12.

Will my benefits continue during Internal Appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the proposed action. If you file your Internal Appeal (or External Appeal with MAHS on a Medicaid benefit) within 10 calendar days of the date on our notice or prior to the intended effective date of the action, we will continue your benefits for the service while the Internal Appeal is pending.

If you are appealing to get a new service from SWMBH then you would not get that service unless your appeal is finished and the decision is that the service is covered.

8.12 External Appeal for covered Behavioral Health services and items

If the plan says *No* to the Internal Appeal, what happens next?

If we say no to part or all of your Internal Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get an External Appeal with the Independent Review Entity (IRE) as soon as the Internal Appeal is complete.
- If your problem is about a **Medicaid** service or item, you can file an External Appeal yourself with the Michigan Administrative Hearings System (MAHS). The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get an External Appeal with the IRE. You can also ask for an External Appeal with MAHS.

What is an External Appeal?

An External Appeal (also called a Level 2 Appeal) is the second appeal, which is done by an independent organization that is not connected to the plan. Medicare's External Appeal organization is called the Independent Review Entity (IRE). Medicaid's External Appeal is a Fair Hearing through the Michigan Administrative Hearings System (MAHS).

My problem is about a Medicaid covered service or item. How can I make an External Appeal?

You can request a Fair Hearing to make an External Appeal for Medicaid services and items:

Fair Hearing

You have the right to request a Fair Hearing from the Michigan Administrative Hearings System (MAHS). A Fair Hearing is an impartial review of a decision made by SWMBH. You may request a Fair Hearing before, during, after, or instead of the Internal Appeal with SWMBH.

You must ask for a Fair Hearing within 120 calendar days from the date on the letter that told you that a Medicaid covered service was denied, reduced, or stopped. If you are asking for a Fair Hearing because the plan decided to reduce or stop a service you were already getting, you must file your appeal within 10 calendar days from the date of the adverse action notice or prior to the date of action if you want your benefits for that service to continue while the appeal is pending (see below in *Will My Benefits Continue During External Appeals* for more information).

To ask for a Fair Hearing from MAHS, you must complete a Request for Hearing form. We will send you a Request for Hearing form with the coverage decision letter. You can also get the form by calling the Medicaid Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656), open Monday through Friday from 8 a.m. to 7 p.m. Complete the form send it to:

Michigan Administrative Hearing System
Department of Community Health
PO Box 30763
Lansing, MI 48909
FAX: 517-373-4147

You can also ask for an expedited (fast) Fair Hearing by writing to the address or faxing to the number listed above.

After your Fair Hearing request is received by MAHS, you will get a letter telling you the date, time, and place of your hearing. Hearings are usually conducted over the phone, but you can request that your hearing be conducted in person.

MAHS must give you an answer in writing within 90 calendar days of when it gets your request for a Fair Hearing. If you qualify for an expedited Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

Following receipt of the MAHS final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court.

My problem is about a Medicare covered service or item. What will happen at the External Appeal?

An Independent Review Entity will do a careful review of the Internal Appeal decision, and decide whether it should be changed.

- You do not need to ask for the External Appeal. We will automatically send any denials (in whole or in part) to the Independent Review Entity. You will be told when this happens.
- The Independent Review Entity is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file. Please contact SWMBH for more information.

The Independent Review Entity must give you an answer to your External Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting behavioral health services or items.

However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

If you a had “fast appeal” at the Internal Appeal, you will automatically have a fast appeal at the External Appeal. The review organization must give you an answer within 72 hours of when it gets your appeal. However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

What if my service or item is covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your External Appeal to the Independent Review Entity. You can also submit an External Appeal to MAHS. Follow the instructions in section 8.12.

Will my benefits continue during External Appeals?

If we previously approved coverage for a service but then decided to reduce or stop the service before the authorization expired, you can continue your benefits during External Appeals in some cases.

- If the service is covered by **Medicare** and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the External Appeal process with the IRE.
- If the service is covered by **Medicaid**, your benefits for that service will continue if:
  - » You ask for an External Appeal from MAHS within 10 calendar days from the date of the letter that told you that the service would be reduced or stopped; or
  - » You qualified for continuation of benefits during your Internal Appeal and you ask for an External Appeal from MAHS within 10 calendar days from the date of our Internal Appeal decision.
- If the service could be covered by **both Medicare and Medicaid** and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the IRE review. You may also qualify for continuation of benefits during MAHS review if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) all entities that got your appeal (the IRE or MAHS) decide "no" to your request; or 3) the authorization expires or you receive all of the services that were previously approved.

How will I find out about the decision?

If your External Appeal went to MAHS for a Fair Hearing, MAHS will send you a letter explaining its decision.

➔ If MAHS says *Yes* to part or all of what you asked for, we must approve the service for you as quickly as your condition requires, but no later than 72 hours from the date we receive MAHS' decision.

➔ If MAHS says *No* to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal."

If your External Appeal went to the Independent Review Entity, it will send you a letter explaining its decision.

o If the Independent Review Entity says Yes to part or all of what you asked for, we must authorize the coverage as quickly as your condition requires, but no later than 72 hours from the date we receive the IRE's decision.

o If the Independent Review Entity says No to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I appealed to MAHS and/or the IRE and they have different decisions?

If MAHS and/or the IRE decide "yes" for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If your External Appeal went to MAHS for a Fair Hearing, you can appeal the decision within 30 days to the Circuit Court. You may also request a rehearing or reconsideration by MAHS within 30 days.
See Section 8.20 for more information on additional levels of appeal.

➔ **Please note:** Your benefits for the disputed service will not continue during the additional levels of appeal.

8.13 Payment problems

If you want to ask us for payment for behavioral health care, start by reading section 7 of this booklet: Asking us to pay a bill you have gotten for covered services or drugs. Section 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

How do I ask the plan to pay me back for medical services or items I paid for?

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item and we will check to see if you followed all the rules for using your coverage.

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we get your request.
  Or, if you haven't paid for the services or items yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying *Yes* to your request for a coverage decision.
- If the medical care is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item and explain why.

What if the plan says they will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 7.4. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.

o If we answer "no" to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity. We will notify you by letter if this happens.

o If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is Yes at any stage of the process after review by the IRE, we must send the payment you asked for to you or to the provider within 60 calendar days.

- If the IRE says No to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 8.12 for more information on additional levels of appeal.
- If we answer “no” to your appeal and the service or item is usually covered by Medicaid, you can file an External Appeal with MAHS yourself (see Section 8.12).

8.14 Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your symptoms.

During your hospital stay, your doctor and the clinical staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.” Our plan’s coverage of your hospital stay ends on this date.
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

8.15 Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights*. If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services (see section 2.2). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The *Important Message* tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does not mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-800-676-5814. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

If you need help, please call Member Services at 1-800-676-5814. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

8.16 Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make an appeal to change your discharge date, call KePRO (Michigan's Quality Improvement Organization) at: 1-855-408-8557 (TTY: 1-855-843-4776).

Call right away!

Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital after your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a Glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-855-408-8557 and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at 1-800-676-5814. You can also call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. You can also get help from the MI Health Link Ombudsman. For information about the MI Health Link Ombudsman please call 1-888-744-6456.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term** for "fast review" is **"immediate review."

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor and the hospital think it is right for you to be discharged on that date.

The legal term *for this written explanation is called the* **"Detailed Notice of Discharge."** *You can get a sample by calling Member Services at 1-800-676-5814. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/*

What if the answer is *Yes*?

- If the review organization says *Yes* to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the review organization says *No* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the review organization says *No* and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

8.17 Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach KEPRO at: 1-855-408-8557.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

***At a Glance:* How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization in your state and ask for another review.

What happens if the answer is *Yes*?

- We must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No*?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

8.18 What happens if I miss an appeal deadline?

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different*.

➔ **Please note:** Your Integrated Care Organization (ICO) will make coverage decisions for medical care, long term supports and services and drug coverage. Contact your ICO for more information about Alternate Appeals for medical health care, items and long term supports and services.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes* to your fast review**, it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No* to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.

  If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

***At a Glance:* How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term** for "fast review" or "fast appeal" is **expedited appeal."

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 8.21 tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

***At a Glance:* How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the Independent Review Entity says *Yes* to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary.
- If this organization says *No* to your appeal, it means they agree with us and that your planned hospital discharge date was medically appropriate.

  The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

8.19 Appeal options after Level 2 or External Appeals

Next steps for Medicare services and items

If you made a Level 1 or Internal Appeal and a Level 2 or External Appeal for Medicare services or items and both of your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MI Health Link Ombudsman. MI Health Link Ombudsman is available Monday-Friday 8 a.m. to 5 p.m. You can contact MI Health Link Ombudsman at 1-888-744-6465 or e-mail MI Health Link Ombudsman at HELP@mhlo.org

8.20 Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medicaid.

If your appeal went to the Michigan Administrative Hearings System (MAHS) for a Fair Hearing, MAHS will send you a letter explaining its decision. If you disagree with the MAHS final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MAHS at 1-877-833-0870 for information about requirements you must meet to qualify for a rehearing/reconsideration.

If you need assistance at any stage of the appeals process, you can contact the MI Health Link Ombudsman. MI Health Link Ombudsman is available Monday-Friday 8 a.m. to 5 p.m. You can contact MI Health Link Ombudsman at 1-888-744-6465 or e-mail MI Health Link Ombudsman at HELP@mhlo.org

8.21 How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the types of problems handled by the complaint process:

Complaints about quality

- You are unhappy with the quality of care, such as the care you received from a provider.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

At a glance: **How to make a complaint**

Call Member Services or send us a letter telling us about your complaint.

➔ If your complaint is about *quality of care*, you have more choices. You can:

1. Make your complaint to the Quality Improvement Organization,
2. Make your complaint to Member Services and to the Quality Improvement Organization, or
3. Make your complaint to Medicare.

Complaints about poor customer service

- A behavioral health care provider or staff was rude or disrespectful to you.
- SWMBH staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical accessibility

- You cannot physically access the health care services and facilities in a provider's office.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by behavioral health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital, or provider's office is not clean.

Complaints about language access

- Your provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term *for "complaint" is a* ***"grievance."***

The legal term *for "making a complaint" is a* ***"filing a grievance."***

8.22 Details and deadlines

You can make an Internal Complaint and/or an External Compliant. An Internal Complaint is reviewed by SWMBH. An External Complaint is reviewed by an organization that is not affiliated with our plan. Read this section for more information about Internal Complaints. The different types of External Complaints are described in the sections that follow.

➔ **Please note:** Your Integrated Care Organization (ICO) will make coverage decisions for medical care, long term supports and services, and drug coverage. Contact your ICO for information about Internal Complaints about medical care.

How to file an Internal Complaint with SWMBH

- Call Member Services Toll Free at 1-800-676-5814 or 711 MRC. If you are requesting action regarding a Medicare issue, the complaint must be made within 90 calendar days after you had the problem you want to complain about.
- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

The legal term** for "fast complaint" is an **"expedited grievance."

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If we do not agree with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

8.23 You can file complaints with the Office of Civil Rights

If you have a complaint about disability access or about language assistance, you can file a complaint with the Office of Civil Rights at the United States Department of Health and Human Services. The contact information for the Office of Civil Rights is:

233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
Fax: 312-886-1807
TDD: 1-800-537-7697

You can also contact the Michigan Department of Civil Rights at:

110 W. Michigan Ave., Suite 800
Lansing, MI 48933
Phone: 517-335-3165
Fax: 517-241-0546
TTY: 517-241-1965

You may also have rights under the Americans with Disability Act and under the Michigan Mental Health Code. You can also contact MI Health Link Ombudsman for assistance at 1-888-744-6456.

8.24 You can make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and also to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
The phone number for the Quality Improvement Organization is 1-855-408-8557 (TTY: 1-855-843-4776).

8.25 You can tell Medicare about your complaint

You can also send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

8.26 You can tell Medicaid about your complaint

You can also send your complaint to Medicaid. You can call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656), open Monday through Friday from 8 a.m. to 7 p.m.

8.27 You can tell the MI Health Link Ombudsman about your complaint

The MI Health Link Ombudsman also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we are required to provide. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan.

To find out about the MI Health Link Ombudsman, you can contact them at 1-888-744-6456 Monday through Friday from 8 a. m. to 5 p.m. or email them directly at HELP@mhlo. The services are free.

8.28 You can tell the State of Michigan if you have a problem with your provider

For complaints about how your provider follows your wishes, call 517-373-9196 or write to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Enforcement Division
P.O. Box 30454
Lansing, MI 48909-9897

Section 9
Ending Your Membership In MI Health Link

This section tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. You will still qualify for both Medicare and Medicaid benefits if you leave our plan.

9.1 When Can You End Your Membership In MI Health Link?

- You can end your membership in MI Health Link at any time. The change will be effective the first day of the next month after we get your request. For information on Medicare options when you leave our plan, see the table in section 9.4.
    - For information about your Medicaid services when you leave our plan, see the table in section 9.4 These are ways you can get more information about when you can end your membership:
- Call Michigan ENROLLS at 1-800-975-7630, Monday through Friday 8 a.m. to 7 p.m. TTY users should call 1-888-263-5897.
- Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at 1-800-803-7174.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

9.2 How Do You End Your MI Health Link Membership?

If you decide to end your membership, tell Michigan Medicaid or Medicare that you want to leave MI Health Link:

- Call Michigan ENROLLS at 1-800-975-7630, Monday through Friday 8 a.m. to 7 p.m. TTY users should call 1-888-263-5897; OR

- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in section 9.4.

9.3 How Do You Join A Different Plan?

If you want to keep getting your Medicare and Michigan Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call Michigan ENROLLS at 1-800-975-7630, Monday through Friday 8 a.m. to 7 p.m. TTY users should call 1-888-263-5897. Tell them you want to leave MI Health Link and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with MI Health Link will end on the last day of the month that we get your request.

9.4 If You Leave MI Health Link and You Don't Want Another Medicare-Medicaid Plan, How Do You Get Medicare and Michigan Medicaid Services

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave MI Heath Link, you will go back to getting your Medicare and Michigan Medicaid services separately.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE)"	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at 1-800-803-7174. You will automatically be dis-enrolled from MI Health Link when your new plan's coverage begins.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at 1-800-803-7174. You will automatically be dis-enrolled from MI Health Link when your Original Medicare coverage begins.
3. You can change to:	**Here is what to do:**
Original Medicare without a separate Medicare prescription drug plan **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union, or other source. If you have questions about whether you need drug coverage, call MMAP at 1-800-803-7174.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at 1-800-803-7174. You will automatically be dis-enrolled from MI Health Link when your Original Medicare coverage begins.

How you will get Michigan Medicaid services

If you leave the Medicare-Medicaid Plan, you will get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long term supports and services and behavioral health care. If you leave the Medicare-Medicaid Plan, you can see any provider that accepts Michigan Medicaid

9.5 Until You Leave MI Health Link You Will Continue To Receive Your Benefits

If you leave MI Health Link, it may take time before your membership ends and your new Medicare and Michigan Medicaid coverage begins. See section 9.1 for more information. During this time, you will keep getting your benefits and services through MI Health Link.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by MI Health Link until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

9.6 Your MI Health Link Will End Under Certain Situations

These are the cases when MI Health Link must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Michigan Medicaid. Our plan is for people who qualify for both Medicare and Michigan Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
- If you go to prison.
- If you lie about or withhold information about other insurance you have for prescription drugs.

We can make you leave MI Health Link for the following reasons only if we get permission from Medicare and Michigan Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in MI Health Link and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your ID card to get medical care.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

9.7 MI Health Link Cannot Ask You To Leave the Plan Due To Reasons Related To Your Health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

You can also call the Beneficiary Help Line at 1-800-642-3195 (or 1-866-501-5656 for TTY users), Monday through Friday, 8:00 a.m. to 7:00 p.m.

9.8 You Have The Right To File A Complaint If Your Membership Is Ended

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also see section 8.21 for information about how to make a complaint.

9.9 Where Can You Get More Information About Ending Your Membership with MI Health Link

If you have questions or would like more information on when we can end your membership, you can call Member Services at 1-800-676-5814.

Section 10 Legal Notices

10.1 Notice About Laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

10.2 Notice About Discrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information. You can also call the Michigan Department of Civil Rights at 1-800-482-3604.

10.3 Notice About Medicare As A Secondary Payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident, or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Section 11
Definitions

Access: The entry point to the Pre-Paid Inpatient Plan (PIHP), sometimes called an "access center," where Medicaid beneficiaries call or go to request behavioral health/substance use disorder services.

Action (Adverse Action): is a decision that negatively impacts your ability to get a service, or the amount of the service you want, when you want it. It may also mean that SWMBH did not make a decision about what services you would receive, or did not begin to provide you the services you were authorized, within certain time frames.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

Amount, Duration, and Scope: How much, how long, and in what ways the services that are listed in a person's plan of service/care plan/treatment plan.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Section 8.6 and 8.7 explains appeals, including how to make an appeal.

Authorization of Services: The process of SWMBH when we decide whether or not you will receive a service based on whether it is medically necessary.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services. We do not allow providers to "balance bill" you. Because MI Health Link pays the entire cost for your services, you should not get any bills from providers. Call Member Services if you get any bills that you do not understand.

Behavioral Health: Supports and services for adults with serious mental illness, children with serious emotional disturbance, people with intellectual/developmental disabilities, and people with substance use disorders.

Care Coordinator: One main person who works with you, with the ICO- Aetna or Meridian, and with your care providers to make sure you get the care you need.

Care plan: A plan for what supports and services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Section 2 explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, network providers, or network pharmacies.

Coverage decision: A decision about what benefits we cover. This includes decisions about services or the amount we will pay for your behavioral health services. Section 8.10 explains how to ask us for a coverage decision.

Covered services: The general term we use to mean all of the health care, long term supports and services, supplies, prescriptions and over-the-counter drugs, equipment, and other services covered by our plan.

Developmental Disability: Is defined by the Michigan Mental Health code meaning either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong. A state level review of members' disagreements with health plans' denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Community Health perform the reviews.

Grievance: A complaint you make about SWMBH or one of our network providers. A member's expression of dissatisfaction about issues other than an action (as defined above). This includes a complaint about the quality of your care.

Health plan (ICO): An organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

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

Inpatient: A term used when you have been formally admitted to the hospital for skilled behavioral services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated Health Care: The comprehensive monitoring and improvement of patient health through collaboration between previously separate health organizations; or providing holistic care for a person.

Long term supports and services (LTSS): Long term supports and services are services that help improve a long term condition. LTSS includes nursing home services as well as home and community-based services. The home and community-based services help you stay in your home so you don't have to go to a nursing home or hospital.

Medicaid: A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term supports and services and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See section 2.6 for information about how to contact Medicaid in your state.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat your condition or maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. The services, supplies, or drugs must meet accepted standards of medical practice. A specific service is determined medically (clinically) appropriate, necessary to meet needs, consistent with your diagnosis or health issue, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity includes those supports and services designed to assist you to attain or maintain a sufficient level of functioning to enable you to live in your community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease. People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See section 2.2 for information about how to contact Member Services.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services; medical equipment; behavioral health, substance use disorder, intellectual/developmental disability, and long term supports and services. They are licensed or certified by Medicare and by the state to provide health care services. We call them "network providers" when they agree to work with the ICO- Aetna or Meridian and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their services at home but who do not need to be in the hospital.

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman's services are free.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Section 8.10 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors,

hospitals, and other health care providers' amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Section 4.4 explains out-of-network providers or facilities.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

PIHP: An acronym for Prepaid Inpatient Health Plan. There are 10 PIHPs in Michigan that manage the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic areas. All 10 PIHPs are also community mental health services programs. Southwest Michigan Behavioral Health is the PIHP that covers the 8 counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren Counties.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the Benefits Chart in section 6.4.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See section 2.4 for information about how to contact the QIO for your state.

Self-Determination: Self-determination is an option available to enrollees receiving services through the MI Health Link HCBS home and community based waiver program. It is a process that allows you to design and exercise control over your own life. This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget." If you choose to do so, you would also have control over the hiring and management of providers.

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

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

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan's service area.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and in most cases, skilled rehabilitative services and other related health services.

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

Specialty Supports and Services: A term that means/defines Medicaid-funded mental health, developmental disabilities and substance abuse supports and services that are managed by the Pre-Paid Inpatient Health Plans.

State Medicaid agency: The Michigan Department of Community Health, Medical Services Administration. This is the agency that runs Michigan's Medicaid program, helping people with limited incomes and resources pay for medical care and long term supports and services.

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

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.