Agreement

Between

Macomb County Community Mental Health Services

and

Total Health Care

This Agreement is made between:

Macomb County Community Mental Health Services
22550 Hall Road
Clinton Township, MI 48036

and

Total Health Care
3011 W. Grand Blvd.
Suite 1600
Detroit, MI 48202

COORDINATION AGREEMENT BETWEEN THE MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES BOARD AND TOTAL HEALTH CARE

INTRODUCTION

This Agreement is entered into and made effective this **1st day of October, 2012**, by and between the Macomb County Community Mental Health Services Board (MCCMH), and Total Health Care (Health Plan). This Agreement shall supersede any and all previous or prior Care Coordination Agreements between MCCMH and the Health Plan. Unless otherwise specified in this agreement, reference to the MCCMH is intended to include all provider organizations that provide services directly or under a contract with the MCCMH, including Substance use disorder Services to pursuant to Attachment A, attached hereto, and incorporated by reference.

This agreement is intended to address coordinated service delivery for Behavioral Health and Substance use disorder Services.

All parties agree to manage this agreement with a goal to maximize the effective service delivery of medical/physical and behavioral health care to Medicaid Recipients who reside in the County of Macomb.

A. Legal Basis

Whereas, P.A. 352 of the Public Acts of 1996 permits the Michigan Department of Community Health to increase the enrollment of Medicaid-eligible persons in health plans on a capitated basis; and

Whereas, in order to expand enrollment, the Michigan Department of Community Health has established a competitive bid process that has resulted in contracts with health plans that are deemed to be qualified to provide specified health care services to Medicaid enrollees; and

Whereas, the majority of Medicaid-covered mental health services will be provided through arrangements between the Michigan Department of Community Health and selected behavioral health providers; and

Whereas, Community Mental Health Service Programs (CMHSPs) are designated as the Behavioral Health Provider under contract with the Michigan Department of Community Health and consistent with the Mental Health Code; and

Whereas, Health Plans and CMHSPs should coordinate and collaborate efforts in order to promote and protect the health of the Medicaid-enrolled population;

Now, therefore, the Health Plan and the CMHSP agree as follows:

B. Term of Agreement

This agreement will be effective on **October 1** in the year of **2012** and for a period not to exceed two years. Agreement will be subject to amendment due to changes in the contracts between the Michigan Department of Community Health and the Health Plan or the contract with the CMHSPs.

Upon signed agreement of both parties, the provisions of this agreement will be extended for a time frame consistent with the contract period of the Health Plan and the Michigan Department of Community Health. Either party may cancel the agreement upon 30 days written notice.

C. Administration and Point of Authority

The Health Plan shall designate in writing to the CMHSP the person who has authority to administer this agreement. The CMHSP shall designate in writing to the Health Plan the person who has authority to administer this agreement.

D. Areas of Shared Responsibility

In order to provide the most efficient and coordinated services to Medicaid enrollees, the responsibilities of the Health Plan and CMHSP will include:

1. Referral

Mutually Served Consumers

This refers to health plan members who also receive specialized CMHSP behavioral health services. Mutual consumer groups will be defined according to clinical criteria agreed upon between the individual CMHSP and the Health Plan. For adults with severe and persistent mental illness, and for children and adolescents with severe emotional disturbance, the criteria should be based upon the combination of diagnosis, degree of disability, duration, and prior service utilization. Services to be provided by the Health Plan and by the CMHSP may vary for different clinically-defined groups.

Entry to CMHSP Specialized Behavioral Health Services

This is the process of obtaining CMHSP approval for a health plan member to receive specialized behavioral health services from CMHSP. Specialized behavioral health services means those provided by a psychiatric hospital or inpatient unit of a community hospital, partial hospitalization services, or those unique services of CMHSP that support persons in community environments and/or provide alternatives to, or decrease the need for, psychiatric inpatient services or state facility services. These might include services such as assertive community treatment, specialized residential services, day program services, mental health clinic services, psychosocial rehabilitation services, homebased services, etc.

Services to Be Provided (Benefit Packages and Limitations)

The intent of establishing written procedures between Health Plans and CMHSPs is to assure service coordination and continuity of care for persons receiving services from both organizations. Therefore, it is essential that the parties define the service/coverage package that will be provided by each party to mutual consumers. This must also specify any limitations on amounts of services, including but not restricted to:

- emergency services;
- inpatient psychiatric hospital and other hospital services;
- outpatient mental health services;
- physician services, especially neurological assessments and treatment, diagnostics, and orders for therapies;
- pharmacy and laboratory services;
- therapies (physical, occupational, speech);
- mental health clinic services;
- personal care services including Home Help and specialized mental health personal care;
- substance abuse services; or
- transportation to medical services and to mental health services.

2. Interagency Assessment and Supports/Services Planning

This includes collaborative joint supports/services, and/or treatment planning activities of the consumer, the CMHSP, and the Health Plan regarding mental health services, specialty developmental disability services and medical services provided by each party to the mutual consumer.

It includes identifying responsibilities to, and processes for: joint service planning meetings, sharing of assessments and background information, employing person-centered processes to develop supports/services plans, assigning supports/services coordination responsibilities, ongoing monitoring (inclusive of health status), and communication about services rendered or additional services needed.

The two parties **must** establish a process for clinical staffings so the clinical staff of the two agencies meet on a regular basis to review the plans and status of mutual consumers.

The interagency treatment/supports planning process further involves sharing of written documents and verbal reports, and discussions at joint supports/services planning meetings.

3. Emergency Services

In accordance with the definition of emergency services described in Section II-I-1 of the Request for Proposal for Comprehensive Health Care Program, emergency services also include those services provided to a person suffering from an acute problem in behavior or mood that requires immediate intervention. The need for the intervention may be identified by the enrollee, the enrollee's family or social unit, other agencies or referral sources, or law enforcement personnel.

It is the responsibility of the Health Plan to ensure that emergency services are available 24 hours a day and 7 days a week. As part of its responsibilities to provide emergency services and mental health outpatient services, the Health Plan must make available mental health crisis services for its enrollees. This applies for all enrollees except those who are receiving specialized behavioral health services. If the emergency is of a medical/physical nature, it is the responsibility of the Health Plan.

The Health Plan has the responsibility to inform all enrollees of emergency service procedures for accessing emergency services, and to inform members of the designated by the Health Plan is not required.

It is the responsibility of the CMHSP to provide for emergency mental health services for all enrollees receiving specialized behavioral health services including:

- access by telephone 24 hours a day, 7 days a week - this number shall be made available to the Health Plan to provide to all enrollees; and
- provision for face-to-face services to persons in need of crisis evaluation, and admission screening for psychiatric inpatient admissions, intervention and disposition.

4. Pharmacy and Laboratory Services

All pharmacy and laboratory services are covered by the Health Plan. This includes drugs prescribed and laboratory services ordered by the Health Plan or by the behavioral health and developmental disability providers (CMHSP).

Prescriptions and Orders for Laboratory Services:

a. The Health Plan cannot restrict prescriptions written by the behavioral health physicians as long as:
   I. The drug prescribed is for the treatment of mental illness or substance abuse and any side effects of psychopharmacological agents.
   ii. The purchase is made from an approved Health Plan pharmacy.
b. The Health Plan cannot restrict orders for laboratory services to test for and monitor the medications prescribed by the behavioral health physician, except that the laboratory must be approved by the Health Plan.
c. The Health Plan and the CMHSP must develop approval mechanisms for other laboratory and imaging services (e.g., MRI, CAT scans, X-rays, etc).

Coordination:

a. The Health Plan and the CMHSP must develop procedures for notifying each other of prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete and up-to-date medication records.

b. The CMHSP, in cooperation with the Health Plan, is responsible to monitor and track pharmaceutical usage in order for the Health Plan to provide comprehensive data and information as required under contract with the Michigan Department of Community Health.

Pharmacies and Laboratories:

The Health Plan must ensure that pharmacy and laboratory services are easily accessible to the recipients of the specialized behavioral health services. Strategies to accomplish this include the location of pharmacies and laboratories in proximity to specialty service locations and/or public transportation, home delivery services, or other methods of the provision of these services. The CMHSP shall assist the Health Plan in identifying existing locations used by consumers and/or alternative delivery strategies.

Drug Formulary:

a. The Health Plan drug formulary for developmental disabilities and for behavioral health must include all of the drugs currently covered for the Medicaid FFS population.
b. The Health Plan must have a process to evaluate requests to add products not included in its drug formulary.

5. Medical Coordination

In order to coordinate the appropriate delivery of health care services to Medicaid enrollees, clarity regarding the respective responsibility is necessary. Both parties will develop referral procedures and effective means of communicating the need for individual referrals.

It is the responsibility of Health Plans to provide or arrange for a limited number of outpatient visits (20 visits). The Health Plan may contract with the CMHSP to provide this benefit. Payment for these services are the responsibility of the Health Plan.

It is the responsibility of the CMHSP to provide or arrange for all inpatient (including entry and exit from state facilities) services and specialty mental health services. Payment for these services will be the responsibility of the CMHSP and the Michigan Department of Community Health.

Health and Medical Services: A number of mutually served consumers will be jointly under the care of at least two physicians, namely the Health Plan primary health care physician and the specialty behavioral health physician. The treatment planning process must clearly define the respective responsibilities for these two physicians. On an individual consumer basis, other health-related services will need to be clarified. Such health-related services include nutrition/dietary, maintenance of health and hygiene, nursing services, teaching self-administration of medications, etc.

It is jointly the responsibility of the Health Plan and CMHSP to conduct utilization review for Medicaid enrollees. This is defined as the process of evaluating the necessity, appropriateness and efficiency of health care services. The information developed in this process is essential to the Quality Improvement Plans of each party.

6. Quality Improvement

Both parties agree that a set of Quality Improvement activities to monitor the coordination of services is necessary. The Quality Improvement process will establish performance standards that will be used to monitor access, coordination, outcome, and satisfaction of services.

7. Data and Reporting Requirements and Release of Information

Both parties will agree to coordinate the data sharing necessary for completing reporting requirements established through their respective contracts with the Michigan Department of Community Health. Such data sharing should involve performance indicators such as:

- mental health emergency services including pre-admission screening for psychiatric inpatient services;
- inpatient utilization;
- referrals to CMHSP specialized mental health services;
- pharmacy and laboratory utilization;
- coordination between the Health Plan and the CMHSP; and
- consumer/enrollee satisfaction with services and coordination.

Both parties shall agree to obtain any necessary signed releases of information from the enrollee so treatment information can be shared without impediment between the two parties to this agreement. The Mental Health Code stipulates that the holder of the mental health record may disclose information “as necessary in order for the recipient to apply for or

receive benefits."

8. Grievance and Complaint

Health Plans are required to establish internal processes for resolution of complaints and grievances from enrollee members. Medicaid enrollees may file a complaint or grievance on any aspect of service provided to them by the health plan or the health plan's contracted providers.

CMHSPs are required to establish second opinion mechanisms and internal recipient rights processes for resolution of complaints from consumers and others.

Both parties are responsible for informing the other about their consumer grievance and complaint process.

Both parties are responsible to provide information to Medicaid enrollee members regarding the health plan's grievance and complaint process and that of the CMHSP.

9. Dispute Resolution

The parties must specify the steps that the Health Plan or CMHSP must follow to contest a decision or action by the other party related to the terms of the agreement. The process should specify the responsibilities of the parties and time frame for each step.

The dispute resolution process should include:

For administrative decisions:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to the Michigan Department of Community Health regarding a disputed decision of a Health Plan, or for a disputed decision of a CMHSP.

For clinical decisions:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to a locally-established clinical review team comprised of Medical Directors, or their designees, from the CMHSP and the Health Plan.
- Appeal to a clinical review team consisting of medical professionals representing the Michigan Department of Community Health.

E. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state, and local laws, regulations, guidelines and directives.

F. Ongoing Education

MCCMH and the Health Plan agree to provide continuing education and information regarding specifics of this agreement, associated interface, coordination and operational

procedures to all levels of staff involved in the implementation of this agreement.

G. Indemnification

All liability to third parties, loss or damages, demands, costs or judgments arising out of activities or in any way related to the decisions of the Health Plan regarding service responsibility, limitations as to amount of services, emergency services, laboratory and imaging services or any services actually rendered by the Health Plan shall be the responbility of the Health Plan if the liability, loss or damage is caused by, or arises out of, the actions or failure to act on the party of the Health Plan, its officers, employees, or agents.

All liability to third parties, loss or damages as a result of claims, demands, costs or judgments arising out of activities to be carried out by MCCMH pursuant to the terms of this agreement shall be the responsibility of MCCMH, if the liability loss or damage is caused by, or arises out of, action or failure to act on the part of any MCCMH employee or agent, provided nothing herein shall be construed as a waiver of any public immunity by MCCMH, the County of Macomb, its agencies or employees, as provided by statute or court decisions.

H. Miscellaneous

a. No Waiver of Governmental Immunity

Notwithstanding any other provision in this agreement, no provision in this agreement is intended, nor shall any such provision be construed, as either waiving or constituting a waiver of any public or governmental immunity granted to MCCMH, the County of Macomb and/or any MCCMH representative as provided by applicable statutes and/or court decisions.

b. Third-Party Beneficiaries

Except as expressly provided herein for the benefit of the parties, this agreement does not, and is not intended to, create, by implication or otherwise, any direct or indirect obligation, duty, promise, benefit, right to be indemnified (i.e. contractually, legally, equitably, or by implication) and/or any right to be subrogated to or to be a direct or indirect beneficiary in or from either party's rights in this agreement and/or any other right, of any kind whatsoever, in favor or any third party.

c. Independent Contractor Status

The parties agree that all work and/or services performed by either party and/or any of its respective agents pursuant to this agreement shall be undertaken by each party as an independent contractor and not as an agent of the other. Nothing in this agreement shall be construed to create a partnership, joint venture, or agency relationship between the parties. Specific Substance Abuse services coordination, in addition to the above, or service exclusion, for Macomb County Medicaid recipients will be managed by Macomb County Community Mental Health and the Health Plan pursuant to Attachment A of this Agreement.

The terms of this agreement shall not supersede any provisions to the contrary in the respective contracts between either of the parties and MDCH

Total Health Care	Macomb County Community Mental Health
By:_____	By:_____
Randy Narowitz	John Kinch
Title: CEO	Title: Executive Director
Date:_____	Date:_____

Attachment A
Care Coordination of Substance use disorder Services

Macomb County Community Mental Health Services is the designated coordinating agency (CA) for substance use disorder services in Macomb County and is responsible for managing substance use disorder services to Medicaid recipients **who reside in the County of Macomb.** Therefore, references to Behavioral Health in this Coordination Agreement includes both mental health and substance use disorder services provided by MCCMH, **except for the following sections which pertain specifically to substance use disorder services.**

1. Entry to Macomb County Community Mental Health Substance use disorder Services

The Health Plan may refer an enrolled member for a screening to determine if that individual is eligible for medically necessary speciality substance use disorder services through the Medicaid Plan. In order to be clinically eligible for services, a consumer must be determined as meeting DSM-IV criteria for one of the substance-related disorders, as well as American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the level of care to be provided. Macomb CMH subcontracts with the following provider for **access** to Medicaid substance use disorder services and **coordination of care:**

CARE of Southeastern Michigan
31900 Utica Road
Fraser, Michigan 48026
(586) 541-2273 FAX (586) 541-2274
Toll-Free: (877) 484-8884

All Medicaid eligibles seeking substance use disorder services under the plan can call CARE for a screening and authorization for treatment.

2. Benefit Packages and Limitations

MCCMH is responsible for the following substance use disorder services for all Medicaid recipients residing in Macomb County, including those individuals who are simultaneously enrolled in the Health Plan:

- Substance use disorder screenings completed by CARE for admission authorizations to covered services
- Outpatient substance use disorder treatment (including individual, family and group)
- Intensive outpatient substance use disorder treatment
- Methadone/LAAM Assisted Treatment (FDA approved supports)
- Sub-acute detoxification is not a Medicaid covered service, but may be made available to Medicaid eligibles through other funds with CARE authorization. (Federal and State admission priorities apply)
- Residential treatment

The following Medicaid services are funded outside of this plan and are not the responsibility of MCCMH

- Acute detoxification is a hospital provided service, billed directly to MDCH.
- Laboratory services related to substance use disorder (except required Methadone/LAAM support) should be billed directly to MDCH by the Medicaid approved laboratory.
- Pharmacy Services for medications prescribed as a support to substance use disorder treatment are paid for either on a fee-for-services basis by MDCH (for recipients not in a capitated plan) or through the recipient's Health Plan (with prior authorization from the plan).

3. Emergency Services

Medicaid beneficiaries cannot be denied access to necessary emergency services in a hospital emergency room. Transportation, initial emergency screening and medical stabilization services in a hospital emergency room are not the responsibility of MCCMH. Acute medical detoxification services may be provided by an enrolled hospital without authorization from MCCMH. Such services will be billed directly by an enrolled hospital and will be reimbursed directly by MDCH in accordance with previously issued Medicaid acute medical detoxification criteria which remain in effect.

4. Laboratory

Specified laboratory tests related to authorized substance use disorder services other than Methadone and LAAM must be billed directly to the MDCH by a Medicaid enrolled laboratory. These procedures are paid fee-for-service and are not the responsibility of MCCMH or the Health Plan.

5. Pharmacy

Medications prescribed as a support to substance use disorder treatment, other than those used for opiod replacement therapy (methadone, LAAM), are paid for either on a fee-for-services basis by MDCH (for recipients who are not in a Health Plan) or through the recipients Health Plan. For recipients enrolled in a Health Plan, substance use disorder providers must obtain authorization for any necessary prescription medications related to substance use disorder treatment from the enrollee's primary care physician. Any additional procedures for substance use disorder programs to obtain authorization will be communicated by the Health Plan in writing to MCCMH.

6. Release of Information

All parties recognize and agree that information about substance use disorder clients is protected by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, requiring signed releases of information from members to facilitate sharing of substance use disorder treatment information regarding mutual clients.