

**Medicaid Managed Specialty  
Supports and Services  
1915 (b)/(c) Waiver Program**

Contract Attachment

P 6.4.5.1 A

**CMHSP/PIHP Model Agreement:  
Behavioral Health**

## **CMHSP/HP MODEL AGREEMENT: BEHAVIORAL HEALTH**

The agreements between the Health Plan and the local behavioral health contractor (CMHSP) must incorporate and address all of the items and areas listed and described below. These standard provisions are as follows:

- Legal Basis
- Term of Agreement
- Administration
- Areas of Shared Responsibility
- Referral
- Interagency Assessment and Supports/Services Planning
- Emergency Services
- Pharmacy and Laboratory Service Coordination
- Medical Coordination
- Quality Improvement Coordination
- Data and Reporting Requirements
- Grievance and Complaint Resolution
- Dispute Resolution
- Governing Laws

This agreement is made and entered into this \_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_ by and between \_\_\_\_\_ (Health Plan) and \_\_\_\_\_ (CMHSP).

### **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 \_\_\_\_\_ in the year \_\_\_\_\_ for a period not to exceed \_\_\_\_\_. 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 emergency phone number through member services materials and programs. Prior approval 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:
  - (1) The drug prescribed is for the treatment of mental illness or substance abuse and any side effects of psychopharmacological agents.
  - (2) 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. Signature**

Approved as to form by local Counsel.

