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County Executive

COMMUNITY MENTAL HEALTH
ADMINISTRATION
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DATE: August 21, 2014

TO: MCCMH Inpatient and Outpatient Contracted Service Providers

FROM: John L. Kinch
Executive Director

RE: **EXECUTIVE DIRECTIVE 2 / 2014**

Dual-Eligible (Medicare/Medicaid) Contract Providers

Effective August 25, 2014, all MCCMH inpatient and outpatient contract service providers who provide services to dual-eligible Medicare/Medicaid consumers shall comply with the attached Mandated Requirements Directive pertaining to the MI Health Link, also known as the Demonstration to Integrated Care for Persons Eligible for Medicare and Medicaid Project.

Pursuant to your contract with Macomb County Community Mental Health, compliance with MCCMH Executive Directives is a mandated provision of said contract.

Service provision to this population under the Demonstration Project is anticipated to be implemented on or about May 1, 2015.

In the interim, Network Provider meetings for contract providers who provide services to this dual-eligible population will be scheduled by MCCMH. Your attendance will be mandatory.

JLK:PJJ/maf
Attachment

Effective August 25, 2014, Macomb County Community Mental Health Services ("MCCMH" or "PIHP") hereby adopts the following Executive Directive which shall apply to all programs and contracts (including, but not limited to, the MI Health Link also know as Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid ("Demonstration")) under which MCCMH and its contracted providers who have executed a Specialty Services Contract or other similar agreement (each such contracted provider being an "Agency" or "Downstream Entity") provide Medicare services to Medicare beneficiaries, including those who are eligible for both Medicare and Medicaid ("Enrollees" or "enrollees" or "Covered Persons"). For purposes of the Demonstration, each Integrated Care Organization ("ICO" or "Plan") is a Medicare Advantage Organization, and MCCMH is a First Tier Entity, all as defined below.

MANDATED REQUIREMENTS EXECUTIVE DIRECTIVE

This MANDATED REQUIREMENTS EXECUTIVE DIRECTIVE ("Executive Directive") is deemed incorporated into each existing Specialty Services Contract and other contract between the MCCMH and any Agency. When any portion of this Executive Directive provides that a contract between MCCMH/PIHP and Agency/Downstream Provider must include a particular provision, the incorporation of this Executive Directive into the contract between MCCMH and the Agency shall be deemed to constitute the inclusion of such required provision. In the event and to the extent that any provision of this Executive Directive is determined to be out of compliance with any applicable statute, regulation, government program requirement, judicial decision, any contract to which PIHP is a party, or the Three-Way Contract between CMS, MDCH and any ICO with which MCCMH contracts, this Executive Directive shall be deemed automatically amended in such manner and to such extent necessary to eliminate such noncompliance and, as amended, shall be deemed incorporated into each existing Specialty Services Contract and other contract between the MCCMH and any Agency.

A. Michigan Statutory/Regulatory Requirements

1. PIHP and Agency are prohibited from seeking payment from Enrollees for services provided, except for applicable copayments and deductibles, which may be collected directly from Enrollees. [MI ADC R. 325.6345(2)]

2. PIHP and Agency must meet applicable licensure or certification requirements [MI ADC R. 325.6345(3)(a)]

3. PIHP and Agency must allow appropriate access to records or reports concerning services to Enrollees [MI ADC R. 325. 6345(3)(b)]

4. PIHP and Agency must cooperate with Plan's quality assurance activities. [MI ADC R. 325. 6345(3)(c)]

B. Medicare Regulatory Requirements

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or

Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"). Except as expressly provided herein, all other provisions of the contracts between the Board and the Medicare Advantage Organization and between the Board and the Agency not inconsistent with these Medicare Regulatory Requirements shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate PIHP of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of PIHP-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. PIHP and Agency will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal and State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. PIHP will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. PIHP may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. PIHP will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement between PIHP and an MA organization are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and PIHP or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay PIHP under the terms of the contract between the Plan and PIHP [42 C.F.R. §§ 422.520(b)(1) and (2)]. In accordance with 42 C.F.R. § 422.520(b), PIHP shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay PIHP for Covered Services rendered to Covered Persons in accordance with contract between the Plan and PIHP. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the PIHP Manual. Plan's payment of such interest shall be PIHP's sole remedy for Plan's failure to pay a Clean Claim within the applicable time period and shall be inclusive of any applicable penalties.

7. PIHP and any related entity, contractor or subcontractor, including but not limited to Agency, will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

C. Provisions Required by Three-Way Contract and Applicable to Demonstration

PIHP and each Agency agree to the following:

1. The delegated activities and reporting requirements, if any, are contained in the Agreement between the MA organization and PIHP. PIHP shall ensure compliance in any delegated activities with 42 C.F.R. §§ 422.504, 423.505, and 438.6(l), as applicable.

2. HHS, the Comptroller General, MDCH, MDCH's Office of Inspector General, the Medicaid Fraud Control Unit of the Michigan State Police, the Michigan Auditor General, and their designees, and other State and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities, including but not limited to each Agency. HHS, the Comptroller General, MDCH Office of Inspector General, the Medicaid Fraud Control Units of the Michigan State Police, the Michigan Auditor General, and or their designees', and other State and federal agencies with monitoring authority related to Medicare and Medicaid, retain the right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

3. PIHP and Agency shall not hold Enrollees liable for payment of any fees that are the obligation of ICO.

4. Any services or other activity performed by PIHP or any First Tier, Downstream and Related Entities, including but not limited to each Agency, shall be performed in accordance with the ICO's contractual obligations to CMS and MDCH.

5. The delegated activities and reporting requirements, if any are specified in the Agreement between the ICO and PIHP.

6. ICO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the MDCH or the ICO determine that PIHP has not performed delegated activities or reporting requirements satisfactorily.

7. The performance of the parties is monitored by ICO on an ongoing basis and ICO may impose corrective action as necessary.

8. PIHP and all First Tier, Downstream and Related Entities, including but not limited to each Agency agree to safeguard Enrollee privacy and confidentiality of Enrollee health records.

9. PIHP and all First Tier, Downstream and Related Entities including but not limited to each Agency must comply with all Federal and State laws, regulations and CMS instructions.

10. To the extent that PIHP or a First Tier, Downstream and Related Entities, including but not limited to each Agency, provides credentialing of medical Providers, such agreement shall contain the following language:

A. The credentials of medical professionals, including Agency, affiliated with the PIHP will be reviewed by ICO; or
B. The credentialing process will be reviewed and approved by ICO and ICO shall audit the credentialing process on an ongoing basis.

11. ICO retains the right to approve, suspend, or terminate any PIHP credentialed behavioral health Medicare provider including but not limited to Agency.

12. ICO has the right to terminate the ICO-PIHP Agreement for cause upon ninety (90) days' notice, and without cause only to the extent provided herein and permitted in ICO's contract with MDCH and CMS, and the PIHP and Agency shall be required to assist with transitioning

Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee. In the event of a for-cause termination, ICO must have an internal grievance procedure that allows the PIHP to contest the grounds for the termination prior to the effective date of the termination.

13. ICO shall provide a written statement to PIHP of the reason or reasons for termination for cause.

14. ICO is obligated to pay PIHP under the terms of the Agreement.

15. Services shall be provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

16. PIHP and Agency shall abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information.

17. PIHP and Agency shall ensure that medical information is released in accordance with applicable Federal and State law, or pursuant to court orders or subpoenas.

18. PIHP and Agency shall maintain Enrollee records and information in an accurate and timely manner.

19. PIHP and Agency shall ensure timely access by Enrollees to the records and information that pertain to them.

20. Enrollees will not be held liable for Medicare Part A and B cost sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

21. PIHP and Agency shall ensure that a medical PIHP Provider's, including Agency's, EMTALA obligations, if any, are fulfilled as described by law and/or in the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA.

22. PIHP and Agency shall not limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees.

23. ICO shall not refuse to contract or pay PIHP for the provision of Covered Services solely because PIHP or Agency has in good faith:

(a) communicated with or advocated on behalf of one or more of its prospective, current or former patients regarding the provisions, terms or requirements of the ICO's health benefit plans as they relate to the needs of such PIHP's patients; or
(b) Communicated with one or more of its prospective, current or former patients with respect to the method by which such PIHP or Agency is compensated by the ICO for services provided to the patient.

24. PIHP and Agency are not required to indemnify ICO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against ICO based on ICO's management decisions, utilization review provisions or other policies, guidelines or actions.

25. PIHP and Agency shall comply with all ICO's requirements and ICO Policies for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

26. ICO shall notify PIHP in writing of modifications in payments, modifications in Covered Services or modifications in ICO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of PIHP, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the ICO and PIHP or unless such change is mandated by CMS or MDCH without 30 days prior notice.

27. All First Tier, Downstream and Related Entities, including but not limited to Agency, must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities, including but not limited to Agency, shall not include incentive plans that include a specific payment made directly or indirectly to a PIHP or Agency as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Enrollee. First Tier, Downstream and Related Entities, including but not limited to Agency, shall comply with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a policy for ICO to identify and revoke or provide other specified remedies for any member of ICO's First Tier, Downstream and Related Entities, including but not limited to Agency, that does not comply with such provisions.

28. PIHP and Agency shall not bill Enrollees for charges for Covered Services other than co-payments, including pharmacy copayments, if applicable.

29. No payment shall be made by ICO to PIHP for a PIHP-Preventable Condition as defined in 42 C.F.R. § 447.26(b).

30. As a condition of payment, PIHP and Agency shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by ICO. PIHP and Agency shall comply with such reporting requirements to the extent PIHP or Agency directly furnishes services.

31. ICO shall monitor and ensure that all Utilization Management activities provided by a First Tier, Downstream, or Related Entity, including PIHP and Agency, comply with all provisions of ICO's Three-Way Contract with CMS and MDCH.

32. Contracts or arrangements with First Tier, Downstream and Related Entities, including but not limited to Agency, shall not include incentive plans that include a specific payment made directly or indirectly to a PIHP as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services.

33. ICO shall not impose a financial risk on PIHP for the costs of medical care, services or equipment provided or authorized by another Physician or health care PIHP unless such contract includes specific provisions with respect to the following:
(a) Stop-loss protection;

33. ICO shall not impose a financial risk on PIHP for the costs of medical care, services or equipment provided or authorized by another Physician or health care PIHP unless such contract includes specific provisions with respect to the following:

(a) Stop-loss protection;

(b) Minimum patient population size for the Physician or Physician group; and

(c) Identification of the health care services for which the Physician or Physician group is at risk.

34. All contracts or arrangements with First Tier, Downstream and Related Entities, including but not limited to Agency, for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

35. Nothing in this section shall be construed to restrict or limit the rights of ICO to include as Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding PIHP's status for religious nonmedical Providers.

36. PIHP shall meet all terms and requirements of ICO's Three-Way Contract that are applicable to PIHP.

37. PIHP and any subcontractors, including but not limited to Agency, shall cooperate with and utilize ICO's Quality Assurance requirements.

38. PIHP, any Affiliated Providers and Subcontractors, including but not limited to Agency, shall allow ICO to access the medical records of ICO Enrollees.