SUBJECT MHP-PIHP Coordination and Integration of Care		**CHAPTER** 06	**SECTION** 02	**SUBJECT** 02
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I. APPLICATION:

☐PIHP Board ☒CMH Providers ☐SUD Providers
☒PIHP Staff ☒CMH Subcontractors

II. POLICY STATEMENT:

It shall be the policy of Region 10 PIHP to provide coordination and integration of healthcare services which meet the contractual and regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) contract and the Center for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR).

This policy is achieved through coordination and integration of health care services between behavioral health providers and physical health providers, including Community Mental Health Service Programs (CMHSPs), Medicaid Health Plans (MHPs), and ancillary providers on an individual's care team, utilizing the person-centered planning process.

III. DEFINITIONS:

CareConnect360: A State of Michigan (SOM), secure, web-based application designed to facilitate care coordination and care integration for persons who are Medicaid beneficiaries.

Care Coordination: A set of activities designed to ensure needed, appropriate and cost effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:

- Outreach and contacts / communication to support patient engagement,
- Conducting screening, record review and documentation as part of Evaluation and Assessment,
- Tracking and facilitating follow-up on lab tests and referrals,
- Care Planning,
- Managing transitions of care activities to support continuity of care,
- Addressing social supports and making linkages to services addressing housing, food, etc., and
- Monitoring, Reporting and Documentation.

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Care Integration / Integrated Care: Integrated care takes place when the health care professionals simultaneously assess and address all health conditions based on a single interdisciplinary treatment plan tailored to the individual. Integrated care allows for health care professionals to more effectively understand and treat the whole person.

Interactive Care Plan: A coordinated behavioral healthcare and physical healthcare treatment plan for an individual involving the individual's PIHP, MHP, and CMHSP.

MHP-PIHP Collaboration Work Group: The entity comprised of representatives from Michigan PIHPs, Michigan MHPs, and MDHHS, that is tasked with creating systems and processes to meet MDHHS contractual MHP-PIHP integration of care requirements.

Shared Member: An individual receiving Medicaid services for behavioral healthcare from a PIHP and physical healthcare from an MHP.

Stratified Shared Member: An individual receiving Medicaid services for behavioral healthcare from a PIHP and physical healthcare from an MHP who has been identified as meeting the at-risk criteria agreed upon by the MHP-PIHP Collaboration Work Group.

IV. STANDARDS:

A. Care coordination and integrated healthcare aims to improve the quality of care, improve outcomes and control costs by acting together to develop and implement a plan to eliminate barriers and duplication of services. The foundation of care coordination and integration of healthcare is the timely communication of relevant health information among providers. Region 10 PIHP will:
    1. Promote care coordination and integrated healthcare initiatives to our participant CMHSPs.
    2. Inventory our participant CMHSPs regarding current plans to develop and provide co-located and integrated healthcare programs.
    3. Coordinate with our participant CMHSPs to assure IT system capability for supporting care coordination and integrated healthcare.
    4. Participate in the state-wide data analytics process and will work with our participant CMHSPs to ensure access to meaningful integrated healthcare data to enhance the quality of care for our consumers.
    5. Monitor the integrated healthcare efforts of our participant CMHSPs and will forward collected data as required by MDHHS and CMS.
    6. Work cooperatively with our partner MHPs to jointly identify priority needs populations for purposes of care coordination.
    7. Work to secure appropriate consents, share necessary electronic data, and conduct routine care coordination activities.
B. Each participant CMHSP will retain responsibility to develop models for integration and coordination of care which meet their unique demographics and are within best practice guidelines.

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C. Consumer information contained within CareConnect360 will be freely discussed and securely exchanged between MHP, PIHP, and CMHSP for purposes of care coordination without obtaining additional consumer consent. A PIHP or CMHSP shall not release consumer information from sources outside CareConnect360 or SUD information to an MHP without obtaining additional consumer consent.
D. Interactive care plan meetings are for the purposes of: reviewing the behavioral healthcare (non-SUD unless consumer consent has been obtained) and physical healthcare being provided to selected stratified shared members based on the information contained in CareConnect360, creation of interactive care plans for those selected stratified shared members, and for assignment of goals and tasks to MHP, PIHP, and/or CMHSP staff related to a consumer's interactive care plan. After an interactive care plan has been developed for selected stratified members, progress on assigned goals and tasks will be reviewed at subsequent interactive care plan meetings. Interactive care plan meetings are to be held monthly with each MHP, discussing a minimum of one case at each meeting.
E. On a monthly basis, Region 10 PIHP will generate stratified lists of shared members utilizing the Risk Stratification features available in CareConnect360. Stratified shared members will comprise the population that is to be considered for interactive care plans. Region 10 PIHP's top 10 stratified shared members meeting the at-risk criteria agreed upon by the MHP-PIHP Collaboration Work Group and stratified shared members identified through plan-to-plan discussions between Region 10 PIHP and our partner MHPs will be considered for interactive care plan meetings and interactive care plans. The at-risk stratification criteria agreed upon by the MHP-PIHP Collaboration Work Group is as follows:
    1. Highest Emergency Department visits in past 12 months (1st primary criteria)
    2. Lack of Primary Care Provider visit in past 12 months (2nd primary criteria)
    3. Highest number of chronic conditions (secondary criteria)
    4. Number of Inpatient visits (tertiary criteria)
    5. With a minimum of 1 per PIHP/MHP
F. The stratified list feature in CareConnect360 is used to identify the initial at-risk population that will be considered for interactive care plans. Additionally, the PIHP, MHP, and/or CMHSP may identify other shared members that may benefit from an interactive care plan. CMHSPs wishing to refer a shared member into the care coordination planning process should notify Region 10 PIHP.

V. PROCEDURES:

PIHP Responsibilities:

A. Region 10 PIHP will execute care coordination agreements with designated MHPs within our region.
B. Region 10 PIHP will actively participate in meetings of the MHP-PIHP Collaboration Work Group. Region 10 PIHP will provide updates to our participant CMHSPs on MHP-PIHP integration of care and key decisions made by the MHP-PIHP Collaboration Work Group via QAPIP Committees.
C. On a monthly basis, Region 10 PIHP will generate shared members lists utilizing the

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CareConnect360 Quick Analysis feature.

D. On a monthly basis, Region 10 PIHP will generate stratified lists of shared members utilizing the Risk Stratification features available in CareConnect360. Stratified shared members will comprise the population that is to be considered for interactive care plans.
E. Region 10 PIHP will notify participant CMHSPs via the Key Contact person of their consumers who are selected for interactive care plan meetings via stratified shared members lists, through PIHP/MHP plan-to-plan discussion, or by referral.
F. Region 10 PIHP will coordinate the scheduling of interactive care plan meetings involving the PIHP staff, MHP administrative and/or clinical staff, and CMHSP clinical staff. Interactive care plan meetings are to occur monthly.
G. Region 10 PIHP will create new interactive care plans as necessary within CareConnect360.
H. Documentation of interactive care plans is to be recorded in CareConnect360 on the member's Care Coordination page using the Interactive Care Plan feature.

CMHSP Responsibilities:

A. CMHSPs will identify a Key Contact person for MHP-PIHP integration who will be the primary point of contact for Region 10 PIHP.
B. CMHSP Key Contact persons will be responsible to identify their clinical personnel who will participate in interactive care plan meetings involving the PIHP, MHP, and CMHSP to discuss the selected individuals.
C. CMHSP clinical staff will participate in monthly interactive care plan meetings with PIHP / MHPs for all shared members having interactive care plans.
D. CMHSPs will ensure that their clinical staff participating in interactive care plan meetings have or obtain access to CareConnect360.
E. CMHSPs will update existing interactive care plans immediately following an interactive care plan meeting.

VI. REFERENCES:

N/A