A) **Network Provider Contracting-** Behavioral Health Providers

1. The ICO shall through a contract with the PIHP have an adequate network of behavioral health, intellectual/developmental disability, and substance use providers to meet the needs of the population, including their community mental health rehabilitative service needs. Examples of these types of providers include, but are not limited to, psychiatrists, clinical psychologists, licensed clinical social workers, outpatient substance use treatment providers, and residential substance use treatment providers for pregnant women, etc.

2. The PIHP and its providers must comply with and apply the United States Supreme Court's Olmstead decision which requires that Enrollees be served in the most integrated setting appropriate to their needs. Any appropriate home and community-based service options must be exhausted prior to an Enrollee's admission into an institution. The PIHP must have sufficient capacity to provide home and community-based services to meet the needs of Enrollees who choose to receive supports and services in community settings.

3. Enrollees must be assured choice of all Providers, including the PIHP Care Coordinator and others that will participate in their ICT.

B) **Network Provider Requirements**

1. Network providers must serve all Enrollees, as appropriate for their credentials.

2. All providers' physical sites must be accessible to all Enrollees as must all providers that deliver services in the Enrollees' locations.

3. All network providers that provide Medicare Covered Services must be enrolled as Medicare providers in order to submit Claims for reimbursement or otherwise participate in the Medicare program.

4. All network providers, including out-of-State network providers that provide Medicaid Covered Services must be enrolled in the Michigan Medicaid Program, if such Enrollment is required by MDCH's rules or policy in order to submit Claims for reimbursement or otherwise participate in the Michigan Medicaid program.

5. Providers of Medicaid covered behavioral health services must have the appropriate licensure and qualifications as outlined in the in the Michigan Public Health Code (MCL 330.1001) et seq. and the Michigan Medicaid Provider Manual.

6. Providers and facilities must be appropriately licensed or certified, as applicable, if required pursuant to the Michigan Public Health Code, 1978 PA 368, as amended, MCL 333.1101-333.25211.

C) Network Provider Credentialing, Recredentialing, and Board Certification

1. The PIHP's standards for licensure and certification shall be included in its participating Provider Network contracts with its providers which must be secured by current subcontracts or employment contracts.

2. The PIHP shall, ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted as appropriate for initial credentialing.

3. The PIHP shall ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other State or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;

4. The PIHP shall obtain disclosures from all network providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R.§ 1002.3, including but not limited to obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the PIHP for exclusions and provided to MDCH in accordance with this Contract, including this Section, and relevant State and federal laws and regulations; and

5. Include the consideration of performance indicators obtained through the quality improvement plan (QIP), UM program, Grievance and Appeals system, and Enrollee satisfaction surveys in the ICO's recredentialing process.

6. The PIHP shall require its providers to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or Children's Health Insurance Program, as described in 42 C.F.R. § 455.

7. The PIHP shall collect sufficient information from providers to assess compliance with the ADA. As necessary to serve Enrollees, provider locations where Enrollees receive services shall be ADA compliant. In addition, PIHP shall include within its network provider locations that are able to accommodate the unique needs of Enrollees.

8. Re-credentialing shall occur every three (3) years (thirty-six (36) months). At re-credentialing and on a continuing basis, the PIHP shall verify minimum credentialing requirements and monitor Enrollee Grievance and Appeals, quality of care and quality of service events, and medical record review. The re-credentialing process shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews UM information, and Enrollee satisfaction surveys.

D) PIHP Responsibilities

1. The PIHP ensures that Enrollees have access to the most current and accurate information by updating the online provider directory on a timely basis. This information includes provider compliance with the ADA in terms of physical and communications accessibility for Enrollees who are blind or deaf as well as other reasonable accommodations.

2. The PIHP must provide or arrange accessible care twenty-four (24) hours per day, seven (7) days per week. The PIHP must guarantee that Emergency Services are available twenty four (24) hours per day, seven (7) days per week.

3. The PIHP shall ensure that multilingual network providers and, to the extent that such capacity exists within the PIHP's Service Area, all Network Providers, understand and comply with their obligations under State or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist network providers to meet these obligations.

4. The PIHP shall ensure that Network Providers and interpreters/translators are available for those within the PIHP's Service Area who are deaf or vision- or hearing-impaired.

5. The PIHP shall ensure that its network providers have a strong understanding of disability, recovery, and resilience cultures.

6. The PIHP shall make best efforts to ensure that minority-owned or controlled agencies and organizations are represented in the Provider Network.

7. At the Enrollee's request, the PIHP shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.
8. Provider Contracting

9. If the PIHP declines to include individuals or groups of providers in its Provider Network, the PIHP must give the affected providers written notice of the reason for its decision.

10. The PIHP may not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et. seq., or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and §1001.1901;

11. The PIHP shall, at a minimum, check the MDCH health professions website at least twice per month for excluded providers.

12. The PIHP shall, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)] for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing.

13. If a provider is terminated or suspended from the MDCH Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the PIHP shall terminate, suspend, or decline a provider from its Provider Network as appropriate.

14. Upon notice from MDCH or CMS, the PIHP shall not authorize any providers who are terminated or suspended from participation in the Michigan Medicaid Program, Medicare, or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:

    a) The PIHP shall notify CMS and MDCH, when it terminates, suspends, or declines a provider from its Provider Network because of Fraud, integrity, or quality; and
    b) The PIHP shall notify CMS and MDCH on a quarterly basis when a provider fails credentialing or re-credentialing because of a program integrity or Adverse Action reason, and shall provide related and relevant information to CMS and MDCH as required by CMS, MDCH, or State or federal laws, rules, or regulations.

15. The PIHP shall maintain a protocol that shall facilitate communication to and from providers and the PIHP, and which shall include, but not be limited to, a provider newsletter and periodic provider meetings;

    a) Except as otherwise required or authorized by CMS, MDCH, or by operation of law, the PIHP shall ensure that providers receive thirty (30) calendar days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and
    b) The PIHP shall work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Strategic Work plan and all other requirements of this Contract.
    c) The PIHP shall perform an annual review to assure that the health care professionals under contract with the Network Provider are qualified to perform the services covered under this Contract.

E) <u>Network Provider Education and Training</u>

1. Prior to any Enrollment of Enrollees under this Contract and thereafter, the PIHP shall conduct network provider education regarding the PIHP's policies and procedures as well as the Demonstration.

a) The PIHP must educate its Provider Network about its responsibilities for the **integration and coordination** of Covered Services;
b) The PIHP must inform its Provider Network about its policies and procedures, especially regarding **in and out-of-network referrals**;
c) The PIHP must inform its Provider Network about its **service delivery model and Covered Services, flexible benefits, excluded services (carved-out) and, policies, procedures**, and any modifications to these items;
d) The PIHP must inform its Provider Network about the procedures and timeframes for **Enrollee Grievances and Enrollee Appeals**, per 42 C.F.R. § 438.414;
e) The PIHP must inform its Provider Network about its **quality improvement efforts** and the providers' role in such a program;
f) The PIHP must ensure that all network providers receive proper education and training regarding the **Demonstration t**o comply with this Contract and all applicable federal and State requirements. The PIHP shall offer educational and training programs that cover topics or issues including, but not limited to, the following:
    i. Eligibility standards, eligibility verification, and benefits;
    ii. The role of MDCH (or its authorized agent) regarding Enrollment and disenrollment;
    iii. Special needs of Enrollees that may affect access to and delivery of services, to include, at a minimum, transportation needs;
    iv. ADA compliance, accessibility and accommodations;
    v. The rights and responsibilities pertaining to Grievance and Appeals procedures and timelines; and
    vi. Procedures for identifying, preventing and reporting Fraud, waste, neglect, abuse, exploitation, and critical incidents;
    vii. References to Medicaid and Medicare manuals, memoranda, and other related documents;
    viii. Payment policies and procedures including information on no balance billing;
    ix. Cultural competencies;
    x. Person-Centered Planning Processes taking into consideration the specific needs of subpopulations of Enrollees;
    xi. Billing instructions which are in compliance with the Demonstration Encounter Data submission requirements; and,
    xii. Marketing practice guidelines and the responsibility of the provider when representing the ICO.

2. The PIHP must train or assure training of its behavioral providers on disability literacy, including, but not limited to the following information:

    a) Various types of chronic conditions prevalent within the target population;
    b) Awareness of personal prejudices;
    c) Legal obligations to comply with the ADA requirements;
    d) Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;
    e) Types of barriers encountered by the target population;

f) Training on the Person-Centered Planning Process and Self-Determination, the social model of disability, the Independent Living Philosophy, and the recovery model;
g) Use of evidence-based practices and specific levels of quality outcomes; and
h) Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.

F) Provider Manual

1. The Provider Manual shall be a comprehensive online reference tool for the provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, Claims and Encounter Data submission processes, and plan benefits.

2. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs and Enrollee rights, including Enrollees rights not to be balanced billed.

G) Provider Directory

1. The PIHP shall make its Provider Directory available to providers via the PIHP's website. Upon request, the PIHP must be able to provide a paper copy to providers.

2. The PIHP shall educate providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and Federal law to communicate with Enrollees and Potential Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

H) Network Provider Responsibilities

1. The Network Provider must offer options for independent facilitators for Person-Centered Planning, peer support specialists, and fiscal intermediaries to facilitate arrangements that support self-determination.

2. The Network Provider shall ensure that its providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities served by the PIHP. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.

I) Care Coordination Model

1. General
   a) The PIHP and its Network Providers and Supports Coordination Agencies shall offer Care Coordination services to all Enrollees to ensure effective integration and coordination between providers of medical services and supplies, behavioral health,

substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD), pharmacy.

b) The PIHP and its Network Providers and Supports Coordination Agencies contract will be monitored by the ICOs to ensure the PIHP and its Network Providers and Supports Coordination Agencies meets all delivery system requirements of the Demonstration and all Enrollees receive the appropriate Care Coordination services. The PIHP and its Network Providers and Supports Coordination Agencies will focus on providing services in the most integrated and least restrictive setting.

c) Wherever possible, the PIHP and its Network Providers and Supports Coordination Agencies must include a person familiar with the needs, circumstances and preferences of the Enrollee when the Enrollee is unable to participate fully in or report accurately to the ICT.

d) The PIHP and its Network Providers and Supports Coordination Agencies will be required to utilize the MI Care Connect and MHWIN (i.e. Care Bridge), the Care Coordination framework for the Demonstration. The Care Bridge includes a Care Coordination platform supported by web-based technology.
   i. The Care Bridge allows secure access to information and enables all Enrollees and members of the ICT to use and (where appropriate) update information.
   ii. Through the Care Bridge, the members of the Enrollee's ICT facilitate access to formal and informal supports and services identified in the Enrollee's IISCP developed through a Person-Centered Planning Process.
   iii. The approved electronic Care Coordination platform will include a mechanism to alert ICT members of emergency department use or inpatient admissions.
   iv. The approved electronic Care Coordination platform will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and provide for the exchange of data in a standard format.
   v. The Care Bridge includes an electronic Care Coordination Platform which will support an Integrated Care Bridge Record (ICBR) to facilitate timely and effective information flow between the members of the ICT.

2. Care Coordination services will provide for:

a) A person-centered, outcome-based approach, consistent with the CMS model of care and Medicare and Medicaid requirements and guidance.

b) The opportunity for the Enrollee to choose arrangements that support self-determination.

c) It is the Enrollee's right to determine the appropriate involvement of other members of the ICT in accordance with applicable privacy standards.

d) Medication Review and Reconciliation conducted at least annually and when there is a change in condition or transition between settings.

3. The ICO will include the appropriate PIHP Care Coordinators, Case Managers and Supports Coordinators in conducting the Level I Assessment if the Enrollee has been active in the PIHP system during the previous twelve (12) months or is currently residing in a nursing facility.

   a) The Level I Assessment and the validated screening tool for BH, SUD, I/DD, if applicable, will be used to determine need for a Level II Assessment, referral for PIHP services, or development of the IICSP.

   b) The ICO will make referrals according to the process identified in ICO/PIHP contract to the PIHP/BH system for Enrollees identified as having BH, SUD, and/or I/DD needs.

   c) The PIHP Care Coordinators, Case Managers and Supports Coordinators will conduct in person Level II Assessments for Enrollees identified as receiving services from the Habilitation Supports Waiver and/or the Specialty Services and Supports Program.

   d) The PIHP will coordinate service referrals to ICO or PIHP network providers or conduct further assessment as needed.

   e) The PIHP will document the results from the Level II assessment and referral in the ICBR.

4. Level II Assessment

   a) The ICO will collaborate with the PIHP Care Coordinators, Case Managers and Supports Coordinators to ensure that the Level II Assessment is conducted for Enrollees identified through the telephonic screen as needing referral to the PIHP for Level II Assessment.

   b) The PIHP Care Coordinators, Case Managers and Supports Coordinators will conduct a Level II using the following assessment tools:

      i. Supports intensity scale (SIS) for Enrollees with I/DD needs;
      ii. Level of care utilization system (LOCUS) for Enrollees with mental illness needs; and
      iii. American Society of Addiction Medicine (ASAM) tool for Enrollees with SUD needs.

   c) Level II Assessments will be conducted by professionally knowledgeable and trained PIHP Care Coordinators, Case Managers and Supports Coordinators, who have experience working with the population.

d) Any Level II Assessment that may have been completed prior to Enrollment by the PIHP Care Coordinators, Case Managers and Supports Coordinators may be adopted if it is not past the Reassessment date. The Level II Assessment should be reviewed to determine if it is complete, accurate and appropriate for the Enrollee's current status.

e) Level II Assessments will be conducted in person within fifteen (15) calendar days of completion of the Level I Assessment.

f) Level II Assessments will be documented in the ICBR and results used in the development of the IICSP.

5. Reassessments
   a) The ICO is responsible to ensure that an annual Reassessment for each Enrollee (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within twelve (12) months of the last Level I Assessment.

   b) If prior to the annual Reassessment, the Enrollee experiences a major change impacting health status, the ICO is required to reassess the Enrollee and review and revise the IICSP with members of the ICT as needed.

   c) The ICO is responsible to complete a Reassessment as often as desired by the Enrollee and update the IICSP with members of the ICT as needed.

   d) The PIHP Care Coordinators, Case Managers and Supports Coordinators are encouraged to conduct Reassessments in person.

   e) Level II Reassessments will be completed according to the Reassessment timeframe of the assessment tool utilized.

   f) Reassessments will be documented in the ICBR and results used in the development of the IICSP.

6. Individual Integrated Care and Supports Plan (IICSP)/Individual Plan of Service/Treatment Plan

   a) The PIHP Care Coordinators, Case Managers and Supports Coordinators, ICO Care Coordinator, the Enrollee, his or her family, caregiver or authorized representative, providers, and other ICT members develop a comprehensive, person-centered, written IICSP for each Enrollee.

   b) Every Enrollee must have an IICSP, unless the Enrollee refuses and such refusal is documented in the ICBR.

   c) If the Enrollee refuses the IICSP, at a minimum the ICO Care Coordinator or PIHP Care Coordinators, Case Managers and Supports Coordinators must provide his or her contact information to the Enrollee and re-visit the refusal at the time of Reassessment or a change of condition.

d) The ICO Care Coordinator/ PIHP Care Coordinators, Case Managers and Supports Coordinators, must complete the initial IICSP within ninety (90) calendar days of Enrollment.

e) Existing person-centered service plans or plans of care can be incorporated into the IICSP.

f) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators must review the adopted plan with the Enrollee to determine if revisions are necessary to address the Enrollee's goals and meet the Enrollee's needs.

g) The IICSP must be contained in the ICBR and shared with the Enrollee and the ICT.

7. IICSP Monitoring

a) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators will review the Enrollee's IICSP to ensure the IICSP continues to meet the Enrollee's needs and is updated accordingly.

b) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators must review IICSPs of high-risk Enrollees at least every thirty (30) calendar days.

c) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators must review IICSPs of moderate-risk Enrollees at least every ninety (90) calendar days.

d) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators must review IICSPs of low-risk Enrollees at least every one hundred and eighty (180) calendar days.

e) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators must update the Enrollee's IICSP at least annually, and more frequently if conditions warrant, or if an Enrollee requests a change.

f) The IICSP must:
   i. Focus on supporting the Enrollee to achieve personally defined goals in the most integrated setting;
   ii. Be developed following MDCH principles for person-centered planning;
   iii. Include the Enrollee's preferences for care, services, and supports;
   iv. Include the Enrollee's prioritized list of concerns, goals and objectives, and strengths;
   v. Include specific providers, supports and services including amount, scope, and duration;
   vi. Include a summary of the Enrollee's health status;

vii. Include the plan for addressing concerns or goals and measures for achieving the goals;

viii. Include person(s) responsible for specific interventions, monitoring, and Reassessment; and

ix. Include the due date for the interventions and Reassessment.

8. Integrated Care Team (ICT)

a) Every Enrollee shall have access to and input in the development of an Integrated Care Team (ICT) to ensure the integration of the Enrollee’s medical, behavioral health, and psychosocial care, and LTSS.

b) The ICT will be person-centered, built on the Enrollee’s specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and Cultural Competence, and dignity.

c) The ICT will honor the Enrollee’s choice about his or her level of participation. This choice will be revisited periodically by the ICO Care Coordinator as it may change.

9. Integrated Care Team Members

a) The ICO Care Coordinator will lead the ICT. It will be the responsibility of the ICO Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members. LTSS and PIHP Supports Coordinators will be members of ICTs (as applicable) to encourage communication and collaboration between ICOs, PIHPs and other providers. While the ICO Care Coordinator will be the lead of the ICT, the Enrollee may request his or her LTSS or PIHP Supports Coordinator to remain his or her main point of contact regarding the ICT.

b) Membership will include the Enrollee and the Enrollee’s chosen allies, ICO Care Coordinator, PCP, and LTSS Supports Coordinator and/or PIHP Supports Coordinator (as applicable). Additional membership on the ICT may vary depending on the changing needs of the Enrollee. The team may also include the following persons as needed and available:

i. Family caregivers and natural supports
ii. Primary care nurse care manage
iii. Specialty providers
iv. Personal care providers
v. Hospital discharge planner
vi. Nursing facility representative
vii. Others as appropriate

10. Integrated Care Team Responsibilities.

    a) The role of ICT is to work collaboratively with the Enrollee and other team members. The ICO Care Coordinator is responsible to assure the completion of these tasks. ICT members will:

        i. Ensure the IICSP is developed, implemented, and revised according to the Person-Centered Planning Process and the Enrollee's stated goals including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT;
        ii. Participate in the Person-Centered Planning Process at the Enrollee's discretion to develop the IICSP;
        iii. Collaborate with other ICT members to ensure the Person-Centered Planning Process is maintained;
        iv. Assist the Enrollee in meeting his/her goals;
        v. Monitor and ensure that their part of the IICSP is implemented in order to meet the Enrollee's goals;
        vi. Update the ICBR as needed pertinent to the ICT member's role on the ICT;
        vii. Review assessment, test results and other pertinent information in the ICBR;
        viii. Address transitions of care when a change between care settings occur;
        ix. Ensure continuity of care requirements are met; and
        x. Monitor for issues related to quality of care and quality of life.

    b) The operations of ICTs will vary depending on the needs and preferences of the Enrollee. An Enrollee with extensive service needs may warrant periodic meetings with all ICT members. An Enrollee with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator, PIHP and its Network Providers and Supports Coordination Agencies and other direct communication with ICT members.

    c) The ICT will adhere to an Enrollee's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for individuals in substance use disorder treatment, C.F.R. 42, Part 2.

11. PIHP Care Coordinators, Case Managers and Supports Coordinators Qualifications

    a) PIHP Care Coordinators, Case Managers and Supports Coordinators must have the experience, qualifications and training including MDCH required training appropriate to the needs of the Enrollee.

    b) ICO Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, substance use disorder, physical and developmental disabilities, issues related to accessing and using durable medical equipment as appropriate, available community services and public benefits, quality ratings and information about available options such as nursing facilities, applicable legal non-discrimination requirements such as the ADA, person centered planning, cultural competency, and elder abuse and neglect.

c) The PIHP Care Coordinators, Case Managers and Supports Coordinators must be either a Michigan:
   i. Licensed registered nurse;
   ii. Licensed nurse practitioner;
   iii. Licensed physician's assistant;
   iv. Licensed Bachelor's prepared social worker;
   v. Limited license Master's prepared social worker; or
   vi. Licensed Master's prepared social worker.

d) PIHP Care Coordinators, Case Managers and Supports Coordinators Training:

   i. PIHP Care Coordinators, Case Managers and Supports Coordinators will participate in train-the-trainer Person-Centered Planning educational opportunities.
   ii. PIHP Care Coordinators, Case Managers and Supports Coordinators will participate in train-the-trainer Self-Determination education opportunities.
   iii. The PIHP Care Coordinators, Case Managers and Supports Coordinators will participate, train and report on any other training required or offered by MDCH or its designee.

12. PIHP Care Coordinators, Case Managers and Supports Coordinators Responsibilities:

a) The PIHP Care Coordinators, Case Managers and Supports Coordinators will be responsible for Care Coordination for each Enrollee;

b) Support an on-going Person-Centered Planning Process;

c) Assess clinical risk and needs by conducting an assessment process that includes a Level II Assessment, inclusive of the Bio-Psychosocial Assessment, LOCUS, SIS and/or ASAM (as appropriate);

d) Facilitate timely access to primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the Enrollee, including referrals to address any physical or cognitive barriers or referrals;

e) Facilitate communication among the Enrollee's providers through the use of the Care Coordination Platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;

f) Notify ICT of the Enrollee's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;

g) Facilitate face-to-face meetings, conference calls, and other activities of the ICT as needed or requested by the Enrollee;

h) Facilitate direct communication between the provider and the Enrollee or the Enrollee's authorized representative and/or family or informal supports as appropriate;

i) Facilitate Enrollee and family education;

j) Coordinate and communicate, as applicable, with the ICO Care Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative supports and services are provided;

k) Collaborate with the ICO Care Coordinator to develop, with the Enrollee and ICT, following the Person-Centered Planning Process, an IICSP specific to individual needs and preferences, and monitor and update the plan at least annually or following a significant change in needs or other factors;

l) Coordinate and make referrals to community resources (e.g. housing, home delivered meals, energy assistance programs) to meet IICSP goals;

m) Perform ongoing Case Management and Supports Coordination;

n) Monitor the implementation of the IICSP with the Enrollee, including facilitating the Enrollee's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;

o) Advocate with or on behalf of the Enrollee as needed, to ensure successful implementation of the IICSP.

13. Support transitions in care when the Enrollee moves between care settings including:

a) The PIHP Care Coordinators, Case Managers and Supports Coordinators will contact the Enrollee once notified of an emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the IICSP to include additional supports and services to remain in or return to the community;

b) The PIHP Care Coordinators, Case Managers and Supports Coordinators will ensure immediate and continuous discharge planning including electronic and verbal communication with the Enrollee and ICT members following an Enrollee's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the Enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the

Enrollee has all necessary medications or prescriptions upon discharge, and conducting follow-up with the Enrollee and/or caregiver.

c) The PIHP Care Coordinators, Case Managers and Supports Coordinators shall make every effort to ensure that HCBS are in place upon hospital discharge. The Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to assure prompt initiation of appropriate HCBS.

d) The PIHP Care Coordinators, Case Managers and Supports Coordinators will inform the Enrollee of his or her right to live in the most integrated setting, inform the Enrollee of the availability of services necessary to support his or her choices, and record the home and community-based options and settings considered by the Enrollee.

14. Engage in other activities or services needed to assist the Enrollee in optimizing his or her health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status;

    a) Assure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits; and

    b) The ICO Care Coordinator must collaborate with the applicable PIHP Care Coordinators, Case Managers and Supports Coordinators when:
        i. The Enrollee has received services through a PIHP within the last twelve (12) months, or
        ii. A new Enrollee requests or is identified as having potential need for BH, I/DD, or SUD services.

15. PIHP Care Coordinators, Case Managers and Supports Coordinators Caseloads:

    a) The PIHP must ensure that the PIHP Care Coordinators, Case Managers and Supports Coordinator's caseload is reasonable to provide appropriate Care Coordination.

    b) The PIHP Care Coordinators, Case Managers and Supports Coordinators shall maintain contact with Enrollees as frequently as appropriate.
        i. Participate in conducting the Level II Assessment specific to the Enrollee's needs;
        ii. Participate on the Enrollee's ICT;
        iii. Develop, with the Enrollee and the ICT, an IICSP;
        iv. Ensure optimal utilization of information and community supports;
        v. Arrange services as identified in the IICSP;
        vi. Update the ICBR with current Enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery;

vii. Monitor service implementation, service outcomes, and the Enrollee's satisfaction;
viii. Collaborate with the ICO Care Coordinator to assist the Enrollee during transitions between care settings, including full consideration of all options; and
ix. Advocate for the Enrollee and support self-advocacy by the Enrollee.

16. Coordination Tools

a) Care Coordination Platform and Integrated Care Bridge Record (ICBR):

b) The PIHP Care Coordinators, Case Managers and Supports Coordinators will utilize a MI Care Connect/MHWIN Platform, supported by web-based technology, that allows secure access to information and enables all Enrollees and members of the ICT to use and (where appropriate) update information.

c) The PIHP Care Coordinators, Case Managers and Supports Coordinators will be required to share information with ICOs, across providers, and between ICOs through its Care Coordination Platform.

d) To minimize the duplicate data entry burden on providers that have already invested in certified electronic health records and who have or will soon achieve meaningful use stage one, two, or three compliance, the PIHP will also support automated electronic data exchange from providers using the Office of the National Coordinator (ONC) compliant protocols and formats.

e) The Care Coordination Platform will:
i. Manage communication and information flow regarding referrals, care transitions, and care delivery;
ii. Facilitate timely and thorough coordination and communication among the PIHP, the primary care provider, ICOs, and other providers; and
iii. Provide prior authorization information for services.
iv. The approved electronic Care Coordination Platform will generate and maintain an individualized Enrollee record referred to as ICBR including:
v. Current integrated condition list;
vi. Contact information for the PIHP Care Coordinators, Case Managers and Supports Coordinators ICO Care Coordinator and ICT members;
vii. Current medications list;
viii. The date of service and the name of the provider for the most recently provided services;
ix. Historical and current utilization and Claims information;
x. Initial screening, Assessments (Level I and Level II) and Reassessments;
xi. Service outcomes, including specialty provider reports, lab results, and emergency room visits;
xii. IICSP; and
xiii. Notes and correspondence across provider settings.

f) The Care Coordination Platform will allow PIHP Care Coordinators, Case Managers and Supports Coordinators and providers to post key updates and notify ICT members.

g) The PIHP will maintain the Care Coordination Platform (MI Care Connect/MHWIN) and address technological issues as they arise.

h) The PIHP is responsible for initiating an ICBR for the Enrollee and granting access to appropriate ICT members.

i) The PIHP will provide ICBR in paper format to the Enrollee upon request.

j) The PIHP will verify the accuracy of the ICBR and amend or correct inaccuracies. Corrections or amendments must be dated and attributed to the person making the change.

k) The PIHP will have a mechanism to alert ICT members of emergency department use or inpatient admissions using the electronic Care Coordination Platform or other methods such as telephonic notification.

17. Health Promotion and Wellness Activities

a) The PIHP Care Coordinators, Case Managers and Supports Coordinators must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behavior in the Medicare-Medicaid population. Interpreter services must be available for Enrollees who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to the following:
   i. Chronic condition self-management;
   ii. Smoking cessation;
   iii. Nutrition; and,
   iv. Prevention and treatment of alcohol and substance abuse.

18. Self-Determination

a) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators will offer Enrollees the opportunity to use arrangements that support Self-Determination for LTSS including the personal care benefit and appropriate waiver services.

b) The ICO/ PIHP Care Coordinators, Case Managers and Supports Coordinators will establish and submit policies and procedures to DWMHHA that develop and implement mechanisms for Enrollees to access arrangements that support Self-Determination consistent with MDCH requirements and guidance.

c) These policies and procedures will include provisions to:
   i. Inform the Enrollee of his or her right to use arrangements that support Self-Determination and document the Enrollee's decisions regarding these arrangements;
   ii. Reflect current statutory, policy and regulatory requirements related to arrangements that support Self-Determination including the authority to control an individual budget (with the assistance of a fiscal intermediary) and the right to employ (hire, manage, and when necessary fire) workers and contract with providers; and
   iii. Make personnel available to help inform, navigate, connect, and refer the Enrollees who are using arrangements that support Self-Determination.

19. Notification of Self-Determination Options

a) Enrollees must be informed of the option to self-direct their own services. The ICT must inform Enrollees of the option to self-direct their services when their IICSPs are created or updated.

b) Explanations of the Self-Direction Option must:
   i. Make clear that self-direction of services is voluntary and that Enrollees can choose the extent to which they would like to self-direct their services;
   ii. Provide the options to select self-directed supports or services; and
   iii. Provide an overview of the supports and resources available to assist Enrollees to participate to the extent desired in self-direction.