Mi Health Link

Implementation – Lessons Learned
Region 4

MACMHB Conference, Feb, 2015
Agenda

- Introductions
- Mi Health-Link
  - Background
  - Core objectives
  - Key components
  - Changes required to meet NCQA
  - Status and lessons learned
Introductions

Southwest Michigan Behavioral Health – Region 4

• Lori Ryland, Chief Clinical Officer
• Patrick Visser, Integrated Care Projects Mgr.
• Tim Dubois, IT Projects Mgr.
Overview

- New CMS-MDCH demonstration program that will integrate all Medicare and Medicaid benefits, rules, and payments into a single coordinated delivery system.
  - Authorized under Affordable Care Act of 2010.
  - 12 Participating States.

- Demonstration occurs in four PIHP regions of Michigan with 90,000 – 100,000 eligible duals.
  - Region 4 - Southwest Michigan Behavioral Health
    o Duals in SW Region: Appx. 18,000-21,000.
    o Integrated Care Organizations (ICOs) – Aetna; Meridian Health Plan.
  - Region 1 - Upper Peninsula
    o ICO - Upper Peninsula Health Plan.

Sources: MDCH
Background – Mi Health Link

Overview, cont’d.

- Regions 7 & 9 - Macomb and Wayne County
  o ICOs - AmeriHealth, CoventryCares, Fidelis SecureCare, Midwest Health Plan, Molina, and United Healthcare.

• Eligible Populations:
  - Age 21 or older,
  - Eligible for full benefits Medicare Part A, and enrolled under Parts B and D.
  - Receiving full Medicaid benefits; and
  - Reside in a Demonstration region.

Sources: MDCH
Overview, Cont’d – Enrollment Timeline

  • Letter explains ability to select an ICO, and other enrollee options including ability to dis-enroll from an ICO, opt out, or enroll in a different ICO.

• Opt-In Services Begin (Launch) for Region 1 & 4 on March 1.

• Passive Enrollment of eligible individuals if they do not opt-out.
  - Includes 60-day and 30-day notification letters beginning March 1.
  - Services start no earlier than May 1, 2015 for people passively enrolled.
  - Passive enrollees will be phased in over 2-3 months.

• Demonstration ends December 31, 2018.
Background – Mi Health Link

Michigan Duals

- Well over 200,000 dual eligible beneficiaries.
- Chronic and costly population.
- Medicaid: 12% of total Medicaid enrollment, but 38% of total Medicaid spending = $3.6 billion.
- Medicare: Cost $4.1 billion.
- Combined Medicare and Medicaid spending on duals nearly $8.0 billion.
- Despite significant spending, current system results in redundancies in treatment, system incompatibility, inadequate care coordination, limited quality assurances and other issues.
- End result is costly care delivered in a manner that does not support simple, easy access to care or improved health outcomes for beneficiaries.

Source: MDCH, 2010
Understand 5 Core Objectives

Five Core Objectives

The goal of the Demonstration is to integrate supports and services in an organized and coordinated delivery system for enrollees that:

1) Provides access to supports and services through person-centered planning and service delivery process, focused on enrollee satisfaction.
   • Improve quality of care.
   • Reduce health disparities.

2) Creates service and supports coordination model in Care Bridge that communicates with and links back to all domains of the delivery system.

Source: MDCH
Understand 5 Core Objectives

Five Core Objectives, cont’d...

3) Streamlines administrative processes for enrollees and providers.

4) Eliminates barriers to and encourages home and community based services.
   - Improve transitions among care settings.
   - Ability to self-direct care, be involved in one’s care, and live independently in community.

5) Demonstrates cost effectiveness for State and federal governments through improved supports and care coordination, financial realignment, and payment reforms.

Source: MDCH
Seven Key Components

Seven key components

1) Medicare and Medicaid services managed by a single entity-- health plans/Integrated Care Organizations (ICOs) and select Michigan PIHPs.
   • ICO’s with risk-based Contracts to coordinate and manage physical health care, long term supports and services (LTSS), and pharmacy services.
   • ICO must coordinate and contract with the PIHP to manage all Medicare/Medicaid behavioral health (BH), intellectual/developmental disabilities (I/DD), and substance use disorder (SUD) services.

2) Clinical and Care Coordination:
   • A Care Coordinator and an Integrated Care Team (ICT) is available to all enrollees to ensure the integration of the member’s medical, behavioral health, long-term services and supports, and social needs.
   • PIHP Supports Coordinator for those with behavioral health diagnosis.
   • Level 1 and Level 2 Assessments.
   • Approach is holistic with person-centered processes rather than physician-only driven care.

Sources: MACMHB, MDCH
Seven Key Components

Seven key components, cont’d...

3) Choice and Continuity:
   • Beneficiaries may choose ICO.
   • Enrollees will have freedom of choice of providers within the ICO and PIHP networks.
   • Continuity of care requirements to ensure beneficiaries can continue to see their current providers during transitions into the ICOs.

4) IT - Data sharing capacity will be increased through a “Care Bridge”, and integrated care bridge record (ICBR). Care Bridge is a care coordination platform designed to ensure that all members of a beneficiary’s care and supports team can adequately track the care plans developed for beneficiaries participating in the demonstration, as well as the services provided.


Sources: MACMHB, MDCH
Seven Key Components

Seven key components, cont’d:

6) Quality:
   • MDCH measures; Michigan worked with stakeholders to identify measures for the demonstration.
   • NCQA; ICO contracts hold PIHP to NCQA Health Plan standards for delegated functions (Clinical & UM, PNM & Credentialing, Claims, Customer/Member Services).
   • Quality Withholds.
   • Evaluation of demonstration by third party hired by CMS.
   • Customer Satisfaction Survey
   • Access Standards - 15 days from Level 1 assessment to Tool & Face-to-Face bio psychosocial assessment for mental illness
   • Seven day follow-up after discharge from hospitalization or detox.

7) ICO, PIHP and provider implementation of independent living and recovery philosophy, wellness principles, cultural competence, and promotion of culture change.

Sources: MACMHB, MDCH
Four Changes Required for SWMBH to Meet NCQA

Four changes required for SWMBH to Meet NCQA:

1) Denial and Appeals.

2) National recognition of Medical Necessity Criteria.

3) Practice Guidelines.

4) Complex Case Management & Quality Improvement Projects.
A Level 1 Assessment is completed by the ICO.
If MH/SUD/DD triggers behavioral health needs, the ICO refers for a Level 2.
Level 2 (ASAM and LOCUS plus biopsychosocial/Supports Intensity Scale).
For SWMBH, warm transfer when possible to PIHP who completes the ASAM, LOCUS, SIS and coordinates with CMH/Provider for the biopsychosocial assessment.
Status – Clinical/UM

Status – Clinical/UM, Cont’d.

• Integrated Health Specialist at the PIHP is the point of contact coordinating with the ICO and Provider (Fee for Service).

• PIHP Call center is available for routine requests/calls 8-8 Monday through Friday, customer services available 8-6. After hours availability for crisis and urgent requests 24/7.
  - Call abandonment rate is below 5%.
  - Staff making UM decisions must pass Nationally recognized behavioral health medical necessity criteria fidelity.
  - Only an MD or LP can make denial or appeal determinations.
Status - IT

Status IT

- **Carebridge – ICBR:** What have we done and what are we doing?
- **Current state:** Where are we now?
- **Future state:** Where are we going?
ICBR Timeline

January, 2014
• Region 4 Executive Meeting—Winners announced.

February, 2014
• Two workgroups established (Clinical & IT).
• Parallel process initiated:
  - Integrated Care Bridge Record (ICBR) data file
  - Web portal solution
  - Internal ICBR screens

April, 2014
• Memorandum of Understanding (MOU) released
• CareBridge interoperability document created
  - Confirmed federated approach (centralized, federated, & hybrid).

May, September, 2014
• Regional workgroup meetings with IT and Clinical workgroups
Status - IT

ICBR Timeline, cont’d.

Fall, 2014
• Region 4 ICBR layout submitted to DCH and IT Workgroup for review and approval.

November, 2014
• ICBR Data Definition sub-workgroup created.
Status - IT

Initial Tasks/Deliverables

• Reviewed MOU (ICBR 9 Components):
  - MOU between CMS/MDCH – Federal-State partnership to test a capitated financial alignment model for dual enrollees.

• CareBridge interoperability document created:
  - Federated approach.

• Each Team held meetings with their relative IT departments, Management Teams, and Care Coordination Teams:
  - Discussed the required data fields necessary for each of the 9 components.
  - Researched system to validate source of data.
  - Presented project to IT Engineering & Operations Department.
Status - IT

Areas of Attention

• Created GAP Analysis by ICO
  - Identified all required data fields.
  - Identified data source for each of the ICBR 9 components.
  - Identified fields that could not be sourced.

• Scheduled recurring meetings with Region 4 team to review suggested data fields and content:
  - Met as a team, and also met in breakout sessions.
  - Agreed upon a summarized ICBR standard format.
  - Created final, approved ICBR layout.
Areas of Attention, cont’d.

- Data inclusion criteria:
  - Excluded data everyone already had e.g. Historical claims.
  - Included all information from valid source of truth e.g. Medications.
  - Excluded any information that was confusing or had questionable quality.
    - e.g. Labs (multiple coding sets – SNOMED vs. LOINC, multiple reference ranges, etc.)

In parallel:

- All members of the Region 4 team are developing electronic data sharing solutions.
- ICOs developing portal solutions in their native systems (federated approach).
  - To meet all stakeholders where they are.
Status - IT

So Where are we now?

Current state:
• Data sharing via portal uploads, with parallel work on CCD sharing via MiHIN.
• Continued work with DCH and IT Workgroup on ICBR and CCD definition.
• Continued work with individual IT systems to share data with ICO systems.

Future State:
• Automated, electronic data sharing between ICOs and PIHP via MiHIN
• ICT Members sharing and working off of the same information
Three Lessons Learned

1) IT requires long lead times....Hello CMS!
   • Smart Care
   • Care Bridge
   • CCD

No regrets, just lessons learned.
Three Lessons Learned

2) Medicare is a different animal
   • Services: Mild-to-Moderate; In-Patient Psych.
   • Practitioner and organization Medicare IDs, credentialing.
   • NCQA.
   • Reporting.
   • Policies & Procedures.
Three Lessons Learned

2) Medicare is a different animal, cont’d

- Billing and care management system (Smart Care 4.0):
  - MSWs or LPs required to bill outpatient therapy services under Medicare.
  - All clinicians billing Medicare services to be registered in SWMBH care management system.

- Benefits crosswalk with ICOs.
- On-line provider directory.
- New member handbook.
- Access & Call center requirements.
- Claims adjudication – SWMBH.
- Provider contracts with SWMBH.
- Medicare compliance.
- UM – SWMBH Auth for all.
Three Lessons Learned

3) Challenges of PIHP – ICO Coordination
   • Contracts
   • Complex Case (Care) Management
   • Delegation
Three Lessons Learned + 1

4) **Collaboration and coordination were essential:**
   - Workgroup partnerships between SWMBH and ICO’s:
     - Steering
     - Finance & Contracts
     - Clinical/UM
     - IT
   - SWMBH coordination with CMHs and provider network:
     - Conducted two half-day duals sessions.
     - Educational emails.
     - Q&A conference calls.
     - One-on-one meetings with CMHs:
       - Review of Emergent/Urgent Flowchart provided at RUMCP.
       - Review of Inpatient Provider Service Authorization Communication.
       - Review of Service Authorization Determination Document provided at RUMCP.
       - CMHSP Emergency Services.
       - SWMBH/CMHSP Coordination - Routine services.
   - Attended bi-weekly Steering and Workgroup meetings with MDCH.
   - Public forums by MDCH – Stakeholder input.
Questions?

Mi Health Link

Implementation – Lessons Learned
Region 4
Appendix - Resources

- MI Health-Link  [http://www.michigan.gov/mdch/0,4612,7-132-2945_64077---,00.html](http://www.michigan.gov/mdch/0,4612,7-132-2945_64077---,00.html)


# Appendix – SWMBH Duals Team

## SWMBH Region 4 - Duals Workgroup Members

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Management &amp; Back-Up</strong></td>
<td>Patrick Visser</td>
<td><a href="mailto:patrick.visser@swmbh.org">patrick.visser@swmbh.org</a></td>
</tr>
<tr>
<td><strong>Clinical &amp; UM</strong></td>
<td>Lori Ryland</td>
<td><a href="mailto:Lori.Ryland@swmbh.org">Lori.Ryland@swmbh.org</a></td>
</tr>
<tr>
<td></td>
<td>Kim Rychener</td>
<td><a href="mailto:Kim.Rychener@swmbh.org">Kim.Rychener@swmbh.org</a></td>
</tr>
<tr>
<td></td>
<td>Natalie Tenney</td>
<td><a href="mailto:Natalie.Tenney@swmbh.org">Natalie.Tenney@swmbh.org</a></td>
</tr>
<tr>
<td><strong>IT/Quality:</strong></td>
<td>Tim Dubois</td>
<td><a href="mailto:Tim.Dubois@swmbh.org">Tim.Dubois@swmbh.org</a></td>
</tr>
<tr>
<td></td>
<td>Robert Schleichert</td>
<td><a href="mailto:Robert.Schleichert@swmbh.org">Robert.Schleichert@swmbh.org</a></td>
</tr>
<tr>
<td><strong>Customer Service:</strong></td>
<td>Kim Rychener</td>
<td><a href="mailto:Kim.Rychener@swmbh.org">Kim.Rychener@swmbh.org</a></td>
</tr>
<tr>
<td></td>
<td>Sarah Ameter</td>
<td><a href="mailto:Sarah.Ameter@swmbh.org">Sarah.Ameter@swmbh.org</a></td>
</tr>
<tr>
<td><strong>Operations &amp; Training</strong></td>
<td>Anne Wickham</td>
<td><a href="mailto:Anne.Wickham@swmbh.org">Anne.Wickham@swmbh.org</a></td>
</tr>
<tr>
<td><strong>Provider Network &amp; Credentialing</strong></td>
<td>Moira Kean</td>
<td><a href="mailto:Moira.Kean@swmbh.org">Moira.Kean@swmbh.org</a></td>
</tr>
<tr>
<td><strong>Compliance</strong></td>
<td>Laura Ferrara</td>
<td><a href="mailto:Laura.Ferrara@swmbh.org">Laura.Ferrara@swmbh.org</a></td>
</tr>
<tr>
<td><strong>SUD</strong></td>
<td>Mindie Smith</td>
<td><a href="mailto:Mindie.Smith@swmbh.org">Mindie.Smith@swmbh.org</a></td>
</tr>
</tbody>
</table>
Appendix
Background – Mi Health Link

• Affordable Care Act of 2010 provided for States to develop demonstration programs integrating care for dual eligible, to better coordinate benefits and services for the Medicare-Medicaid enrollee population.

• The dual-eligible population accounts for almost 40 percent of the overall Medicaid costs, which is about $110 billion a year. In Medicare, dual-eligibles account for 30 percent of the costs, or more than $162 billion a year.

• Over 9 million Americans enrolled in both the Medicare and Medicaid programs.

• Participating States - CMS and a State will develop a Memorandum of Understanding (MOU) to establish the parameters of the initiative. States with a MOU are listed below: California, Colorado, Illinois Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia, Washington.
Appendix
Eligibility for MI Health Link

Eligible Populations:

• Age 21 or older at the time of enrollment;
• Eligible for full benefits under Medicare Part A, and enrolled under Parts B and D,
• Receiving full Medicaid benefits; and
• Reside in a Demonstration region.

Populations excluded from enrollment in the Demonstration:

• Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 CFR 438.56
• Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage
• Individuals without full Medicaid coverage (spend downs or deductibles)
• Individuals with Medicaid who reside in a State psychiatric hospital
• Individuals with commercial HMO coverage
Appendix - Enrollment

• **Opt-In Enrollment**
  • Opt-In Letters being sent by MDCH/Enrollment Broker beginning **January 30, 2015**.
  • Letter explains ability to Opt-In to demonstration if Enrollee responds to letter.
  • Enrollee may select an Integrated Care Organization (ICO).
  • Opt-In Services Begin (Launch) for Regions 1 & 4 on **March 1, 2015**.

• **Passive Enrollment**
  • Includes 60-day and 30-day notification letters beginning **March 1, 2015** explaining the Enrollee’s options.
  • Services start no earlier than **May 1, 2015** for people passively enrolled.
  • Passive enrollment will be phased in over 2-3 months.
  • State is developing an “assignment” algorithm for passive enrollment to select one of the ICO’s. It will consider beneficiaries’ previous managed care enrollment, common case numbers for Medicaid eligibility, and additional ICO measures for quality, administration, and capacity as data becomes available.

• **Disenrollment**
  • Enrollees may opt out, or enroll in a different ICO, throughout the course of the demonstration.
Appendix - Enrollment

Individuals excluded from Passive Enrollment:

• Individuals participating in the Program for All-Inclusive Care for the Elderly (PACE);
• Individuals participating in the MI Choice Home and Community-Based Services Waiver; and
• Individuals with Medicare health or drug coverage from an employer or union sponsored plan.

• Prior to the effective date of coverage, Enrollees will receive from the ICO:
  • A comprehensive integrated formulary
  • A combined Provider and Pharmacy Directory
  • A single ID card with information on the ICO and PIHP
  • A Enrollee Handbook (Evidence of Coverage)
## Enrollment: Duals Demo Projections

<table>
<thead>
<tr>
<th>Total ICO Region 4</th>
<th>302</th>
<th>575</th>
<th>904</th>
<th>9,837</th>
<th>11,293</th>
<th>12,748</th>
<th>14,040</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIHP BH Dropout 6%</td>
<td>18</td>
<td>34</td>
<td>54</td>
<td>590</td>
<td>678</td>
<td>765</td>
<td>842</td>
</tr>
<tr>
<td></td>
<td>284</td>
<td>540</td>
<td>850</td>
<td>9,247</td>
<td>10,615</td>
<td>11,983</td>
<td>13,198</td>
</tr>
<tr>
<td>Percentage of Enrollees w/BH</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td>Total PIHP Region 4</td>
<td>145</td>
<td>276</td>
<td>434</td>
<td>4,716</td>
<td>5,414</td>
<td>6,111</td>
<td>6,731</td>
</tr>
</tbody>
</table>

**Notes:**
- ICO’s assuming 25% opt-out
- PIHP assuming additional 6% opt-out
- PIHP assuming 51% of duals with BH needs
<table>
<thead>
<tr>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Rights and Choices</strong></td>
</tr>
<tr>
<td>Care Plans</td>
</tr>
<tr>
<td>Percentage of members with documented discussions of rights and choices of providers</td>
</tr>
<tr>
<td><strong>Discharge Follow Up</strong></td>
</tr>
<tr>
<td>percentage of members with 30 days between hospital discharge and first follow-up</td>
</tr>
<tr>
<td><strong>Self Direction Training</strong></td>
</tr>
<tr>
<td>percentage of care coordinators that have undergone state-based training for supporting self-direction under demo.</td>
</tr>
<tr>
<td><strong>Tracking Demographic Information</strong></td>
</tr>
<tr>
<td>Care Goals</td>
</tr>
<tr>
<td>percentage of members with documented discussions of care goals</td>
</tr>
<tr>
<td><strong>Access to PIHP Supports Coordinator</strong></td>
</tr>
<tr>
<td>percentage of members with bh needs who have a PIHP supports Coordinator or opt out</td>
</tr>
<tr>
<td><strong>Quality of Life Survey</strong></td>
</tr>
<tr>
<td>Population based quality of life survey</td>
</tr>
<tr>
<td><strong>Falls with a Major Injury</strong></td>
</tr>
<tr>
<td>percentage of residents experiencing one or more fall with a major injury</td>
</tr>
<tr>
<td><strong>Abuse, Neglect, Exploitation</strong></td>
</tr>
<tr>
<td>the number of abuse, neglect, exploitation that meet state adult protective services definitions that are reported investigated and addressed.</td>
</tr>
<tr>
<td><strong>Satisfaction with Info Delivery Access to Records and Care Coordination</strong></td>
</tr>
<tr>
<td>percentage of members who report that they were satisfied with their information delivery, access to care records, and care coordination</td>
</tr>
<tr>
<td><strong>Person-Centered Planning using DCH definition</strong></td>
</tr>
<tr>
<td>number of all members with person-centered plans that are developed in accordance with DCH principles</td>
</tr>
<tr>
<td><strong>Care Assessment for persons with I/DD</strong></td>
</tr>
<tr>
<td>percentage of members with I/DD who have a completed assessment and related goals in the care plan</td>
</tr>
<tr>
<td><strong>Care Assessment for persons with MI</strong></td>
</tr>
<tr>
<td>percentage of members with MI who have a completed assessment and related goals in their care plan. Percentage of members who have a completed functional assessment that evaluates the member’s progress with activities of daily living with related goals in care plan.</td>
</tr>
<tr>
<td><strong>Community and Social Connectedness</strong></td>
</tr>
<tr>
<td>percentage of members satisfied with their involvement in natural supports and their communities.</td>
</tr>
<tr>
<td><strong>Self-Determination</strong></td>
</tr>
<tr>
<td>establish a baseline followed by rate of increase measurement of individuals who use self-directed arrangements.</td>
</tr>
<tr>
<td><strong>Prompt Intervention for Complex Care Needs</strong></td>
</tr>
<tr>
<td>percentage of members with complex care needs that receive prompt and timely interventions</td>
</tr>
<tr>
<td><strong>Antipsychotic and Biopolar Medication Management</strong></td>
</tr>
<tr>
<td>percentage of people diagnosed who are prescribed medication and choose to remain on their regimen.</td>
</tr>
</tbody>
</table>
Quality

• NCQA Standards- both ICO contracts hold us to NCQA Health Plan standards for delegated functions.

• Improvement Projects – are not well defined; at this point both ICOs could create improvement projects around other population then what we serve.

• Customer Satisfaction Survey: Likely participation in CAHPs (and/or ECHO) survey for this population annually.
Quality

• Access Standards:
  • Availability of Services (include monitoring tools)
  • Assessment Against Access Standards
    • Regular and Routine Appointments
    • Urgent/Emergency Care Appointments
    • After-Hours Care
    • Member Services, by telephone
  • BH Access Standards
    • Routine Non-Life Threatening Emergency (within 6 hours)
    • Urgent Care (within 48 hours)
    • Routine Office Visit (within 10 business days)
  • Member/Behavioral Healthcare Telephone Access Standards
    • Calls are answered by a live voice within 30 seconds
    • Telephone call abandonment rate is within 5%

• 15 days from Level 1 assessment to Face-to-Face assessment. Services must be provided within 14 days of completion of assessment.

• 7 day follow-up after discharge from hospitalization or detox.
Key Terms from ICO-PIHP Contracts

- **Care Bridge** means the care coordination framework for Michigan’s integrated care program. Through the Care Bridge, the members of an Enrollee’s care and supports team facilitate formal and informal services and supports in an Enrollee’s person-centered care plan. The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the care and supports team.

- **ICO Care Coordinator** means a Michigan licensed registered nurse, nurse practitioner, physician’s assistant, or Bachelor’s or Master’s prepared social worker employed or contracted with the ICO who is accountable for providing Care Coordination services. The ICO Care Coordinator will conduct at a minimum the Level I Assessment, assure the Person-Centered Planning Process is complete, prepare the IICSP, coordinate care transitions and lead the ICT. Care Coordinators must coordinate these activities with PIHP Supports Coordinator/Case Manager or LTSS Supports Coordinator and ICT members as appropriate.
Key Terms from ICO-PIHP Contracts

- **Individual Integrated Care and Supports Plan** ("IICSP") means the plan of care developed by an Enrollee, the Enrollee’s ICO Care Coordinator, and the Enrollee’s Integrated Care Team which incorporates the following elements: assessment results; summary of the Enrollee’s health; the Enrollee’s preferences for care, supports, and services; the Enrollee’s prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers, and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring and reassessment; and the due date for the intervention and reassessment. The IICSP is also referred to as person-centered plan or plan of care. The IICSP will be maintained in the Integrated Care Bridge Record.
Key Terms from ICO-PIHP Contracts

- **Integrated Care Bridge Record** ("ICBR") means an individualized Enrollee record generated and maintained within the electronic Care Coordination Platform which allows secure access for Enrollees and the ICT to use and (where appropriate) update information.

- **Integrated Care Team** ("ICT") means a team including the Enrollee, Enrollee’s chosen allies or legal representative, Primary Care Physician, ICO Care Coordinator, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed. The ICT works with the Enrollee to develop, implement, and maintain the IICSP and to coordinate the delivery of services and benefits as needed for each Enrollee.

- **PIHP Supports Coordinator** means a care management specialist and/or an integrated health care specialist who is: (1) employed or contracted by PIHP; (2) a member of an Enrollee’s ICT; and (3) available to Enrollees assigned to PIHP. PIHP Supports Coordinators collaborate with the Enrollee and the ICO Care Coordinator to assure all necessary services and supports are provided to enable the Enrollee to achieve desired outcomes. PIHP may assign more members of its staff meeting all necessary qualifications to fill the roles of PIHP Supports Coordinators for purposes of the Demonstration.
PIHP Supports Coordinator

• The PIHP Supports Coordinator responsibilities:
  • Support the person-centered planning process.
  • Participate in Level I Assessment when enrollee has BH, SUD, and/or I/DD need.
  • Conduct Level II Assessment Tool, and coordinate completion of the Biopsychosocial Assessment.
  • Develop, with the enrollee and the ICT, an IICSP.
  • Coordinate resources and authorize services (as permitted in the contracts between MDCH and the PIHP and between the ICO and PIHP).
  • Coordinate psychiatric, psychopharmacological, rehabilitative, and habilitative services and supports in response to needs identified in the Level I Assessment, the Level II Assessment, and the IICSP.
  • Manage transitions among psych acute and sub-acute levels of care and the community.
  • Ensure urgent and emergent care (including emergency department and/or inpatient diversion) due to exacerbation of BH, SUD and/or I/DD conditions (including crises secondary to medical or chronic illness).
  • Coordinate and monitor in accordance with the IICSP activities for health-related behavioral conditions of enrollees with BH, SUD, and/or I/DD conditions.
  • Collaborate and consult with the ICO Care Coordinator regarding health, wellness, and preventive services for BH, SUD, and/or I/DD specialty populations.
  • Communicate, coordinate and monitor peer support/peer health navigator services, including enrollee engagement, health advocacy, and training in self-management of chronic illness.
  • Document in the ICBR and communicate with the enrollee and providers as needed.

-source: MOU
## INTEGRATED CARE FOR DUAL ELIGIBLES - COMPARISON

<table>
<thead>
<tr>
<th>SWBH Services</th>
<th>Non-Duals</th>
<th>Dual Eligibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Demographics</td>
<td>All Ages (Medicaid).</td>
<td>21 and Over (Duals) at time of Enrollment and entitled to benefits under Medicare Part A, and enrolled under Parts B and D and receiving full Medicaid benefits. Persons enrolled in the MI Choice waiver program (a 1915(c) waiver) or the Program for All-inclusive Care for the Elderly (PACE) may choose to participate in the Integrated Care Program, but must dis-enroll from MI Choice or PACE.</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Capitated Medicaid Medicare FFS.</td>
<td>Sub-Capitation; Shared Savings.</td>
</tr>
<tr>
<td>Risk (Financial)</td>
<td>Risk Corridor with MDCH through Medicaid Internal Service Fund: 100% up to 5%; 50% from 5 – 10%</td>
<td>Risk Corridor with Integrated Care Organization (ICO) through Medicaid Internal Service Fund: 100% up to 5%; 50% from 5 – 10%</td>
</tr>
<tr>
<td>Eligibles</td>
<td>156,000 approximately.</td>
<td>18,000 – 20,000 approximately.</td>
</tr>
<tr>
<td>Enrollee Projections</td>
<td>19,000 approximately.</td>
<td>6,000 - 7,000 estimate.</td>
</tr>
</tbody>
</table>
## INTEGRATED CARE FOR DUAL ELIGIBLES – COMPARISON

<table>
<thead>
<tr>
<th>SWBH Services</th>
<th>Non-Duals</th>
<th>Dual Eligibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network Management (PNM)</td>
<td>CMHSP’s manage contract.</td>
<td>SWMBH holds contract w/Medicare Providers.</td>
</tr>
<tr>
<td>Credentialing</td>
<td>CMHSP’s Credentials; SWMBH Credentials too.</td>
<td>SWMBH Credentials.</td>
</tr>
<tr>
<td>Clinical/Utilization Management (UM)</td>
<td>Local Care Management at CMHSP can</td>
<td>SWMBH Authorization for all.</td>
</tr>
<tr>
<td></td>
<td>Authorization/Approve some services.</td>
<td></td>
</tr>
<tr>
<td>Customer/Member Services/Grievance and</td>
<td>Medicaid Regulations; BBA #’s.</td>
<td>Medicare Regulations; Members Access both Medicaid and/or Medicare Grievance &amp; Appeals.</td>
</tr>
<tr>
<td>Appeals (G&amp;A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>CMH Claims Adjudication.</td>
<td>SWMBH Claims Adjudication; Report Encounters to Integrated Care Organization (ICO).</td>
</tr>
<tr>
<td>Compliance</td>
<td>Medicaid Compliance Standards.</td>
<td>Medicaid and Medicare Standards.</td>
</tr>
<tr>
<td>Quality Assurance and Provider Improvement (QAPI)</td>
<td>MDCH/Medicaid.</td>
<td>NCQA standards; Medicare Regulations Case Management.</td>
</tr>
<tr>
<td>Information Technology</td>
<td>Streamline Care Management.</td>
<td>Streamline + Care Bridge Platform &amp; Integrated Care Bridge Record.</td>
</tr>
</tbody>
</table>