# POLICY AND PROCEDURE MANUAL

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| SUBJECT<br>Care Coordination | ACCOUNTABILITY<br>NMRE, NMRE Network Providers | Effective Date:<br>April 27, 2016 | Pages: 3 |
| REQUIRED BY | PIHP Contract Section: I. Behavioral/Physical Health Integration "Primary Care Coordination, "Information Requirements "Medicaid Health Plan Agreements," BHH Services SUDHH Other: 42 CFR §438.208(b)(1) | Last Review Date: July 18, 2019<br>3/11/2026 | Past Review Date: |
| Policy: ☒<br><br>Procedure: ☐ | Review Cycle: Annual<br>Author: NMRE Chief Clinical Officer | Responsible Department: Access & UM | Reviewers: NMRE Board of Directors |

Definitions

**Beneficiary:** A person served by the publicly funded behavioral health and substance use disorder system or his/her representative.

**Community Health Worker:** A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served who serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

**Health Insurance Portability and Accountability Act (HIPAA):** a US federal law designed to protect sensitive patient health information from disclosure without consent. It mandates national standards for securing electronic, written, and spoken Protected Health Information (PHI) and improves health insurance portability.

**Individual Plan of Services (IPOS):** The written details of the supports, activities, and resources required for the individual to achieve personal goals. An individual and his/her team are responsible for developing the individual plan of services.

**Managed Care Organization:** An entity that has, or is seeking to qualify for, a comprehensive risk contract with a State Medicaid agency. It must be a federally qualified Health Maintenance Organization (HMO) or any other entity that makes state-defined comprehensive services available to enrollees and assumes risk.

**Michigan Department of Health and Human Services (MDHHS):** The principal department of the state of Michigan, headquartered in Lansing, which provides public assistance, child and family welfare services, and oversees health policy and management.

**Medicaid Health Plan (MHP):** A managed care organization that provides comprehensive health care services to beneficiaries

**Network Provider:** Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel.

**Northern Michigan Regional Entity (NMRE):** Region 2 PIHP covering Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle Roscommon, and Wexford counties in northern Lower Michigan.

**Peer Recovery Coach:** Trained, supervised individuals with lived experience in recovery who provide non-clinical, person-centered support to help people maintain long-term recovery from substance use disorders (SUDs) and related conditions.

**Person-centered Planning:** The process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities.

**Prepaid Ambulatory Health Plan (PAHP):** An entity that provides services to Medicaid enrollees under a state contract, typically on a capitation or other non-State plan rate basis, without being responsible for inpatient hospital or institutional services, and without a comprehensive risk contract.

**Prepaid Inpatient Health Plan (PIHP):** One of ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, development disabilities, and substance use.

**Quality Assessment and Performance Improvement Program (QAPIP):** A mandated framework for Michigan's Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) to monitor, evaluate, and improve the quality and safety of behavioral health services. It ensures compliance with federal regulations and state standards.

**Substance Use Disorder (SUD):** The taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety or welfare, or a combination thereof.

**Long-Term Services and Supports (LTSS):** A broad range of paid and unpaid medical and personal care services designed to help individuals with chronic illnesses, disabilities, or aging-related needs remain independent. These Medicaid-funded services assist with daily activities (bathing, dressing) and community living, often delivered via managed care.

Purpose

The purpose of this procedure is to ensure appropriate care through the coordination of behavioral health providers, primary care physicians, Medicaid Health Plans (MHP) and any other entity providing care to beneficiaries.

To promote care coordination for beneficiaries with complex needs, the NMRE will ensure that each beneficiary has an ongoing source of care appropriate to their needs, including a formally designated entity or person responsible for coordinating the care.

Policy

It is the policy of the Northern Michigan Regional Entity (NMRE) to coordinate care provided to Medicaid beneficiaries with Medicaid Health Plans (MHP), Health Home Partners, other specialty care providers or fee-for-service (FFS) Medicaid, and community or social supports. Care Coordination occurs between settings/levels of care, including appropriate discharge planning for short-term and long-term hospital/institutional stays, or SUD residential services. It is further the policy of the NMRE to work cooperatively with MHPs to jointly identify priority need populations for the purposes of care coordination. In support of this policy, the NMRE will secure appropriate consents, share necessary electronic data, and conduct routine care coordination activities. In the process of coordinating care, the NMRE will ensure that each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

In support of this policy, the NMRE will:

(1) At least monthly, identify beneficiaries who have requested services through the NMRE and are assigned to an MHP and review them in joint care coordination calls with the MHP;
(2) Receive and review information from electronic sources;
(3) Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, an enrollee health record in accordance with professional standards;
(4) Share with the state or other MCOs, PIHPs, and PAHPs serving the enrollee, the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;
(5) Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 days of the admission, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful;
(6) Maintain up- to-date contact information for CMHSP and Emergency Intervention Service network providers and share this information with each MHP serving any part of Contractor’s service area To further facilitate referrals for behavioral health care.
(7) Have a written and active Coordinating Agreement with each MHP serving any part of PIHP service area.

Approval Signature

NMRE Chief Executive Officer

April 1, 2026

Date

| SUBJECT<br>Care Coordination | ACCOUNTABILITY<br>NMRE, NMRE Network Providers | Effective Date:<br>April 27, 2016 | Pages: 4 |
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| REQUIRED BY | I. Behavioral/Physical Health Integration Other: | Last Review Date:<br>July 18, 2019<br>3/11/2026 | Past Review Date: |
| Policy ☐<br><br>Procedure ☒ | Review Cycle: Annual<br>Author: NMRE Chief Clnical Officer | Responsible Department:<br>Access & UM | Reviewers:<br>NMRE CEO |

Procedure

The NMRE will ensure high quality service in part, through the effective coordination of behavioral health care with primary care physicians, and other health care providers, MHPs and their contracted behavioral health managed care organizations.

**A. Coordination of Care**

1. Coordination with the Primary and Other Health Care Providers

   a. The PIHP/CMHSP/SUD provider initiates affirmative efforts to ensure the integration of primary, specialty behavioral health services, and substance use disorder treatment for Medicaid beneficiaries. These efforts focus on persons that have a chronic condition such as a serious mental health illness, (co-occurring) substance use disorder, children with serious emotional disorders, or a developmental disability and have been determined by the CMHSP/PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports. Network Providers will ask for the beneficiary's primary care physician's name, phone number, and address at the time of intake and document this in the clinical record. If no primary care physician is identified, the primary clinician will make efforts to help the beneficiary obtain one, and document accordingly. If the beneficiary is Medicaid eligible, they must have selected a primary care physician, or the Medicaid Health Plan (MHP) has or will assign one to them. Primary Care Physician information for Medicaid beneficiaries may be obtained from the MHP. Client treatment case files must include a signed release of information, or a statement that the client has refused to sign a release, for the purposes of coordination.

   b. The PIHP/CMHSP/SUD provider will encourage all beneficiaries eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the beneficiary's MHP. Beneficiaries will be encouraged to include their primary care physician and any other health care providers they deem appropriate in their person-centered planning (PCP) process.

   c. As authorized by the beneficiary, the PIHP/CMHSP/SUD provider must include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the PCP process.

d. When specialty services or supports are no longer medically necessary, as determined through the person-centered planning process, and with proper consent/authorization from the beneficiary or their legal representative, a copy of the discharge summary will be provided to the beneficiary's primary care physician and/or MHP.

2. Coordination with Medicaid Health Plan

a. The NMRE will identify priority need populations/individuals enrolled in MHP and receiving PIHP services at least monthly utilizing data extracted through the MDHHS Care Connect 360 data warehouse. The individual cases will be reviewed by the NMRE and MHP at least monthly.

b. As an established Qualified Data Sharing Organization, the NMRE will receive information from electronic sources to support the integration of care as permitted through Use Case Agreements with those electronic sources.

c. The NMRE and/or its Network Providers will inform the MHP when and individual receiving services has reported any of the following:

i. That they do not have a Primary Care Physician;

ii. That they have not had a basic health screening within the last 12 months; or

iii. They have not visited their Primary Care Physician for more than 12 months.

3. Health Home Benefit

Substance Use Disorder Health Home (SUDHH)

a. The SUDHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder, alcohol use disorder and/or stimulant use disorder who also have or are at risk of developing another chronic condition. For enrolled beneficiaries, the SUDHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop an individualized care plan to best manage their care. The model will also elevate the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

b. SUDHH receives reimbursement for providing the following federally mandated core services:

i. Comprehensive care management
ii. Care coordination and health promotion
iii. Comprehensive transitional care
iv. Patient and family support
v. Referral to community and support services

Behavioral Health Home (BHH)

a. BHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

b. BHH receives reimbursement for providing the following federally mandated core services:

i. Comprehensive care management
ii. Care coordination and health promotion
iii. Comprehensive transitional care
iv. Patient and family support
v. Referral to community and support services

**B. Documentation in the Clinical Record**

Documentation in the individual's health record will include, but not be limited to, the following:

1. The name, contact information, address of the primary care physician, other health care providers, and any individual health care supports;

2. A plan for how care will be coordinated as documented in the Individual Plan of Services (IPOS);

3. Any refusal by the beneficiary to coordinate care;

4. Each attempt to address coordination of care activities as well as actual coordination of care activities.

**C. Communication**

1. Information will only be shared in accordance with applicable laws, which include, Michigan's Mental Health Code (Public Act 258 of 1974 as amended), 42 CFR part 2, Confidentiality of Alcohol & Drug Abuse Patient Records, 42 USC Section 290 dd – 2 Confidentiality of Records 2, and HIPAA Privacy Standards (45 CFR parts 160 and 164 subparts A and E) to the extent that they are applicable; keeping disclosures to a minimum amount of information necessary and only on a "need to know" basis, with proper authorization/consent as required.

2. Network Providers, primary care physicians, and other organizations may share health information verbally or through mail, fax, or electronically with proper safeguards in place and according to organizational policy and consent.

**D. Inpatient Stays**

When a beneficiary is admitted to inpatient psychiatric services, the following procedures will occur:

1. The beneficiary's consent for coordination between behavioral health provider and the primary care physician or organization will be obtained in writing and will be noted in the clinical record with the provider's signature. An individual's refusal to provide consent for coordination will be noted in the clinical record with the provider's signature and no information will be forwarded to the primary care physician.
2. In cases of signed consent for coordination, the primary care physician or organization will be notified of the admission in writing, and this will be noted in the clinical record with the provider's signature.
3. In cases of signed consent for coordination, a copy of the discharge sheet including discharge medications, next scheduled appointment and discharge diagnosis(es) will be forwarded to the primary care physician or organization immediately upon discharge by the hospital liaison. The date forwarded will be noted in the clinical record.

**E. Continuity of Care**

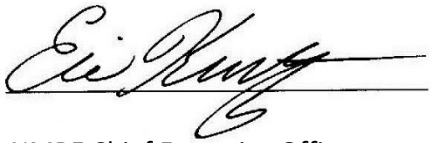
The NMRE's Quality Assessment and Performance Improvement Program (QAPIP) defines the long-term services and supports (LTSS) population and identifies beneficiaries who have special health care needs. Assessments are completed to identify any ongoing special conditions of the beneficiary that requires a course of treatment or regular care monitoring. The development of an IPOS for this population must follow all Person-centered Planning requirements listed under (42 CFR §441.301(c)(1). The PIHP/CMHSP will have mechanisms in place for beneficiaries with special health care needs determined through an assessment to require a course of treatment or regular care monitoring, to allow them to directly access specialists (for example, through a standing referral or an approved number of visits) as appropriate for the beneficiaries' condition and identified needs.

The assessment mechanisms will use appropriate providers for individuals meeting the LTSS service coordination requirements per 42 CFR §438.208(c)(2)42 CFR §457.1230(c).

**F. Compliance**

Compliance with stated guidelines will be monitored by clinical record audits conducted in accordance with the NMRE's QAPIP.

Approval Signature



NMRE Chief Executive Officer

April 1, 2026

Date