

Michigan Department of Community Health

Director Nick Lyon



Linking Medicare and Medicaid for you

Program Overview

- MI Health Link
- Eligibility Criteria
- Benefits of MI Health Link
- Covered Services
- Enrollee Protections
- What to Consider
- Enrollment and Beyond



MI Health Link

- A new program that joins Medicare and Medicaid benefits, rules and payments into one coordinated delivery system
- New MI Health Link health plans and current Michigan Pre-paid Inpatient Health Plans (PIHPs) receive payments to provide covered services





MI Health Link

- Three-way contract between CMS, MDCH and Integrated Care Organizations (ICOs) called MI Health Link health plans
- MI Health Link health plans hold sub-contracts with Pre-Paid Inpatient Health Plans (PIHPs) for Medicare behavioral health services
- Operates under a capitated financial alignment model





MI Health Link

- Three year program with services beginning in the first regions no earlier than March 1, 2015
- Provided in four regions in the state





MI Health Link Regions

- Region 1 Entire Upper Peninsula
- Region 4 Southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties)
- Region 7 Wayne County
- Region 9 Macomb County





MI Health Link Regions Ontonagon Baraga Marquette Chippewa Schoolcraft Mackinac Dickinson Region 1 – Entire Upper Peninsula Menom -inee Haron Region 9 -**Macomb County** Region 2 -Region 7 – Wayne Allegan Southwest Michigan County Jackson Witchiener M HEALTH LINK

Region 1 – Upper Peninsula

MI Health Link health plan

Upper Peninsula Health Plan

Pre-Paid Inpatient Health Plan

NorthCare Network





Region 4 – Southwest Michigan

MI Health Link health plan options

- Aetna Better Health of Michigan
- Meridian Health Plan

Pre-Paid Inpatient Health Plan

Southwest Michigan Behavioral Health





Region 7 – Wayne County

MI Health Link health plan options

- Aetna Better Health of Michigan
- AmeriHealth
- Fidelis SecureCare
- HAP Midwest Health Plan
- Molina Healthcare

Pre-Paid Inpatient Health Plan

Detroit-Wayne Mental Health Authority





Region 9 - Macomb County

MI Health Link health plan options

- Aetna Better Health of Michigan
- AmeriHealth
- Fidelis SecureCare
- HAP Midwest Health Plan
- Molina Healthcare

Pre-Paid Inpatient Health Plan

Macomb PIHP





Eligibility Criteria







Eligibility Criteria

People may be eligible for MI Health Link if they

- Live in one of the four regions
- Are age 21 or over
- Are eligible for full benefits under both Medicare and Medicaid, and
- Are not enrolled in hospice

Adults age 21 or over who are enrolled in the Children's Special Health Care Services program are not eligible for MI Health Link



Eligibility Criteria

- People enrolled in PACE and MI Choice are eligible, <u>but</u> <u>must leave their programs</u> before joining MI Health Link
- People with a Medicaid deductible are not eligible for MI Health Link
- People in a nursing home are eligible and must continue to pay their patient pay amount to the nursing home
- People with Medigap (Medicare supplemental insurance)
 can enroll in MI Health Link if they meet all other eligibility
 criteria



Benefits of Joining MI Health Link







- No co-payments or deductibles for in-network services, including medications
 - Nursing home patient pay amounts still apply
- One health plan to manage all Medicare and Medicaid covered services
- One card to access all MI Health Link services
 - People should keep their Medicare and Medicaid cards in the event they choose to leave MI Health Link





- Person-centered care with a focus on supports for community living, not just doctor-driven medicine
- Access to a 24/7 Nurse Advice Line to answer questions





Each enrollee will have a Care Coordinator who will

- Work with the enrollee to create a personal care plan based on the enrollee's goals
- Answer questions and make sure that health care issues get the attention they deserve
- Connect the enrollee to supports and services needed to be healthy and live where the enrollee wants





Bertha

Age: 88 years old

Lives in: Marquette

Other information: Bertha and her husband, George (92 years old), live in their home of 60 years and wish to stay there.

Health issue: Bertha wants to go to the dentist for a routine teeth cleaning but does not have transportation.







Bertha

Identification of Need: Bertha's Care coordinator calls Bertha knowing she's due for an appointment and learns she needs transportation to the appointment.

Scheduling of Service: The care coordinator asks Bertha when she'd like to have the appointment and schedules it for her with a dentist in the network that the health plan has established.





Bertha

Unmet Need: The Care Coordinator arranges for transportation which is paid for by Bertha's health plan and shares the driver's contact information with Bertha.

Service Delivery: Bertha makes it to her appointment to get her teeth cleaned. She is not charged anything for the cleaning because she selected a dentist who is in the health plan's network.





Dan

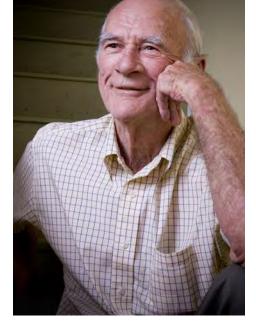
Age: 67 years old

Lives in: Battle Creek

Other information: Dan is residing in a nursing facility because he is recovering from an accident.

Health issue: Dan would like to move back home and live with his dog, Bronco, but his current health condition is preventing him from doing so.







Dan

Discharge Plan: Dan's Care Coordinator works with Dan and the nursing home staff to develop his discharge plan including the need for a wheelchair and other services in the community.

Modifications: Following a home evaluation, Dan will need a ramp in order to enter and exit his home with his wheelchair so they arrange to have one installed prior to him returning home. Grab bars for the bathroom and a raised toilet seat are additional home modifications arranged for Dan prior to him returning home.





Dan

Service Delivery: Dan will need assistance with snow removal, activities of daily living and cooking, so the Care Coordinator also arranges for chore services, personal care and home delivered meals. Dan selects his providers from those in the plan's network.

Quality of Life: Dan returns home to live independently with a few services, a new wheelchair and Bronco.





Matty

Age: 32 years old **Lives in:** Warren

Other information: Matty lives in an Adult Foster Care home and receives services through the Habilitation Supports Waiver. He has a developmental disability and a behavioral health issue, which he manages by visiting his therapist.

Health issue: Matty trusts his PIHP Supports Coordinator to help him accomplish his goals. Matty is worried that he will lose his coordinator by joining MI Health Link.







Matty

Coordination: Care Coordinator will work together with PIHP Supports Coordinator. Matty will be able to have both of them help him meet his needs, but Matty requests that the PIHP Supports Coordinator be his primary point of contact. Most importantly, Matty can remain on the Habilitation Supports Waiver and be enrolled in MI Health Link.

Unmet Need: While working together with Matty, the coordinators realize that he has a family history of diabetes.





Matty

Service Delivery: Matty sees his new Primary Care Physician which the Care Coordinator helped him pick. Matty will have no co-payments for the check-up from an in-network doctor or any medications the doctor prescribes.

Care Planning: The Coordinators arrange for check-ups and help him to develop a nutrition and exercise program to help Matty prevent diabetes. Matty enjoys swimming so he joined a water aerobics class.





Each enrollee may

- Change or select the Care Coordinator assigned to them by the MI Health Link health plan
- Choose to have an existing supports coordinator or case manager to serve as his or her primary point of contact
 - In this situation, the Care Coordinator would work through this person to coordinate care and arrange supports and services





Each enrollee will have access to an Integrated Care Team

- The team will include doctors, other providers, and anyone else the enrollee would like to have on the team
- The team will work with the enrollee to identify goals and preferences for care and services















All health care covered by Medicare and Medicaid

- Medications (without co-pays)
- Dental and vision services
- Equipment and medical supplies
- Physicians and specialists
- Emergency and urgent care including emergency care when out of the demonstration region





All health care covered by Medicare and Medicaid

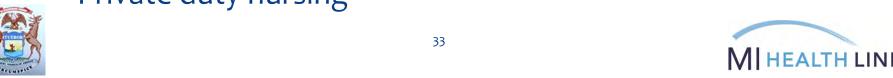
- Hospital stays and surgeries
- Diagnostic testing and lab services
- Skilled nursing and rehabilitation services
- Home health services
- Transportation for medical emergencies and medical appointments





Long Term Supports and Services (LTSS)

- Personal care
- Equipment to help with activities of daily living
- Chore services
- Home modifications
- Adult day program
- Private duty nursing



Long Term Supports and Services (LTSS)

- Preventive nursing services
- Respite
- Home delivered meals
- Community transition services
- Fiscal intermediary services
- Personal emergency response system



Nursing home care



Additional services offered by the health plan

- Health plans can offer services not covered by Medicare and Medicaid
- Health plans can enhance Medicare and Medicaid services
 - May cover supplies or services more often
 - May cover a higher dollar amount when there is a dollar limit on a service





Behavioral Health Services

- Provided to individuals who have a mental illness, intellectual/developmental disability and/or substance use disorder
- May be accessed by contacting the MI Health Link health plan, PIHP or local Community Mental Health Service Provider (CMHSP)





Covered Services

Behavioral Health Services

- If currently receiving services through the CMHSP, services will not change or be interrupted
- Personal care services previously provided through the Home Help program are the responsibility of the MI Health Link health plan





Covered Services

Behavioral health services are medically necessary services, including these examples

- Individual, group, and/or family therapy
- Medication review
- Supported employment
- Community living supports (meal preparation, laundry, chores, food shopping)
- Substance use disorder services (assessment, treatment planning, stage-based interventions, referral and placement)





Enrollee Protections



Enrollee Protections

- MI Health Link follows the current grievance and appeal processes for Medicare and Medicaid services
- Enrollees are offered appropriate appeal rights
- With a timely appeal request, Medicare and Medicaid services will continue to be provided during the appeal
- The MI Health Link health plan and the PIHP will use the same notice which will direct enrollees to the entity they should contact if they wish to appeal an action



Enrollee Protections

- A MI Health Link Ombudsman program will be available to help resolve problems and answer questions
- Health plans must offer a choice of providers and care coordinators
- Health plans must honor the continuity of care requirements per the three-way contract





The health plan must

- Allow enrollees to continue to see current doctors and other providers during the transition period
- Pay out-of-network doctors and other providers during the transition period at no cost to the enrollee





The health plan must

- Allow choice of personal care service providers including paying family members or friends to provide the service if the provider meets the criteria to enroll in the health plan's network
- Work to bring enrollees' current providers into the health plan's network
- Cover current prescriptions not on the plan's drug list



The health plan must

- Honor current authorizations for services
 - These can be reported to the health plan by the enrollee or provider
 - Personal Care authorization information is provided to the health plan by MDCH





- Enrollees in nursing homes at the time of enrollment are not required to move to a nursing home in the health plan's network
- The MI Health Link health plan must enter into single-case agreements with out-of-network nursing homes for enrollees meeting the following criteria





Criteria

An enrollee has the right to live in an out-of-network nursing home for the life of the program if the enrollee

- Resides in the nursing home at the time of enrollment, or
- Residents in a bed not certified for both Medicare and Medicaid at the time of enrollment (applies to in-network and out-of-network providers)
- Has a family member or spouse that resides in the nursing home, or
- Requires nursing home care and resides in a retirement community that includes a nursing home which is not in the health plan's network





Timeframes

Home Health and Personal Care Providers,
 Physician and Practitioners

For people receiving services from the PIHP Specialty Services and Supports Program or Habilitation Supports Waiver, the health plan must maintain current provider and level of services at the time of enrollment for 180 days





Timeframes

Home Health and Personal Care Providers,
 Physician and Practitioners

For all other enrollees, the health plan must maintain current provider and level of services at the time of enrollment for 90 days





Timeframes

- Prescriptions
 - The health plan must cover at least a temporary 30-day supply of the drug for at least 90 days if
 - The enrollee is taking a drug that is not on the health plan's drug list, or
 - The health plan's rules do not cover the amount ordered by the prescriber, or
 - The drug requires prior approval by the health plan, or
 - The enrollee is taking a drug that is part of a step therapy restriction
 - The enrollee can ask the health plan to make an exception to cover a drug that is not on the drug list





Timeframes

- Prescriptions in a Nursing Facility
 - The health plan must refill prescriptions for enrollees in a nursing facility for a minimum of 91 days
 - The health plan must refill the drug multiple times during the first
 90 days of enrollment, as needed
 - This gives the prescriber time to change the drugs to ones on the drug list or ask for an exception





Timeframes

Scheduled Surgeries

The health plan must honor surgeries and the associated providers which were authorized within 180 days prior to enrollment

Dialysis

The health plan must maintain current level of service and same provider at the time of enrollment for 180 days





Timeframes

Chemotherapy and Radiation

Treatment initiated prior to enrollment must be authorized by the plan through the course of treatment with the specified provider

 Organ, Bone Marrow, and Hematopoietic Stem Cell Transplant

The health plan must honor specified provider, prior authorizations, and plans of care





Timeframes

Durable Medical Equipment

The health plan must honor prior authorizations when the item has not been delivered and must review ongoing prior authorizations for medical necessity

Dental and Vision

The health plan must honor prior authorization when an item has not been delivered





Timeframes

 MI Choice Home and Community Based Services (HCBS) Waiver services

For enrollees previously participating in the MI Choice HCBS waiver, the health plan must maintain the providers and level of services at the time of enrollment for 90 days

Applicable only to the MI Choice services which are also covered by the MI Health Link HCBS waiver





What to consider when joining MI Health Link



What to Consider

- Do current doctors and other providers participate in the MI Health Link health plan?
 - If not, would the provider consider joining the MI Health Link plan?
- Are current medications covered by the MI Health Link health plan?
 - Each plan offers its own list of covered medications



What to Consider – MI Choice

- Participants have to leave the MI Choice program to join MI Health Link
- There are differences between the MI Choice and MI Health Link home and community based wavier services
 - For example, private duty nursing is limited to 16 hours/day in MI Health Link and not all MI Choice services are available in MI Health Link
- If the person wants to return to MI Choice, he or she may have to wait for an opening





What to Consider – MI Choice

When a MI Choice participant calls to enroll

- MDCH will take additional steps before enrollment to determine if the person will be eligible for MI Health Link HCBS waiver services
- MDCH will contact the person to explain options for the different programs and any impact MI Health Link enrollment could have on Medicaid eligibility before the person makes a final enrollment decision





What to Consider – MI Choice

For MI Choice participants living in an adult foster care home or a home for aged

- This setting may not be approved under the new Home and Community Based Services rules applicable to the MI Health Link HBCS waiver
- Participants should discuss this issue with their current MI Choice supports coordinator





What to Consider - PACE

PACE integrates Medicare and Medicaid services

- Services are primarily provided in the PACE Center
- Participants must use the PACE primary care physicians in the PACE centers and other providers (such as hospitals) that are contracted with the PACE organization
- PACE provides social interaction in the PACE Center for participants





What to Consider - PACE

- MI Health Link services are not centralized at a center like PACE and are primarily delivered at various provider offices or in the person's home
- If enrolling in MI Health Link, people must use the MI Health Link health plan provider network and not the PACE network
- Participants have to leave PACE to join MI Health Link
- If the person wants to return to PACE, he or she will have to reapply for PACE





What to Consider – Home Help

- MI Health Link enrollees can use the same personal care provider they had in Home Help if the provider meets the MI Health Link health plan criteria, including a background check, to enroll as a network provider
- The personal care provider will need to contact the MI Heath Link health plan to enroll in the provider network to receive payment for personal care services





What to Consider – Home Help

- The MI Health Link health plan must provide the same amount of services until a new assessment is performed
- Personal care services will be provided through the MI Health Link health plans and not through the Home Help program
- If a person disenrolls from MI Health Link, there could be a delay in receiving personal care services while reapplying to the Home Help program





What to Consider

People and their dependents with employer or union sponsored **Medicare** insurance plans who join MI Health Link may not be able to return to those insurance plans

- The individual should check with his or her retiree benefits management system or human resources for more information
- People's private employer or union sponsored insurance (as their primary insurance) will not be impacted by enrollment in MI Health Link





What to Consider

Most people eligible for both Medicare and Medicaid who are enrolled in a Medicaid managed care plan and opt-out of MI Health Link will receive Medicaid services through original Medicaid and not a Medicaid Managed Care plan.

 Services will no longer be coordinated or arranged through a health plan.





What to Consider – Habilitation Supports Waiver

- Habilitation Supports Waiver (Hab waiver) participants do not have to leave the Hab waiver to enroll in MI Health Link
- Medicaid behavioral health services will not be affected by enrolling in MI Health Link





What to Consider – Habilitation Supports Waiver

- For people enrolled in the Hab waiver, the settings where people live and/or receive services do not have to be in compliance with the HCBS Final Rule waiver setting requirements until September 30, 2018.
- Hab waiver participants receiving personal care services through Home Help will receive this service from the MI Health Link health plan and not through the Home Help program





Enrollment and Beyond



Enrollment Periods

UP and Southwest Michigan

- Opt-in enrollment
 - People can enroll no earlier than February 1, 2015
 - Services start no earlier than March 1, 2015
- Passive enrollment of eligible people if they do not opt-out
 - People will receive notices 60 days and 30 days before they are passively enrolled
 - Services start no earlier than May 1, 2015





Enrollment Periods

Wayne and Macomb counties

- Opt-in enrollment
 - People can enroll no earlier than April 1, 2015
 - Services start no earlier than May 1, 2015
- Passive enrollment of eligible people if they do not opt-out
 - People will receive notices 60 days and 30 days before they are passively enrolled
 - Services start no earlier than July 1, 2015





Enrollment

People eligible for MI Health Link will receive a letter explaining

- How to enroll in a MI Health Link health plan
 - Michigan ENROLLS manages MI Health Link enrollment functions
- Whom to contact for help, including the Michigan Medicare/Medicaid Assistance Program (MMAP)
- How to opt-out if they do not want to be part of MI Health Link

Enrollment

- People may change plans or opt-out at any time
 - Changes are effective on the first day of the month
- If people opt-out, the state can not automatically enroll them into a MI Health Link health plan
 - These people are still eligible to enroll if they wish





Selecting A Plan

- In regions in which there is more than one plan, people may compare drug formularies, extra services the plan offers, and other information to choose the best plan for them
- MMAP counselors and Michigan ENROLLS staff will be able to help people understand the differences between plans





Michigan ENROLLS must ensure that enrollment decisions are only made by the individual or an authorized representative of the individual.

- The Department of Human Services records information on responsible parties in its system. This information authorizes family or others to assist with the Medicaid application process.
- Michigan ENROLLS may not use this authorization to assist with enrollment options for MI Health Link.



- When calling Michigan ENROLLS, the customer service representative will ask the caller questions to verify his or her identity
- The beneficiary may give permission on the phone for the customer service representative to speak to another person who is also on the phone. This authorization is valid for that day only.
 - If this authorized person calls back later in the day, Michigan ENROLLS will ask the caller to verify the beneficiary's information as well as the caller's information to be able to assist with enrollment options.



Enrollment – Guardian or DPOA

- If the person calling is the beneficiary's legal representative through a court appointed guardianship or activated durable power of attorney (DPOA) for health care, Michigan ENROLLS will need to verify this in its system.
 - If this cannot be verified in the system, the letter of guardianship or DPOA with two physician letters confirming incapacity, can be submitted to MDCH.
 - MDCH will process this information, send a letter of confirmation to the guardian or DPOA, and transmit this information to Michigan ENROLLS.
 - The guardian or DPOA can then contact Michigan ENROLLS to discuss enrollment options for the beneficiary.





- If the person calling does not have legal authority and the beneficiary cannot give verbal authorization on the phone, Michigan ENROLLS will send the MDCH 1183 form which can be completed and returned to authorize Michigan ENROLLS to speak to another person.
- Letters of Guardianship, DPOA with physician letters or the 1183 can be sent to MDCH at:

Michigan Department of Community Health P.O. Box 30479 Lansing, Michigan 48909-7979

You can fax this information to (517) 241-8556.





People calling to enroll will be asked simple questions during the call

- Nine "yes" or "no" questions to identify current services and immediate or unmet needs
- For people choosing not to answer on the phone, the health plan will work with them to complete the questions





Passive Enrollment

- Phase I passive enrollment will be conducted over two months
- Phase II passive enrollment will be conducted over three months
- People on the same Medicaid case number who are eligible for MI Health Link will be assigned to the same plan unless they choose a different health plan





Passive Enrollment

- Some people are eligible for MI Health Link but are excluded from passive enrollment.
 - MI Choice, PACE and Independence at Home (IAH) participants
 - People in Union or Employer sponsored Medicare health plans
 - Native Americans
 - People already passively enrolled in a health plan in the current calendar year
- These people will only receive the introductory letter #33 and would only be enrolled if they called to join MI Health Link.



Passive Enrollment Notices

When people are passively enrolled in MI Health Link, they may receive multiple notices in the mail

- Michigan ENROLLS will send a 60-day enrollment letter including the name of the MI Health Link health plan in which the person will be enrolled
- If the person was in a Medicare Part D or Medicare
 Advantage plan, that plan will send a letter notifying the
 person that he/she is being disenrolled due to enrollment in
 another plan (MI Health Link)

Passive Enrollment Notices

- These letters may arrive within days of one another
- The MI Health Link health plan becomes your new Medicare Part D plan. You cannot keep your current Part D plan and be enrolled into a MI Health Link health plan at the same time.
- There should be no gap in coverage between your prior Part D plan and your enrollment into your new MI Health Link health plan.

Passive Enrollment Notices

- If a person receiving these letters opts out of MI
 Health Link prior to the enrollment effective date, the
 person's Part D Plan will be restored automatically.
- If a person enrolls in MI Health Link and then decides to opt-out, the person would need to call 1-800-MEDICARE to return to the previous Part D plan.







Enrollees receive a member packet from the health plan including

- A new MI Health Link card
- Provider directory
- Summary of benefits
- Member handbook
- Formulary
- Welcome letter





Proof of Insurance Coverage

- Enrollees can use the welcome letter to receive services for scheduled appointments or emergency services before the new MI Health Link card arrives
- Enrollees should take their Medicare and Medicaid cards to appointments until the MI Health Link card is received as these cards contain information that will help the provider confirm enrollment in MI Health Link





Level I Assessment

- A broad assessment used to identify and evaluate current health and functional needs
- Completed within 45 days of enrollment start date
- MI Health Link health plans are allowed to do this assessment 20 days before the enrollment start date, if the enrollee agrees
- Serves as the basis for further assessment
 - Triggers assessments for personal care services, nursing facility level of care and Level II assessments





Level II Assessment

- Completed within 15 days of the Level I Assessment for people identified with
 - Mental Health or Substance Use Disorder needs
 - Intellectual/developmental disabilities (I/DD) needs
 - Long term supports and services (LTSS) needs
- Health plans will collaborate with PIHPs and LTSS agencies
- Additional supports and services will be coordinated to meet the needs identified





Level II Assessment for people needing Nursing Home or Waiver Services

- The Michigan Nursing Facility Level of Care
 Determination tool will be completed to determine if
 the enrollee meets the requirements for these services
- The health plan will coordinate with long term supports and services providers to meet the enrollee's needs





Level II Assessment for people with Behavioral Health needs

- The health plan will make a referral to the PIHP
- The PIHP will complete a screen to determine mental health service needs and referral to a provider and/or complete Level II assessments







- Each enrollee will help develop his or her own Individual Integrated Care and Supports Plan
- Existing plans of care will be incorporated into the IICSP to avoid disruption of services
- The goal of the IICSP is to identify gaps in services to ensure the enrollee's needs are met





Each enrollee will choose the people to participate in the IICSP process

- Selected family, friends, and providers
- Invited integrated care team members
- Existing care coordinators or case managers





- Follows a person-centered planning process
- Is completed within 90 days of enrollment
- Is the single plan that coordinates care for all services and providers and includes the PIHP and LTSS service plans





- Plan for addressing concerns and goals, as well as measures for achieving them
- Identifies specific providers, supports and services including amount, scope and duration
- Lists the person responsible and time lines for specific interventions, monitoring and reassessment





Ongoing Coordination

Care coordinators will maintain ongoing relationships with enrollees to assure

- Assessments and care plans are revisited and updated periodically
- Questions and concerns are answered and addressed
- Health issues get the attention they deserve
 - The enrollee is satisfied with MI Health Link





Hospice Services

When a MI health Link enrollee decides to receive Hospice services

- The enrollee will be disenrolled from MI Health Link the first day of the month following Hospice election
- The Health plan will continue to pay for services not related to the terminal illness
- The Hospice agency will begin to provide Hospice services starting on the date of Hospice election
- The enrollee does not have to wait to be disenrolled from
 MI Health Link to begin receiving Hospice services

Resources

www.michigan.gov/mihealthlink

MOCH Michigan Department of Community Health



MDCH > PROVIDERS > MI HEALTH LINK



What is MI Health Link?

MI Health Link is a new health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid. The goal of MI Health Link is to provide seamless access to high quality care that reduces costs for those who are eligible. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet the individual needs of the enrollees.

People eligible for MI Health Link will receive services by joining a MI Health Link health plan. Each MI Health Link health plan has a network of doctors and other providers to care for its members. MI Health Link allows those enrolled to use one plan and one card to access services. They will also have a Care Coordinator, who will help get the supports and services needed to make it easier to receive care and live in the community.



Those who are eligible for both Medicare and Medicaid and qualify for MI Health Link will be given their enrollment options through a letter from Michigan ENROLLS.

Spotlight

- NEW MI Health Link Timeline Change
- MI Health Link Brochure





Resources

Visit the MI Health Link webpage to learn more about the program by clicking on

- Spotlight
- Beneficiaries
- Providers
- Other Resources





Resources

www.michigan.gov/mihealthlink

MICHigan Department of Community Health



Birth, Death, Marriage and Divorce Records MDCH > PROVIDERS > MI HEALTH LINK







Physical Health &

Pregnant Women, Children & Families

Behavioral Health & Developmental Disability

lealth Care Coverage

Statistics and Reports

providers

ligh Utilizers

IIPAA

Health Professional Shortage Area

State Innovation

MI Health Link Information for Providers

MI Health Link is a new health care option for Michigan adults, age 21 or older, who are enrolled in both Medicare and Medicaid. Currently, these individuals navigate multiple sets of rules, benefits, insurance cards, and providers in accessing services covered by Medicare Parts A and B, Part D, and Medicaid. Many also have multiple or chronic conditions and will benefit from better care coordination, person-centered planning, and management of health and long term supports and services.

The goal of MI Health Link is to provide seamless access to high quality care through coordination of services currently covered separately by Medicare and Medicaid. MI Health Link offers a broad range of medical and behavioral health services, nursing home care, pharmacy and home and community based services through new managed care entities called Integrated Care Organizations (ICO) and Medicaid's existing Pre-paid Inpatient Health Plans (PIHP). ICOs, PIHPs and providers will be connected through the Care Bridge, a web-based platform for information exchange that is used to coordinate supports and services.

Frequently Asked Questions for Providers





Questions or comments?

If you have questions or comments about the MI Health Link program, please e-mail

MSA-MHL-Feedback@michigan.gov







MI Health Link Provider Webinar: Questions and Answers

1. What is the difference between MI Health Link and the duals program?

MI Health Link is the name of Michigan's new Medicare and Medicaid duals program. This program combines Medicare and Medicaid services for those individuals who are eligible for both Medicare and Medicaid.

2. Is there a list of the MI Health Link health plans [also known as Integrated Care Organizations (ICOs)] for the State of Michigan?

The ICOs participating in MI Health Link are the following:

Upper Peninsula	Upper Peninsula Health Plan	Phone: 877-349-9324
Southwest Michigan	Aetna Better Health of Michigan	Phone: 855-676-5772
	Meridian Health Plan	Phone: 888- 437-0606
Macomb County	Aetna Better Health of Michigan AmeriHealth Michigan Fidelis SecureCare of Michigan HAP Midwest Molina Healthcare of Michigan	Phone: 855-676-5772 Phone: 888-667-0318 Phone: 313-748-4200 Phone: 888-654-0706 Phone: 855-735-5604
Wayne County	Aetna Better Health of Michigan AmeriHealth Michigan Fidelis HAP Midwest Molina Healthcare of Michigan	Phone: 855-676-5772 Phone: 888-667-0318 Phone: 313-748-4200 Phone: 888-654-0706 Phone: 855-735-5604

3. How does MI Health Link interact with Part D prescription plans that most nursing home residents are in?

The Part D prescription coverage is provided through the MI Health Link health plan. When residents enroll in MI Health Link, they will be notified of their disenrollment from their previous Part D plan and that prescriptions will be covered through their new MI Health Link health plan.

4. Will patients entering nursing homes still have to complete the NFLOCD with Medicaid in case they switch out of MI Health link while still in the nursing home?

Yes, the NFLOCD must still be completed prior to admission. For MI Health Link enrollees, the ICO will be responsible for completing the NFLOCD tool. If the resident disenrolls from MI Health Link, the nursing home must complete a new NFLOCD tool in accordance with published Medicaid policy.

5. Is vision care under the Medicaid benefit? Medicare does not cover routine eye care.

MI Health Link combines services and benefits from Medicare and Medicaid. The MI Health Link Health Plan provides vision care which includes routine eye care, glasses and contacts.

6. Are annual well care exams covered in MI Health Link?

Yes, annual wellness checkups are covered in MI Health Link.

7. Is hospice also covered?

No, individuals who are enrolled in hospice are not eligible for MI Health Link. If a MI Health Link enrollee elects hospice, he or she will be disenrolled from MI Health Link the first day of the month following hospice selection. The health plan will continue to pay for services not related to the terminal illness until the time of disenrollment. The hospice agency will begin to provide hospice services starting on the date of hospice election. The enrollee does not have to wait to be disenrolled from MI Health Link to begin receiving hospice services. Please review "Hospice and MI Health Link" in the MI Health Link Toolkit found at www.michigan.gov/mihealthlink.

8. Does this cover chiropractic care?

Yes, MI Health Link covers chiropractic care.

9. Are PIHP/CMH behavioral health services offered as part of MI Health Link? Was the list shown in the presentation all inclusive or just examples?

Yes, behavioral health services are covered in MI Health Link. The list of services in the presentation *is not* all inclusive.

10. Will the DME supply limits follow Medicare guidelines?

Yes, DME supply limits will follow current Medicare and Medicaid guidelines. MI Health Link health plans are able to provide additional or supplemental benefits that cover beyond current guidelines. Please check with the health plan to see if they have enhanced benefits. Benefits may be reviewed through health plan websites, Medicare Plan Finder, and the Michigan Medicare/Medicaid Assistance Program (MMAP).

11. What services will need prior authorizations?

You may check a health plan's Member Handbook and Summary of Benefits to learn which services require prior authorization.

12. Very seldom does a Medicare/Medicaid patient see an out of pocket cost. I am not seeing the additional benefit. For benefits like dental it is more of a challenge to find a dentist who accepts Medicaid. Why is a dentist going to accept MI Health Link but not Medicaid?

An added benefit of MI Health Link is care coordination and person-centered planning. Each MI Health Link enrollee will have his or her own care coordinator to help him schedule appointments, resolve gaps in his services, and give his health care needs the attention they deserve. The MI Health Link health plan must have an adequate number of dental providers as a part of their provider network. Since MI Health Link provides health plans with capitated Medicare and Medicaid rates, MI Health Link plans can set agreeable rates with dental providers. Rate flexibility may attract more providers to serve MI Health Link enrollees.

13. Who is doing the NFLOCDs, and where are they being recorded?

At this time, the MI Health Link health plan will conduct NFLOCDs for enrollees seeking nursing home placement or HCBS wavier services. MDCH is seeking an external entity to conduct NFLOCD for MI Health Link and eventually other programs requiring NFLOCDs. The health plan will not utilize the on-line tool to record the NFLOCD. The health plan will record the enrollee's electronic record, the Integrated Care Bridge Record (ICBR), and will record the outcome of the assessment in the NFLOCD CHAMPS screen for ICO capitation payment verification. If a MI Health Link enrollee would like to enroll in the HCBS waiver, the health plan will submit the NFLOCD for State review.

If a nursing home resident disenrolls from MI Health Link, the nursing home provider must complete a new NFLOCD tool in accordance with published Medicaid policy.

14. How should patient pay amount (PPA) be reflected on a claim?

You should use the current process to report the patient pay amount on a claim to the MI Health Link health plan. Contact your MI Health Link health plan for all claims and billing questions. If a resident is enrolled with a MI Health Link health plan that you have not worked with before, contact the health plan to learn more about its claims and billing process.

15. Are hearing aids covered under MI Health Link?

Some MI Health Link health plans are offering hearing aids as a part of their supplemental benefits. To learn more about health plan benefits, you may go to health plan websites to review their Member Handbook and Summary of Benefits. You may also review benefits through Medicare Plan Finder and by calling MMAP. At this time, hearing aids are not a Medicaid covered benefit, therefore they are not a required service in MI Health Link.

16. Are plans interchangeable? Do providers in Region 1 see patients from other regions?

Plans are not interchangeable. Your care is given by providers in your MI Health Link health plan's in-network providers, unless your health plan gives prior authorization to see an out-

of-network provider or you see the provider during the continuity of care period. You may change your plan if there is another MI Health Link health plan in your region.

17. If there is not a local dentist or optical physician, how far away are nursing homes required to transport individuals to? Are dentists and optical doctors being recruited for the Upper Peninsula?

Medicare requires that providers are no more than 30 minutes or 30 miles away from the individual unless the individual lives in a rural region. The Upper Peninsula has a rural exception for time and distance. Dentists and optical doctors have been recruited by the health plan in the Upper Peninsula.

18. Will all plans reimburse for Medicare coinsurance?

Yes, although following reimbursement requirements, often the amount paid by Medicare is higher than that of Medicaid so the coinsurance payment is \$0. For nursing homes, the ICOs are required to pay the Medicaid co-insurance days for rehab or skilled stays starting on day 21 until the enrollee is discharged from therapy or skilled care.

19. Are the phone numbers that were listed as help numbers on the initial mailing now active? Is someone answering these phones?

The phone numbers listed in the initial mailing were active; however, they were experiencing high call volumes. Please continue to call the phone numbers in the letter. Please check the website for updates on a new specialized outreach opportunity for nursing homes, homes for the aged, and adult foster care homes.

20. How many care coordinators per region will we have to choose from?

Each MI Health Link health plan employs or contracts care coordinators. A health plan must be able to offer choice of care coordinators to its enrollees and meet the enrollees' needs. This activity will be monitored by CMS and MDCH to address any shortages in coordination services.

21. Do providers bill the plans the same way as they bill Michigan Medicaid?

Contact the appropriate MI Health Link health plan for all claims and billing questions.

22. How long is the transition period?

You will find detailed transition period requirements in the attached MI Health Link Continuity of Care Guidance.

23. Why is there passive enrollment? This is what is presenting problems for people that do not want it; cumbersome process to opt-out. 15 minute wait times on hold to opt out.

The Centers for Medicare and Medicaid Services (CMS) required any state participating in the Financial Alignment Demonstration to conduct passive enrollment in the demonstration.

CMS believes beneficiaries still have choice since they can enroll, disenroll or opt-out on a monthly basis

24. I had family members being told they were not able to "opt-out" for the resident even though they were the legal DPOA. We are being told in many instances that the nursing home resident himself must call in to opt-out.

It may be that the individual is not properly recorded as the legal DPOA at Michigan ENROLLS in State systems for Medicaid. We are working on a guardianship and legal representative instructions document which we will be posting on www.michigan.gov/mihealthlink in the next week. Please check back then.

25. Do I need to register my providers with MI Health Program or will we be included as part of their previous Medicare and Medicaid enrollments? How do we know if we are a participating provider? How do we become a participating provider?

You must contact the MI Health Link health plan that you are interested in joining. You will not be automatically included as a MI Health Link provider. You must contract with the MI Health Link health plan to participate as an in-network provider. Contact the MI Health Link health plan(s) in your area. See the response to question #2 for ICO call center contact information. To learn how to become a MI Health Link provider, please contact the individuals in the ICO Provider Contracting Contact list at www.michigan.gov/mihealthlink.

26. Is dental covered in a hospital setting?

Yes, but prior authorization for medical necessity may be needed.

27. Since there is passive enrollment, how often will the patient be able to opt out? Monthly or annually?

An individual may opt in, opt out, or switch plans at any time. The person does not need to continually opt out. Opting out once takes the person out of passive enrollment for the remainder of the program. However, they may choose to voluntarily enroll (opt in) at any time. Changes will be effective on the first of the next month unless the individual opts in or changes plans in the last five days of the month. These changes will be effective the month after the next month. For example, if an individual opts in a health plan on April 29, the enrollment will not be effective until June 1. The individual will start receiving benefits and services on June 1.

28. What is the impact on our reimbursement both as a hospital and long term care provider? Will the reimbursement rates follow Medicare or Medicaid, or will it be a different rate?

Providers must negotiate reimbursement with MI Health Link health plans. For nursing facilities, the ICO are responsible to reimburse at the Medicaid daily rate if other arrangements are not negotiated with the provider. Our website will soon provide a nursing facility guide with more detail. Please periodically check www.michigan.gov/mihealthlink for the guide and other helpful tools.

29. It's great that we are hearing what the patient needs to consider; however, what type of education have the patients received as we are not able to influence them either way?

The Michigan Department of Community Health is available to give presentations to Centers for Independent Living (CILs) & senior centers. There is specialized outreach available in licensed settings, Community Catalysts has been conducting presentations, and MDCH has been hosting webinar trainings in each region as well as hosting regional forums. MDCH offers a brochure and flyer on the MI Health Link website and offers printed brochures for those who request copies. The MI Health Link website has useful information about the program and a toolkit with many helpful materials.

30. Does DHS play any role in participants enrolling?

The Department of Human Services (DHS) continues to determine Medicaid eligibility, but will not participate in MI Health Link enrollment. All enrollment (opt in, opt out or plan changes) must go through Michigan ENROLLS at 1-800-975-7630. TTY uses may call 1-888-263-5897. The office hours are Monday through Friday 8 AM to 7 PM ET.

31. Do you have a sample ID card for us to reference?

You may find a general format of the ID card at http://www.cms.gov/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIIDCard.zip. However, this sample ID card does not include the MI Health Link logo. All MI Health Link health plan member ID cards will include the MI Health Link logo (see image below) at the top right side of the card. This will help providers identify MI Health Link members.



32. Some DHS caseworkers have not entered the "OI" code correctly on the Medicaid record so people with an employer plan are getting the MI Health Link letter and are thoroughly confused.

If eligible for MI Health Link, individuals with employer or union sponsored plans will receive the MI Health Link introductory letter (letter #33). This letter will tell them about MI Health Link and give them the option to enroll. These individual will not receive passive enrollment letters since they are not eligible for passive enrollment. If the OI coding is not correct, people receiving the passive enrollment notices should contact Michigan ENROLLS to opt-out of the program if it is not right for them.

33. What identification number are we using?

The Medicaid ID number will be used for MI Health Link.

34. We were told that the patient could not give permission over the phone.

An individual may give verbal permission for someone else to speak on his or her behalf to Michigan ENROLLS until close of business 7 PM that day.

35. How will an ICO know if a member gives permission to be contacted 20 days prior to enrollment?

The Centers for Medicare and Medicaid Services (CMS) authorized ICOs to contact individuals 20 days prior to enrollment to begin the Level I Assessment. The person may choose to participate in the early assessment or choose to delay this assessment until after the enrollment effective date.

36. Medicaid requires the NFLOCD be completed within 14 days of admission, how will the 45 day timeline for Level I Assessments affect this?

If an individual already resides in a nursing facility at the time of enrollment, the existing NFLCOD is adopted for MI Health Link. In this situation, the ICO will have 90 days after the individual's enrollment to complete a new NFLOCD. If an individual enrolls in MI Health Link and later decides to move into a nursing facility, the ICO will have to complete the NFLOCD within 14 days of admission.

37. What kind of qualifications do the Care Coordinators have? Are they social workers, nurses etc.?

A Care Coordinator must be licensed in Michigan as a registered nurse (RN), nurse practitioner (NP), physician's assistant (PA), Bachelor's prepared social worker (BSW), limited license Master's prepared social worker (LLMSW), or Master's prepared social worker (MSW).

38. Does this program cover swing beds, and does it accept method 2 billing?

Yes. For billing matters, you must contact the ICO for more information.

39. An individual enrolls in the MI Health Link and his Part D plan is cancelled. After a few months the individual decides to disenroll from MI Health Link. Will the individual have to wait for open enrollment to reapply for a Part D plan?

No, the individual will receive a letter asking him to contact Medicare to select a Part D prescription plan. The individual is instructed that if he does not select one, Medicare will choose one for him. In the meantime, prescriptions are covered through the LI NET program. Our website will soon provide a Part D document with more details. Please periodically check www.michigan.gov/mihealthlink for the document and other helpful tools.

40. Are providers that are approved through UPHP also in MI Health link (such as providers that are in WI, Bay Area Medical Center, Greenfield Rehab Services, Prevea, and Aurora Hospital)?

Nursing facility providers must be licensed in Michigan, so out of state providers may not

participate in MI Health Link. However, other provider types will have to join the MI Health Link provider network.

41. Are there CEUs for this presentation or a certificate of completion?

No.

42. In the nursing home, we contract with outside ancillary providers to provide services in the nursing home. I see a problem if our ancillary providers choose not to participate. How will their claim be handled, as not very many providers offer on-site services? If a resident is in the nursing home on a "Medicaid" stay, their Medicare Part B and any other insurance is billed for their labs, x-rays, etc.

The nursing facility should encourage its ancillary service providers to contact the MI Health Link health plan to discuss joining the provider network. The ICO Care Coordinator should be contacted if the enrollee in the nursing home is in needs of services and the facility is not able to identify a network provider for the nursing home resident. The ICO will discuss billing requirements with the provider for services provided outside of those covered by the nursing facility daily rate.

43. Is there a penalty for not enrolling? If so, what is the penalty?

A beneficiary does not have to enroll in MI Health Link. There is no penalty to the beneficiary for opting out. However, Medicaid Health Plan options in the counties have changed, so beneficiaries may not be able to retain their current Medicaid Health Plan and instead may be enrolled in Medicaid fee-for-service. Their Medicare services will remain unchanged. There is no penalty for a provider who does not want to contract as a MI Health Link provider.

44. Will new NFLOCDs be completed for those residents who are already residing in a nursing facility if they chose to enroll in MI Health Link?

Please see question 34.

45. If a nursing home resident has a supplemental insurance plan, will he be able to keep that plan if he is in MI Health link?

Yes, anyone with a supplemental insurance plan can keep that plan while being enrolled in MI Health Link.

46. What happens after the demonstration ends in three (3) years?

If CMS determines the demonstration results in positive health outcomes, CMS may nationally implement the program or continue MI Health Link in Michigan.

47. Currently residents in a nursing facility have to do an annual redetermination for fee-for-service. If they are covered by MI Health Link, is there an annual redetermination?

Medicaid eligibility requires annual redetermination for each Medicaid beneficiary. ICO Care Coordinators are responsible for assuring the redetermination is completed timely and may coordinate with the nursing facility staff to support the resident with the reapplication.

48. Are the ICOs going to be doing trainings for issues that are specific to each ICO? There is great concern about providers, how to do billing, and who will do assessments that are not being specifically addressed in this webinar.

ICOs will conduct their own provider trainings for contracted providers. Information about assessment schedules is available on the resource page found of the MI Health Link website located at www.michigan.gov/mihealthlink.

49. If a beneficiary calls Michigan ENROLLS and gives someone else permission to speak on his behalf to Michigan ENROLLS, the person will have permission for the rest of the day. However, if the permitted person calls again later that day, does the beneficiary need to be with the person? Can the person call on his own without the beneficiary? Does the beneficiary need to be present if the person calls back that day?

No, the beneficiary does not need to be on the line if the beneficiary authorized another person to speak on his behalf earlier in the day. However, Michigan ENROLLS stills need to go through the normal call verification procedures to verify the beneficiary.

50. Will the MI Health Link logo be on the 60 and 30 day passive enrollment letters?

Yes.

51. I know someone who recently received a SNP letter, but the letter did not list both ICOs offered in my region (Southwest Michigan). Which is true? All both Aetna Better Health of Michigan and Meridian Health Plan available in SW Michigan or only one?

If a beneficiary receives a letter about D-SNPs in their area of residence, note that this letter does not concern MI Health Link. D-SNP letters are sent by MDCH on behalf of D-SNP health plans. These letters have been sent to beneficiaries before MI Health Link's origination. Southwest Michigan has two ICOs: Aetna Better Health of Michigan and Meridian Health Plan.

52. Will ICOs be able to speak with individuals who speak non-English languages?

Yes. Many ICOs are hiring multi-lingual member services representatives for their call centers. For languages that representatives are unable to speak, ICOs have contracts with translation organizations.

53. How can someone make sure he has all the right forms for guardianship or power of attorney at Michigan ENROLLS? What documents does Michigan ENROLLS require in order for me to speak on behalf of someone?

We are developing guidance on this process. Please check our website at www.michigan.gov/MIHealthLink for its release. Generally, the DCH 1183 form or letter of guardianship must be on file at MDCH for you to speak on behalf of someone with Michigan ENROLLS.

54. How do I know if my organization is contracted with MI Health Link?

The MI Health Link Health Plans (or ICOs) have developed their own provider networks for this program. You will need to reach out to the ICOs in your region to find out if your organization is contracted with an ICO.

55. Is transportation covered for residents that reside in nursing homes?

For nursing homes, non-ambulance transportation is covered for medical necessity in the facility's daily rate paid to the nursing home by the health plan. For residents meeting the requirements for ambulance transfer, the nursing home must follow the ICO's requirements for prior authorization, scheduling and billing. It is up to the ICO and nursing home to determine how this service will be delivered for individuals in the nursing home.

56. How are Health Risk Assessments communicated to the PCP offices? Who is performing IICSP development?

Health Risk Assessments are referred to as "Level I Assessments" in MI Health Link. Level I Assessments are conducted by the ICO Care Coordinator or an individual contracted by the ICO to conduct assessments. The assessment results as well as the Individual Integrated Care and Supports Plan (IICSP), also known as the plan of care, will be developed by the enrollee and the enrollee's care coordinator with the assistance of additional individuals of the enrollee's choosing through a person-centered planning process. The Level I Assessment and IICSP will be housed in the ICO's Care Bridge Portal for PCPs to access when needed.

57. What should I do if someone is enrolled in hospice but is being passively enrolled in to MI Health Link?

Individuals coded in CHAMPS with a level of care 16 (hospice) will not be passively enrolled in to MI Health Link. If a person is not properly coded and is selected for passive enrollment, please have this person or his or her authorized representative contact Michigan ENROLLS at 1-800-975-7630 to opt-out. TTY uses may call 1-888-263-5897. The office hours for Michigan ENROLLS are Monday through Friday 8 AM to 7 PM ET.

58. Where is Michigan ENROLLS – MDCH or a contracted vendor?

Michigan ENROLLS is a contracted vendor.

59. Can the enrollee select the CMH Supports Coordinator as the ICO Care Coordinator? If so, how do they get trained on that role and is it reimbursable?

All enrollees will have an ICO Care Coordinator. If the individual chooses to have his or her CMH Supports Coordinator be his or her main point of contact, they may. If an enrollee chooses to have their CMH Supports Coordinator as their main point of contact, the CMH Supports Coordinator will be required to regularly communicate and coordinate with the individual's ICO Care Coordinator, but this is not a reimbursable service.

60. Is there a way to opt-out online?

No. Individuals who wish to opt-out of MI Health Link must call Michigan ENROLLS at 1-800-975-7630. TTY uses may call 1-888-263-5897. The office hours for Michigan ENROLLS are Monday through Friday 8 AM to 7 PM ET.

61. How will OBRA assessments and services work with MI Health Link?

The PASRR and OBRA assessment process will remain the same under MI Health Link as well as the nursing facility mental health monitoring service.

62. What metrics are being used to determine the effectiveness of this trial program?

CMS, MDCH, and an independent research organization are all running parallel evaluations of the program. After talking with stakeholders, we've developed over 90 quality measures that health plans must report on a quarterly basis. We will also be conducting consumer satisfaction surveys and eliciting feedback directly from consumers.

63. Will you be using CG-CAHPS for your patient satisfaction surveys? How do we get a list of those 90 measures? Which measures are also PQRS measures?

We will be using CAHPS for patient satisfaction surveys. The exact version of the CAHPS survey is currently under development and will be specific to the dual-eligible population. Many of the measures can be found in Table 16 of the following document: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIEvalPlan.pdf. The remaining measures are in draft and will be released soon and posted on the MI Health Link and CMS Financial Alignment Demonstration websites. By reviewing Table 16 in the preceding document, you will be able to find the measures that are also PQRS measures.

64. What will MI Health Link look like in CHAMPS?

When checking eligibility, individuals enrolled in MI Health Link will have a benefit plan of ICO-MC in CHAMPS.

65.	On a claim, which patient ID number do you want to see? The HIC number or the Medicaio
	ID number of MI Health Link ID?

The MI Health Link ID is the same as the Medicaid ID and should be used on all claims. If the claim allows a second number, the HIC number can also be included.