MI Health Link Public Input Forums

Questions and Answers

Wayne County and Macomb County

June 18, 2015

ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

Q: If someone with Medicaid only hears about MI Health Link, does the individual go to Michigan ENROLLS or go to the local DHHS to apply?

A: An individual must be eligible for both Medicare and Medicaid to be eligible for MI Health Link. Application for Medicaid can be made through the local DHHS office. Once eligible for both Medicaid and Medicare, the individual may call Michigan ENROLLS (1-800-975-7630 or TTY 1-888-263-5897) to select a MI Health Link plan and enroll in the program.

Q: Medicaid beneficiaries lose Medicaid eligibility if they don't submit their redetermination packets timely. How will MI Health Link help with this?

A: Care Coordinators can assist enrollees in submitting the required paperwork to the local DHHS office to avoid loss of Medicaid eligibility. MI Health Link health plans are notified of the redetermination dates for current enrollees.

Q: For MI Health Link (MHL), do you need full Medicare and Medicaid? How can people between 21 and 64 join MHL? What is the Medicare qualification for people under the age 65?

A: You must be eligible for Medicare and Medicaid to join MI Health Link. If you are under age 65, contact the Social Security Administration (SSA) to apply for Medicare. You need to be receiving SSDI for at least 24 months; or have end-stage renal stage, Lou Gehrig's disease, or another specified terminal disease to qualify for Medicare if under age 65. Once eligible for both Medicaid and Medicare, people meeting program eligibility requirements may join MI Health Link.

Q: What is the determination process for passive enrollment assignment to ICOs over the next three months from July-September?

A: There are five MI Health Link health plans, also referred to as Integrated Care Organizations (ICOs). If a person is receiving Medicare services through a Medicare Special Needs Plan (SNP) or Medicaid services from a managed care plan, and the Medicare or Medicaid plan is also participating in MI Health Link, the person would be enrolled in the corresponding MI Health Link health plan. If a person receives Medicare A and B and original Medicaid (not through a health plan), the person is assigned a health plan and is given notice at least 60 days in advance. The person can call Michigan ENROLLS to change to another plan or make another enrollment decision before the effective date of the passive enrollment.

Q: Right now, in order to qualify for Medicaid, there is higher income level. If there is spend down or deductible-eligible, they would not qualify. How does this work?

A: People with a deductible in the community are not eligible for MI Health Link, as this population is not eligible for Medicaid on the first day of the month. There is expanded eligibility available through MI Health Link for people in nursing homes and for those receiving services through the Home and Community Based Services (HCBS) waiver, similar to that of MI Choice. For MI Health Link, the person has to be eligible for Medicare and Medicaid, meeting the financial eligibility standard for Medicaid and the Nursing Facility Level of Care Determination standard before being granted approval for the HCBS waiver.

Q: Why did some beneficiaries who were passively enrolled but opted-out still receive the welcome packet from the health plan?

A: If the disenrollment was not accepted through the state systems, it causes an enrollment discrepancy. Health Plans error on the side of getting information to enrollees if there is an enrollment discrepancy. MDHHS Contract Managers work with enrollment issues to reduce discrepancies and correct any enrollment errors.

Q: For people who want to opt-out of the program and be disenrolled, if they don't do both, will they still be passively enrolled?

A: It is a two-step process that needs to take place during the call with Michigan ENROLLS. Michigan ENROLLS staff is instructed to confirm if the person calling to opt-out of passive enrollment also wants to be disenrolled from the program.

Q: Two steps to disenrollment from MI ENROLLS. What are the two steps?

A: If beneficiary wants to be completely removed from the passive enrollment, he/she has to call a customer service representative (CSR) and tell them "I want to opt-out and disenroll." The reason we have two processes is because someone might want to not enroll at this time (disenroll), but may want to be eligible for passive enrollment next year. Or someone might want to participate in the program (enroll) but not have a plan selected for them in the future (opt-out of passive enrollment).

Q: If someone opts-out or disenrolls, are they able to enroll at a later date?

A: Yes, a person can enroll in the program after disenrolling or opting-out. A person can make different enrollment decisions during the same month and even on the same day. If someone calls Michigan ENROLLS to enroll in the last five days of the month, they will not be enrolled until the following month (for example, if a person calls on 7/29/15 to enroll in MI Health Link, the enrollment will not be effective until 9/1/15.)

PIHP AND BEHAVIORAL HEALTH SERVICES

Q: How will the Mental Health Supports Coordinator be part of MI Health Link?

A: If you are providing Medicaid behavioral health services, these services will not change when the beneficiary enrolls in MI Health Link. The plan of care would only be changed if additional needs were identified, and the enrollee wanted to include these services in the plan of care.

Q: Who is eligible to receive PIHP services? What if they are outside the demonstration region?

A: All Medicaid beneficiaries who have a severe or persistent need for behavioral health services may receive services through the PIHP network of Community Mental Health Services Providers (CMHSP). If they live in a MI Health Link region, they continue to be eligible for PIHP services. The MI Health Link website (www.michigan.gov/mihealthlink) has more information about behavioral health services.

If a beneficiary is living in the MI Health Link region, but the county of fiscal responsibility is not within the MI Health Link region, the beneficiary is still eligible for MI Health Link. Fiscal responsibility does not impact MI Health Link program eligibility.

Q: What happens to a Supports Coordinator if an individual they serve decides to join MHL?

A: The Supports Coordinator from the CMHSP would become part of the integrated care team (ICT) for the individual. Since the Supports Coordinator knows the individual best, the enrollee can request that the Supports Coordinator serve as the main point of contact for the enrollee. The ICO Care Coordinator would maintain responsibility for coordination of services, but would work through the existing Supports Coordinator. Again, very little will change except that the Supports Coordinator may be involved in the ICT as the main point of contact for the enrollee.

Q: If a beneficiary joins MHL, involved in both ICO and PIHP, do they get both coordinators?

A: A beneficiary who heavily relies on PIHP services and their supports coordinator may request this person to serve as the primary point of contact. The ICO Care Coordinator will still be responsible to oversee the ICT and remain responsible for care coordination and service delivery. The beneficiary will gain the support of both coordinators.

SERVICES AND BENEFITS IN MI HEALTH LINK

Q: People are concerned about transportation. How can individuals with end-stage renal disease (ESRD) gain access to services if their current transportation vendor is out-of-network?

A: Under the Continuity of Care requirements, the MI Health Link plans must maintain the same level of services for the first 90 days of enrollment. Enrollees participating in the Habilitation Supports Waiver (HSW) program have 180 days to maintain services under the Continuity of Care requirements. An existing provider may contact the health plan to learn about joining the provider network. An enrollee may talk with the Care Coordinator to discuss having the transportation provider continue to provide services. MI Health Link health plans must provide transportation services to medically necessary appointments and to the pharmacy.

Q: What is the benefit for someone residing in a nursing facility to join MI Health Link?

A: A person would benefit from a dedicated care coordinator who will work with the facility staff to coordinate any additional health care services the person may need. MI Health Link also waives the requirement for a three-day hospital stay prior to receiving skilled or rehabilitation services in a nursing home. Under MI Health Link, people in nursing homes who experience a decline but do not need a three-day hospital stay can receive skilled or rehabilitation services.

Q: If a beneficiary resides in a LTC facility, does he or she have limitation of services provided?

A: All enrollees are provided the same Medicare and State Plan Medicaid services regardless of care setting under MI Health Link. Continuity of Care provisions allow a person in a nursing home at the time of MI Health Link enrollment to stay at the nursing facility for the duration of the program. There is also a 90-day continuity of care requirement for providers and services for anyone who enrolls in the program. People receiving behavioral health and/or Habilitation Supports Waiver services will have 180 days to continue with providers and current service plans.

Q: Is there any difference between type of skilled services and MHL?

A: Medicare requirements for skilled care or rehabilitation services are the same for MI Health Link, except that the three-day hospital stay to quality for skilled care or rehabilitation services in a nursing facility is waived. The type of services and supports remain the same. Plan requirements for prior authorization, referral, and/or documentation of services should be detailed in the contract between the MI Health Link health plan and the nursing facility.

Q: In the case of a Home Help program (Medicare/Medicaid), if a beneficiary does not find the social worker comforting, who can guide him/her?

A: We have a database of providers who have passed the background check from which individuals can choose a provider.

Q: In-patient medical/psychiatric: what if a hospital bills CMS when they were supposed to bill the ICO?

A: The claim would be rejected at the Medicare fiduciary and referred to send the claim to the ICO.

OTHER QUESTIONS ABOUT MI HEALTH LINK

Q: We heard that there is an evaluation requirement in the three-way contract. When will the first evaluation occur and when the result will be available to the public?

A: The Centers for Medicare and Medicaid Services (CMS) is required to perform a program evaluation. CMS's contractor, RTI will oversee the evaluation for Michigan. Quality measures have been established as part of this evaluation. Data provided by the plans and Michigan will be shared with the contractor. CMS has not indicated when the evaluation results will be available to the public.

Q: Are we combining appeal and grievance rights for Medicaid and Medicare?

A: Michigan attempted to incorporate the Medicare and Medicaid appeals processes, but was not able to do so. MI Health Link health plans and the contracted Prepaid Inpatient Health Plans (PIHPs) are required to use the same integrated notices for service denials, discontinuations, or reduction of services. All appeal rights from both Medicare and Medicaid remain available under MI Health Link. Under the federal resources link of the MHL website (www.michigan.gov/mihealthlink), there is a sample letter for the "integrated denial notice."

A MI Health Link Ombudsman program will be operational soon. The role of the ombudsman is to help beneficiaries with the appeal or grievance procedure, respond to inquiries about the program, and help resolve issues. All of the ICOs will have the MHL Ombudsman information in the member handbook, notices, and other enrollee materials.

Q: What is the status of the Integrated Care Bridge?

A: Each MI Health Link health plan must create its own Care Bridge platform to capture, store, and exchange data while providing access to appropriate individuals, including enrollees, via a secure web portal. The Centers for Medicare and Medicaid Services (CMS) did not require the States to develop an integrated platform for the demonstration, although it was initially proposed in our Memorandum of Understanding with CMS. Currently, each MI Health Link health plan has an operational web portal for members, providers, and the PIHPs to access the care bridge record. MDHHS has been working with the MI Health Link health plans and PIHPs to develop consistent electronic exchange of data between these parties. The target date for this exchange is October 2015.