MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-57

Correction made on 1-8-2015. See highlighted text.

Distribution: All Providers

Issued: December 29, 2014

Subject: MI Health Link Program

Effective: March 1, 2015

Programs Affected: MI Health Link, Medicaid

Effective March 1, 2015, the Michigan Department of Community Health (MDCH), in partnership with the Centers for Medicare and Medicaid Services (CMS), will implement a new capitated managed care program, called MI Health Link. This program will integrate into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, and improve quality of care.

Eligibility

Individuals who are eligible to participate are those who are age 21 or older, eligible for Medicare and Medicaid, and reside in one of the four demonstration regions:

Region	Counties in the Region
1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft
4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren
7	Wayne
9	Macomb

Covered Services

CMS and MDCH will contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders.

Individuals enrolled in the MI Health Link program will be able to maintain their current Medicare and Medicaid providers, supports and services for the following timeframes after enrollment:

ICO Transition Requirement for Enrollees receiving services through the HAB waiver and Managed Specialty Services and Supports Program through the PIHPs	
Provider Type	**Timeframe for continuing current services**
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 180 calendar days. (The ICO must honor existing plans of care and Prior Authorizations [PAs] until the authorization ends or 180 calendar days from enrollment, whichever is sooner.)
DME	Must honor PAs when the item has not been delivered, and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 180 calendar days
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 180 calendar days. The Individual Integrated Care and Supports Plan (IICSP) must be reviewed and updated and providers secured within 180 calendar days of enrollment.

ICO Transition Requirements for All Other Enrollees	
Provider Type	**Timeframe for continuing current services**
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 90 calendar days. (ICO must honor existing plans of care and PAs until the authorization ends or 180 calendar days from enrollment, whichever is sooner.)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 90 calendar days

ICO Transition Requirements for All Other Enrollees	
Provider Type	**Timeframe for continuing current services**
Medicaid Nursing Facility Services	Enrollee may remain at the facility through contract with the ICO or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the enrollee chooses to relocate.
Waiver Services	MI Choice Home and Community Based Services (HCBS) waiver enrollees: Maintain current providers and level of services at the time of enrollment for 90 calendar days unless changed during the Person-Centered Planning Process. Not applicable to other enrollees
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 90 calendar days. The Individual Integrated Care and Supports Plan (IICSP) must be reviewed and updated and providers secured within 90 calendar days of enrollment. Not applicable for enrollees transitioning from the MI Choice program.

ICOs are also required to maintain current prescriptions for medications covered by Medicare Part D, according to requirements found at 42 C.F.R. § 423.120(b)(3), for medications that are not included on the ICO's formulary. ICOs must also maintain current prescriptions for 180 days for any medications not covered through Medicare Part D. Medications may not be discontinued after the transition period unless the ICO has notified the enrollee in advance.

Out-of-network nursing facilities must be offered Single Case Agreements by the ICO to continue to care for the enrollee through the life of the program if the nursing facility does not participate in the ICO's network and the Enrollee: 1) resides in the nursing facility at the time of enrollment; 2) has a family member or spouse that resides in the nursing facility; or 3) requires nursing facility care and resides in a retirement community that includes a nursing facility.

The MI Health Link program does not cover hospice services. If MI Health Link enrollees require hospice services, they must disenroll from the MI Health Link program and receive the hospice services through original Medicare and Medicaid.

When does enrollment begin?

Enrollment for the MI Health Link program will occur in two phases, with each phase including an opt-in period followed by a passive enrollment period. Individuals who choose not to participate may opt out of the program. Phase 1 will consist of enrollment for individuals residing in Regions 1 and 4 (listed above). During Phase 1, eligible individuals may choose to opt in to the program beginning no earlier than February 1, 2015. Services for this group will begin no earlier than March 1, 2015. Following the opt-in enrollment period, individuals who have not opted out will be passively enrolled, with services starting no earlier than May 1, 2015.

Phase 2 will consist of enrollment for individuals residing in Regions 7 and 9 (listed above). During Phase 2, eligible individuals may choose to opt in to the program beginning no earlier than March 1, 2015. Services for this group will begin no earlier than May 1, 2015. Following the Phase 2 opt-in period, individuals who have not opted out will be passively enrolled, with services starting no earlier than July 1, 2015.

Individuals will have an opportunity to select the ICO in which they enroll, using the ICO provider networks and drug formularies to assist in making choices. If an ICO is not selected prior to the passive enrollment effective date, individuals will be assigned to an ICO, but will have the option to switch ICOs after enrollment if there is another ICO option in the region.

After enrollment, enrollees will be issued an ID card that is specific to the MI Health Link program. This ID card will be used instead of the traditional Medicare and Medicaid ID cards, and will identify the name of the ICO responsible for coverage along with the MI Health Link logo.

Individuals will be enrolled in the benefit plan called ICO-MC, which is a benefit plan specific to the MI Health Link program.

Care Coordination Process

An important part of the MI Health Link program is person-centered care coordination. The care coordination process will include assessment of the enrollee's health history and current status, development of an IICSP through person-centered planning, creation and maintenance of an Individual Care Bridge Record to promote the storage and sharing of information across providers, collaboration between the enrollee and members of his or her Integrated Care Team, and ongoing monitoring and advocacy.

Provider Participation

Providers have opportunity to participate in MI Health Link by joining the provider networks of the ICOs. ICOs are encouraged to contract with existing service providers for individuals eligible for and enrolling in the program to ensure continuity of care. Likewise, service providers are encouraged to participate in ICO networks to provide choice, continuity of care and high quality service. The ICO will be responsible for authorizing and paying for Medicare and Medicaid services. Additional information about how providers may participate in MI Health Link can be found on the MI Health Link website at: www.michigan.gov/mihealthlink >> MI Health Link Information for Providers.

ICOs are required to make every effort to bring existing Medicaid State Plan Personal Care Services providers or other long term supports and services providers into their network via contract or other agreement if enrollees choose to use their current providers for these types of services. Providers will need to work with the enrollee's ICO to do what needs to be done related to paperwork, services, and payment.

ICOs, ICO provider networks, and other contracted entities must follow the Michigan specific marketing guidance. ICOs in Regions 1 and 4 are not allowed to begin marketing until February 1, 2015. Any questions from providers should be directed to the appropriate ICO.

Medicaid Policy

Any current and future Medicaid policies are applicable to the Medicaid portion of the MI Health Link benefit package.

Level of Care Codes

MDCH has developed level of care codes specific to the MI Health Link program. These codes are as follows:

07: General population in the community
05: Resident of any nursing facility or hospital long term care unit (private or county owned) that is not a County Medical Care Facility
15: Resident of a County Medical Care Facility
03: Individual meets Nursing Facility Level of Care, lives in the community, and participates in the MI Health Link HCBS home and community based services waiver program.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration