Progress in Implementing the Waiver
MI Health Link – Report #1

(FY2017 Appropriation Act - Public Act 268 of 2016)

March 1, 2017

Sec. 1775. (1) By March 1 and September 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office on progress in implementing the waiver to implement managed care for individuals who are eligible for both Medicare and Medicaid, known as MI Health Link, including, but not limited to, a description of how the department intends to ensure that service delivery is integrated, how key components of the proposal are implemented effectively, and any problems and potential solutions as identified by the ombudsman described in subsection (2).

Michigan Department of
Health & Human Services

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Background

The MI Health Link (MHL) Program is intended to integrate care for people who are dually eligible for Medicare and Medicaid. The Program, which operates in four regions of the state (Wayne County, Macomb County, eight counties in the southwest corner of the state, and all counties in the Upper Peninsula) went live in 2015. The Program is administered by seven private health plans known as Integrated Care Organizations (ICO). Participating plans include the Upper Peninsula Health Plan, Meridian and Aetna in southwest Michigan along with Molina, Fidelis, Aetna, AmeriHealth and Health Alliance Plan serving Wayne and Macomb counties. The Program allows dual eligible individuals to voluntarily enroll or to join through passive enrollment. Passive enrollment means that qualifying dual eligible individuals living in any of the four demonstration regions who do not voluntarily enroll or who don't opt out are automatically enrolled into an ICO. Enrollees can chose to leave the Program at any time.

Enrollment

Two changes were implemented that have stabilized enrollment in the MHL Program. First in June of 2016, passive enrollment was set up to occur on a monthly basis. Another change that helped to stabilize eligibility was the implementation of a deeming process that became operational in July 2016. With deeming, individuals who would otherwise be disenrolled from their MHL plan are allowed to maintain enrollment for up to 90 days while issues that have caused a temporary loss of Medicaid eligibility are resolved. During that period, the ICOs are required to provide all services covered under the MHL Program. In many cases, Medicaid eligibility is retroactively reinstated and plans receive all of their capitation payments. However, plans have agreed to accept some financial risk that would result from not receiving a Medicaid capitation payment in situations where Medicaid eligibility is legitimately lost for some or all of the deeming period. There are currently about 800 enrollees in deemed status.

Taken together, monthly passive enrollment and deeming have stabilized MHL enrollment. As of January 31, 2017, there were approximately 37,500 individuals enrolled in the Program. Of that total, approximately 2,050 reside in nursing homes, 603 who qualify for a nursing home level of care live in a community setting as a result of enrollment in the Program's Home and Community-Based Waiver, and the remainder are part of what is referred to as the "community well" group. As previously noted, those who qualify for MHL can enroll or leave the Program at any time.

In addition, collaborative efforts with ICOs and advocate organizations, Medicare/Medicaid Assistance Program, and the Michigan Disability Rights Coalition planned and held MHL Lunch and Learn presentations in the demonstration regions with active and potentially eligible enrollees. In 2016, there were four Lunch and Learn presentations with attendance of approximately 250 individuals.

Program Goals

The integrated care model that has been established for MHL employs care coordination as its foundation with a focus on person-centered planning and self-determination as core values.

Key Program goals of this demonstration project include:

- Seamless access to all services and supports

- Person-centered care coordination model
- Streamlined administrative processes
- Elimination of barriers to home and community-based services
- Nursing facility transition into the community
- Quality services with a focus on enrollee satisfaction
- Realignment of financial incentives
- Cost efficiencies (savings)

Services Integration

The seven ICOs serve as a single management entity that provides integrated coverage of all Medicare and Medicaid Services for each individual who is enrolled in MHL. Services include:

- Medical (physical health) services
- Prescription drug coverage
- Personal care services
- Non-Emergency Medical Transportation
- Nursing facility care
- Dental
- Behavioral health services that would otherwise be covered under Medicare
- Home and Community-Based Services (C waiver)

ICOs receive Medicaid capitation payments from the state of Michigan and Medicare capitation payments from the Federal government. Using these resources, with the exception of some carved-out behavioral health services, ICOs are responsible for covering all of the services noted above for their enrollees. Integration is achieved by having a single managed care organization responsible for the provision of services to each individual member. The Program is based on a robust person-centered care management model which uses a care coordinator to assess an individual's need, oversee all services, and to be available to address the needs and desires of each member.

Program Oversight

The three-way contract that has been established between the states, the Centers for Medicare and Medicaid Services (CMS) and the ICOs includes provisions that ensure integration of services. Both the state and the Federal government (through the Medicare and Medicaid Coordination Office within CMS) provide contract oversight to ensure strict enforcement of these provisions. For each of the seven ICOs, all parties are involved in a contract management team that convenes telephonically on a monthly basis. MHL Program staff includes three contract managers that are part of the contract management team and work on a daily basis with the ICOs to ensure the enforcement of all contract provisions including those which govern services integration. The three-way contract also requires the implementation of a robust quality strategy. To that end, Michigan Department of Health and Human Services and CMS are working together to assess the quality and appropriateness of care and services provided to MHL enrollees through the review and analysis of data from multiple sources.

Ombudsman

An Ombudsman Program, specific to MHL has been operational since December of 2015. Through a procurement process, the Michigan Elder Justice Initiative (MEJI) was selected to serve as the MHL Ombudsman. The purpose of the Ombudsman Program is to offer a channel through which enrolled beneficiaries may seek assistance in resolving any issues they have with the ICO in which they are enrolled or to help file an appeal.

Based on their engagement with enrollees and other stakeholders, the Ombudsman has addressed several issues with the department, including but not limited to problems with referrals for behavioral health services, enrollment discrepancies that are causing confusion and in some cases access issues for beneficiaries, appropriate submission of Home and Community-Based Services waiver applications by the ICOs, issues with operationalizing personal care services, accessing specialized dental services, adequate hospital discharge planning, and accessing people on the MI Choice waiver wait list for potential enrollment into MHL.

Monthly calls occur involving state program staff as well as CMS to discuss issues and solutions with the Ombudsman. In addition, state staff meet periodically with representatives from the Ombudsman Program to review issues that have been presented to them. Solutions are presented and evaluated involving individual cases as well as broader Program concerns. Examples of solutions presented by the Ombudsman include better plan education relative to the submission of home and community-based waiver applications, imposing standard of promptness requirements for care coordinators when responding to enrollee contacts, allowing personal care assessments to carry over to the state Home Help program when someone disenrolles from MHL and instituting penalties for ICOs that allow hospital disharges to occur without an adequate plan for home care. The state evaluates all recommendations for impact on enrollees and for compliance with contractual requirements.

Since April 2016, the Ombudsman Program has handled 445 formal complaints and 137 inquiries.