Progress in Implementing the Waiver
MI Health Link – Report #2

(FY2017 Appropriation Act - Public Act 268 of 2016)

September 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

RICK SNYDER, GOVERNOR
NICK LYON, DIRECTOR

Progress in Implementing the Waiver MI Health Link

(FY2017 Appropriation Act - Public Act 268 section 1775(1) of 2016)

Background

MI Health Link (MHL) is Michigan's demonstration project 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 HAP 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 MI Health Link. 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 MI Health Link 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 Integrated Care Organizations are required to provide all services covered under the MI Health Link 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 547 enrollees in deemed status.

Taken together, monthly passive enrollment and deeming have stabilized enrollment in MI Health Link. As of August 1, 2017, there were approximately 38,728 individuals enrolled in the program. Of that total, approximately 2,067 reside in nursing homes, 766 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 (MMAP) and the Michigan Disability Rights Coalition (MDRC) planned and held MI Health Link Lunch and Learn presentations in the demonstration regions with active and potentially eligible enrollees. From 2016 through August 2017, there were nine Lunch and Learn presentations with attendance of approximately 650 individuals.

Program Goals

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

Key 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 MI Health Link. Services covered under the demonstration 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 coordination model which uses a care coordinator to assess an individual's need, to oversee all services and to be available to address the needs and desires of each member.

Program Oversight

The three-way contact 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. MI Health Link 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, the Michigan Department of Health and Human Services (MDHHS) and CMS are working together to assess the quality and appropriateness of care and services provided to MI Health Link enrollees through the review and analysis of data from multiple sources.

For distribution of the passive enrolls to the ICOs, MDHHS has created an enrollment auto-assignment algorithm. The algorithm will assign passive enrollment to ICOs based on high performance in selected quality measures. These measures were chosen to reward plans for closely following the requirements of the three-way MI Health Link contract in order to best improve quality of life for the individual enrollees.

Based on the requirements of the Memorandum of Understanding, MDHHS established the State Advisory Committee made up of enrollees, providers, and advocates. The State's Committee is organized along region lines, allowing for greater opportunity of access by enrollees, and reduced cost to the state. There are regional committees for Region 1 (the Upper Peninsula), Region 4 (southwest Michigan), and Regions 7 and 9 are combined (Macomb and Wayne Counties). Meetings began in March 2017, with five meetings held among the regions. Prior to formally meeting for the first time, the MDHHS through its contractor, provided training to the enrollee members on holding effective meetings and the role of the Advisory Committee in MI Health Link.

The State Advisory Committees have discussed a range of issues including problems with service providers (mostly transportation service providers), the possibility of persuading the plans to add benefits to their programs, reviewing letters and surveys that the MDHHS either uses or plans on using, and care giver hours under either personal care services or the home and community-based services waiver. There has been discussion related to the extent of the dental benefit and why more enrollees do not take advantage of it and interest in becoming more informed about the program so committee members can help others. Committee members feel very strongly that the State Advisory Committee is an important part of improving and evaluating the demonstration.

Ombudsman

An Ombudsman Program, specific to MI Health Link, has been operational since December of 2015. Through a procurement process, the Michigan Elder Justice Initiative (MEJI) was selected to serve as the MI Health Link 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 Integrated Care Organization 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 MDHHS including but not limited to issues related to enrollment, access to care coordinators, and provider issues. Monthly calls and meetings occur involving state program staff as well as CMS to discuss issues and solutions with the ombudsman. The Ombudsman staff also contacts program staff on an ad-hoc basis to assist with individual cases. The state evaluates all the Ombudsman recommendations for impact on enrollees and for compliance with contractual requirements.

Since April 2016, the Ombudsman program has handled 596 formal complaints and 141 inquiries.