GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

October 1, 2024

**TO:** Interested Party

**RE:** Consultation Summary, MI Health Link Waiver Renewals

Thank you for your comment(s) to the Behavioral and Physical Health and Aging Services Administration related to the MI Health Link 1915(b)(c) draft renewal applications with the proposed effective date of 1/1/2025. Your comment(s) has been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

**Comment:** Please do not passively enroll nursing home residents into the MI Health Link program. Once they enter the nursing home and then are newly qualified for Medicaid, many residents (family) members receive the Michigan Enrolls letter stating they will be enrolled. Many times, these residents do not have traditional Medicare, but are already on a Medicare Advantage plan, along with their spouse.
The process of trying to stop this enrollment is very complicated. The spouse and or power of attorney has to make the phone call and have to prove they can speak for the resident. I've helped a spouse make this phone call (and several in between) and the resident even received a letter that they would not be on the plan. But still were put on the plan. The spouse had to make further phone calls to the State of Michigan and the local DHS office to now state that this person is not paying a premium on the previous coverage. Then their monthly nursing home patient pay will change again. It is too complicated for nursing home residents to be on this plan when automatically enrolled. Unless the resident has this coverage upon admission, please leave nursing home residents out of the enrollment process.

**Response**: Under the current enrollment process, eligible nursing facility residents are included in passive enrollment. Beneficiaries have the option to disenroll if they are automatically enrolled through passive enrollment and have the option to opt out of future passive enrollments. To assure individuals are making their own informed decisions, appropriate consent to speak on behalf of, or make decisions for, the individual is required. If the beneficiary is just disenrolled but the request to opt out is not made, they may be picked up for future passive enrollment. Both the disenrollments and the opt out requests are processed through MI Enrolls. If the beneficiary is covered (by themselves or by a spouse) under an employer sponsored plan, they are excluded from passive enrollment. Individuals enrolled in traditional Medicare Advantage Plans as well as DSNP plans are eligible for passive enrollment. The program will be transitioning

to a new model in 2026 which will have some impacts on the enrollment process. Please refer to www.michigan.gov/mdhhs/doing-business/providers/highly-integrated-dual-eligible-special-needs-plan for more details. The website will be continually updated as information becomes available.

**Comment:** Thank you for the opportunity to provide comments. The Arc Michigan wishes to again state, as we did in a letter to Farah Hanley last year, that while we understand the state is moving to a Highly Integrated Dual Eligibles Special Needs Plan (HIDE), we do not want the state to use this as a step to a Fully Integrated Dual Eligible Special Needs Plan (FIDE).

We oppose a FIDE because we believe that true integration occurs at the point of service, rather than through a top-down change in payer administration. It is key that the state's HIDE initiative is not used as such a step.

When the dual eligibles pilot was initiated some time ago, there was supposed to be a study of the effectiveness of the model. Advocates have never seen the results of this study.

We also find it unfair that people using the Mi Choice Waiver, primarily people who are aging, are not automatically enrolled in MiHealth Link, while people with disabilities are, and must opt out of the program. In fact, our reading of the two waivers finds them to be written from the perspective of the aging community, not the disability community. We found them very medically oriented, particularly the process for individual planning.

We hope that in the future, when writing waiver applications you will consider the following:

- Using performance measures that evaluate quality from the person's perspective.
- Making Goods and Services available in all waivers for all people.
- Using the same terminology across waivers, for example calling a person-centered plan a person-centered plan, not an integrated care service plan.
- Ensuring safeguards for all people like those for people transitioning from the Mi Choice Waiver.
- Making sure that those who decide they don't like MiHealth Link services and disenroll don't go on waiting lists as they do now.
- Allowing guardians to be paid for providing support, particularly during this staffing crisis.

**Response**: At this time, the department has no intention of moving to a FIDE model.

Several program evaluations have been completed and are available publicly. To review these reports, please visit MI Health Link (michigan.gov), and click the menu labeled

"Provider Resources". From here, you will find a list of MI Health Link Evaluation Reports. The evaluation reports may also be accessed through the Michigan Capitated Financial Alignment Model Demonstration website at www.cms.gov/medicaid-chip/medicare-coordination/financial-alignment/mi.

People who are aging and people with disabilities are included in the eligibility categories served by both the MI Choice and MI Health Link waivers. Criteria used to identify individuals eligible for MI Health Link passive enrollment includes exclusions for those that have voluntarily enrolled in MI Choice or PACE and does not distinguish eligibility based on an individual's age or disability.

The MI Health Link program is intended to be a resource for people with disabilities and program staff will continue to evaluate for opportunities to better meet the needs of the community.

Regarding the bulleted feedback:

While a limited set of performance measures are highlighted in the waiver application, the MI Health Link quality team uses a broad spectrum of quality analytics to assess quality from the person's perspective. The MDHHS team is always looking for opportunities to grow this measure set. New federal rules will also shape revisions to the waiver quality strategy and ensure that information related to performance will be more readily available to the public in the near future.

MDHHS endeavors to make waiver services as comprehensive as possible. This priority is balanced by regulatory and budget considerations. Good and Services is available through the MI Health Link 1915c waiver. In accordance with Centers for Medicare and Medicaid Services (CMS) requirements, the service is only available to individuals that self-direct their services.

While the terminology in waiver renewal applications may vary, MDHHS understands the value of using common language in public facing materials. This is a key consideration for the department as options counseling resources for various programs are developed.

All beneficiaries transitioning from other programs to MI Health Link have a required continuity of care period in which their prior Medicare and Medicaid providers, supports, and services must be maintained. Details can be found in Section 6 of the MI Health Link Chapter of the Michigan Medicaid Provider Manual.

Beneficiary choice is a fundamental departmental priority, but unfortunately the capacity of certain programs in certain regions of the state is limited. While it is not within the

scope of this waiver renewal to address that issue, the MI Health Link program continues to prioritize smooth transitions of care for people served.

Future revisions to the waiver, including the addition of legal guardians as acceptable providers of waiver services in limited circumstances are currently under consideration.

**Comment:** MEJI would like to thank the Department for its efforts to update the MI Health Link Waiver, particularly related to the issues identified after the restart of Medicaid redeterminations. Below are additional comments and suggestions related to the Section 1915(b) and 1915(c) MI Health Link Waiver Renewal.
1915(b) Enrollment and Disenrollment (document page 44); 1915(c) Transition Plan (document page 12)
MEJI supports the outlined transition plan, #2b. in particular. The passive enrollment process has shown that many beneficiaries miss letters notifying them of upcoming enrollments, and it seems likely that a person may find themselves in the situation outlined in 2b. Without the transition outlined in 2b the person would lose their waiver enrollment, and MEJI supports doing whatever we can to help folks stay in the waiver. However, it would be nice if this entire section was more explicit not just about the plan transition, but the waiver transition too. MEJI recommends adding language that the state will ensure the beneficiary will maintain their waiver enrollment in any transition, even into an entirely new plan, and outlining what the new plan's obligations re: continuity of care, completing their own waiver assessment(s), and general timelines to complete any of these requirements.
MEJI also recommends that these beneficiaries receive a special letter during the transition period that highlights that they have the MHL waiver and could stand to lose it if they do not choose a new plan (obviously 2b is designed to prevent that scenario, but people can still fall through the cracks and it would certainly be easier for everyone if the beneficiary actively chose a new plan as outlined in 2a.) Some people may not realize that they are in the waiver at all or may not know which services they receive are part of the waiver. By highlighting the waiver issue separately from the general transition outreach all existing MHL enrollees will receive, the existing MHL waiver enrollees may stand a better chance of having a smooth transition. MEJI also recommends that the outgoing care coordinator be required to have a conversation with the beneficiary explaining the situation if the person will be forced to switch plans.
Changes Mirroring the MI Choice Waiver Renewal
MEJI supports the change to make Vehicle Modifications its own unique benefit, much like what was done in the recent MI Choice Waiver renewal. MEJI recommends that the MHL Waiver renewal mirror other elements of the MI Choice Waiver renewal, such as allowing spouses and legally responsible adults to be paid caregivers and grocery delivery services.
Enrollment into MHL Waiver
MEJI renews its request for the Department to mirror the MI Choice Waiver and add an option for enrollees to qualify for Medicaid via the waiver, even if the person only meets

Medicaid eligibility requirements via the 300% SSI income level or other income/asset rules offered by the waiver. As it stands now, a person can only get access to those additional income/asset rules by qualifying for straight Medicaid, enrolling in MI Health Link, then enrolling into the MHL waiver. If a person could qualify for Medicaid like they do in MI Choice, we would greatly expand the number of enrollees in the waiver across the state. This will be even more important once the program goes statewide in 2027. The income/asset rules for the waiver are one of its most essential benefits, and having a second statewide waiver that beneficiaries could utilize and qualify for just like with MI Choice would be an enormous step in the state's efforts to provide home and community-based services.
Language in the HIDE-SNP RFP already hints at a path to implement this policy: "For individuals whose Medicaid eligibility is dependent on them receiving HCBS waiver services, Contractor may enroll the person in the HIDE SNP HCBS Waiver at the same time it enrolls the person in the plan. All enrollment rules apply." Presumably this language exists for scenarios in which a person already in the waiver is switching plans, but it could easily apply to people who cannot qualify for Medicaid without the waiver's income/asset rules. MEJI urges the Department to expand access to the MHL waiver and allow beneficiaries to qualify for the waiver and Medicaid before they enroll into the plan, whether that is in this or a future waiver renewal.

**Response**: Thank you for your comments. MDHHS is committed to operationalizing a seamless transition process that ensures continuity of care and prevents service interruption or loss for beneficiaries. We aim to implement a robust targeted communication strategy to ensure beneficiaries, including those on the MHL Home and Community Based Services (HCBS) waiver, understand their enrollment options, and provide detailed information and additional support if there is a risk of losing HCBS enrollment. We have been in ongoing communication with CMS and have made further revisions to the transition plan to comply with the requirements at §422.60(g). We have also more explicitly stated in the plan that any passive movement of beneficiaries from ICO to HIDE SNP plans will include passive transfer of the HCBS enrollment. The 1915b/c applications with the revised plan will be posted to the MHL website for review. Specific guidance regarding requirements for care coordination activities during the transition period will be forthcoming.

MDHHS is continuing to evaluate future revisions to the 1915c waiver application that align with Department and program goals of improving access to the HCBS waiver and HCBS waiver services. We appreciate your related comments and will consider the feedback in ongoing program development discussions.

**Comment:** On behalf of Careforth, we thank you for this opportunity to comment on MDHHS' proposed MI Health Link 1915 (b/c) Waiver renewal. We acknowledge and appreciate the Department's continued commitment to improving care integration and

health outcomes for dual beneficiaries enrolled in MI Health Link and support the renewal application.

As noted in an ATI profile of Dual Beneficiaries, “The needs of dual beneficiaries have an outsized impact on their families. Dual beneficiaries are one and a half times more likely than Medicare-only beneficiaries to live alone and twice as likely to live with a children and/or grandchildren without a spouse or partner.”

We are grateful that our advocacy work in Michigan has identified broad support for comprehensive services to activate and engage family caregivers, and that the SFY2025 State Budget contains the necessary funding to introduce Structured Family Caregiving (SFC) to Waiver-eligible beneficiaries and their family caregivers. SFC has proven to be impactful in ensuring dual eligible populations, enrolled in Medicaid managed care organizations, can continue to be cared for at home by extending ongoing professional coaching and financial support to their family caregivers. This work is foundational to achieving the Quadruple Aim and aligned with the overarching goals of Medicare and Medicaid integration to improve outcomes for individuals with complex health conditions.

We look forward to the announcement of upcoming stakeholder sessions regarding the development of the SFC service and to subsequent amendments to the MI Choice and MI Health Link Waivers to add SFC as a new service. We are confident the service will further the State’s efforts to improve care and health outcomes for older Michiganders, individuals with disabilities, and those family caregivers who are feeling that “outsized impact”.

**Response**: Thank you for your comments. Due to the way it was approached in legislation, Structured Family Caregiving (SFC) is currently exclusive to the MI Choice waiver. There are no plans to introduce this service in MI Health Link at this time.

Thank you for your inquiry. We trust that previous responses addressed the concerns and questions noted. If you wish to comment further, send your comments to Aimee Miller at: millera64@michigan.gov.

Sincerely,

Meghan Groen, Director
Behavioral and Physical Health and Aging Services Administration