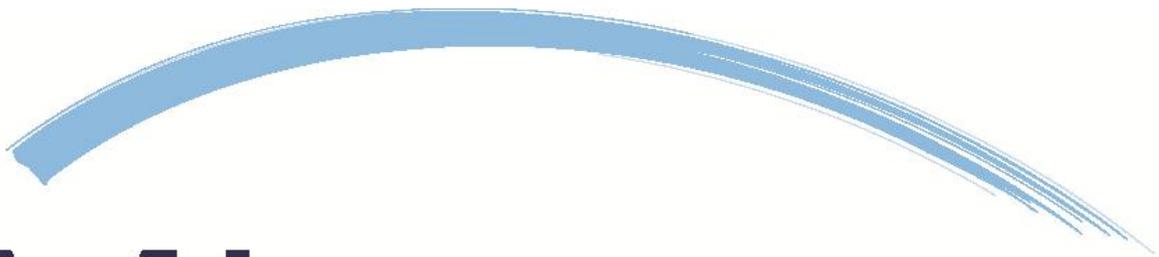




## Michigan Department of Community Health

Director Nick Lyon



# MI HEALTH LINK

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Linking Medicare and Medicaid for you

# Program Overview

- MI Health Link
- Eligibility Criteria
- Benefits of MI Health Link
- Covered Services
- Enrollee Protections
- What to Consider
- Enrollment and Beyond



# MI Health Link

- A new program that joins Medicare and Medicaid benefits, rules and payments into **one** coordinated delivery system
- New MI Health Link health plans and current Michigan Pre-paid Inpatient Health Plans (PIHPs) receive payments to provide covered services



# MI Health Link

- Three-way contract between CMS, MDCH and Integrated Care Organizations (ICOs) called MI Health Link health plans
- MI Health Link health plans hold sub-contracts with Pre-Paid Inpatient Health Plans (PIHPs) for Medicare behavioral health services
- Operates under a capitated financial alignment model



# MI Health Link

- Three year program with services beginning in the first regions no earlier than March 1, 2015
- Provided in four regions in the state

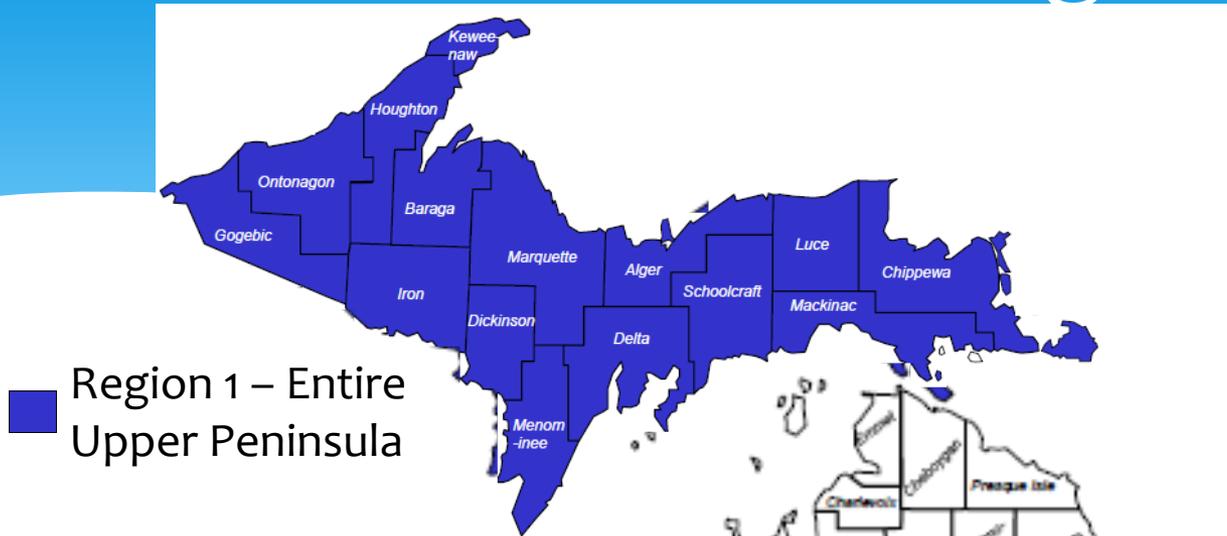


# MI Health Link Regions

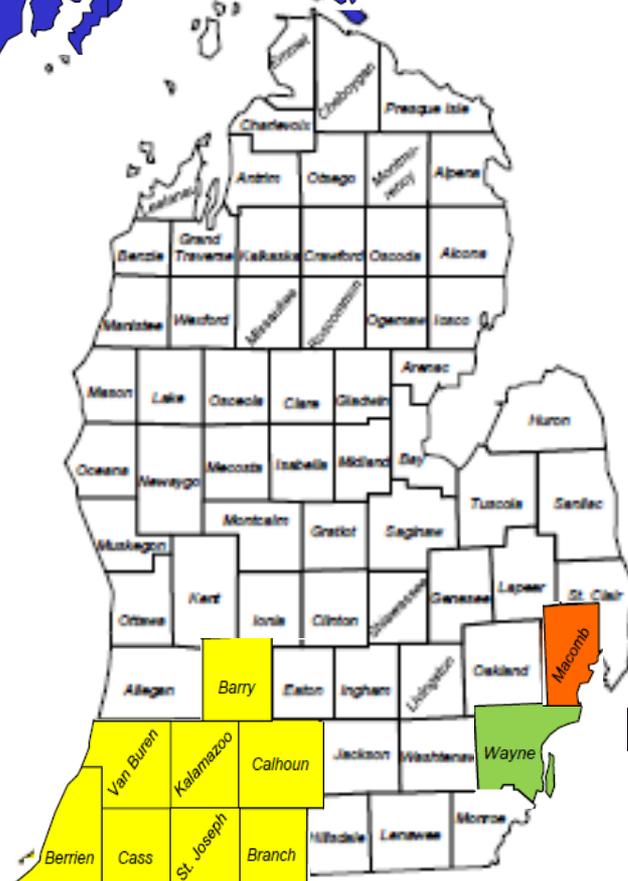
- **Region 1** - Entire Upper Peninsula
- **Region 4** - Southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties)
- **Region 7** - Wayne County
- **Region 9** - Macomb County



# MI Health Link Regions



■ Region 1 – Entire Upper Peninsula



■ Region 2 – Southwest Michigan

■ Region 9 – Macomb County

■ Region 7 – Wayne County



# Region 1 – Upper Peninsula

## MI Health Link health plan

- Upper Peninsula Health Plan

## Pre-Paid Inpatient Health Plan

- NorthCare Network



# Region 4 – Southwest Michigan

## MI Health Link health plan options

- Aetna Better Health of Michigan
- Meridian Health Plan

## Pre-Paid Inpatient Health Plan

- Southwest Michigan Behavioral Health



# Region 7 – Wayne County

## MI Health Link health plan options

- Aetna Better Health of Michigan
- AmeriHealth
- Fidelis SecureCare
- HAP Midwest Health Plan
- Molina Healthcare

## Pre-Paid Inpatient Health Plan

- Detroit-Wayne Mental Health Authority



# Region 9 - Macomb County

## MI Health Link health plan options

- Aetna Better Health of Michigan
- AmeriHealth
- Fidelis SecureCare
- HAP Midwest Health Plan
- Molina Healthcare

## Pre-Paid Inpatient Health Plan

- Macomb PIHP



# Eligibility Criteria



# Eligibility Criteria

People may be eligible for MI Health Link if they

- Live in one of the four regions
- Are age 21 or over
- Are eligible for full benefits under both Medicare and Medicaid, and
- Are not enrolled in hospice

Adults age 21 or over who are enrolled in the Children's Special Health Care Services program are not eligible for MI Health Link



# Eligibility Criteria

- People enrolled in PACE and MI Choice are eligible, but must leave their programs before joining MI Health Link
- People with a Medicaid deductible are not eligible for MI Health Link
- People in a nursing home are eligible and must continue to pay their patient pay amount to the nursing home
- People with Medigap (Medicare supplemental insurance) can enroll in MI Health Link if they meet all other eligibility criteria



# Benefits of Joining MI Health Link



# Benefits of MI Health Link

- No co-payments or deductibles for in-network services, **including medications**
  - Nursing home patient pay amounts still apply
- One health plan to manage all Medicare and Medicaid covered services
- One card to access all MI Health Link services
  - People should keep their Medicare and Medicaid cards in the event they choose to leave MI Health Link



# Benefits of MI Health Link

- Person-centered care with a focus on supports for community living, not just doctor-driven medicine
- Access to a 24/7 Nurse Advice Line to answer questions



# Benefits of MI Health Link

Each enrollee will have a Care Coordinator who will

- Work with the enrollee to create a personal care plan based on the enrollee's goals
- Answer questions and make sure that health care issues get the attention they deserve
- Connect the enrollee to supports and services needed to be healthy and live where the enrollee wants



# Care Coordination Example

## Bertha

**Age:** 88 years old

**Lives in:** Marquette

**Other information:** Bertha and her husband, George (92 years old), live in their home of 60 years and wish to stay there.

**Health issue:** Bertha wants to go to the dentist for a routine teeth cleaning but does not have transportation.



# Care Coordination Example

## Bertha

**Identification of Need:** Bertha's Care coordinator calls Bertha knowing she's due for an appointment and learns she needs transportation to the appointment.

**Scheduling of Service:** The care coordinator asks Bertha when she'd like to have the appointment and schedules it for her with a dentist in the network that the health plan has established.



# Care Coordination Example

## Bertha

**Unmet Need:** The Care Coordinator arranges for transportation which is paid for by Bertha's health plan and shares the driver's contact information with Bertha.

**Service Delivery:** Bertha makes it to her appointment to get her teeth cleaned. She is not charged anything for the cleaning because she selected a dentist who is in the health plan's network.



# Care Coordination Example

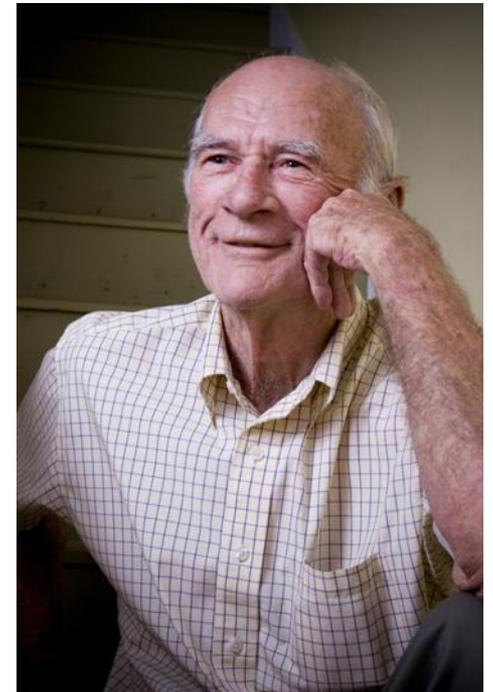
## Dan

**Age:** 67 years old

**Lives in:** Battle Creek

**Other information:** Dan is residing in a nursing facility because he is recovering from an accident.

**Health issue:** Dan would like to move back home and live with his dog, Bronco, but his current health condition is preventing him from doing so.



# Care Coordination Example

## Dan

**Discharge Plan:** Dan's Care Coordinator works with Dan and the nursing home staff to develop his discharge plan including the need for a wheelchair and other services in the community.

**Modifications:** Following a home evaluation, Dan will need a ramp in order to enter and exit his home with his wheelchair so they arrange to have one installed prior to him returning home. Grab bars for the bathroom and a raised toilet seat are additional home modifications arranged for Dan prior to him returning home.



# Care Coordination Example

## Dan

**Service Delivery:** Dan will need assistance with snow removal, activities of daily living and cooking, so the Care Coordinator also arranges for chore services, personal care and home delivered meals. Dan selects his providers from those in the plan's network.

**Quality of Life:** Dan returns home to live independently with a few services, a new wheelchair and Bronco.



# Care Coordination Example

## Matty

**Age:** 32 years old

**Lives in:** Warren

**Other information:** Matty lives in an Adult Foster Care home and receives services through the Habilitation Supports Waiver. He has a developmental disability and a behavioral health issue, which he manages by visiting his therapist.

**Health issue:** Matty trusts his PIHP Supports Coordinator to help him accomplish his goals. Matty is worried that he will lose his coordinator by joining MI Health Link.



# Care Coordination Example

## Matty

**Coordination:** Care Coordinator will work together with PIHP Supports Coordinator. Matty will be able to have both of them help him meet his needs, but Matty requests that the PIHP Supports Coordinator be his primary point of contact. Most importantly, Matty can remain on the Habilitation Supports Waiver and be enrolled in MI Health Link.

**Unmet Need:** While working together with Matty, the coordinators realize that he has a family history of diabetes.



# Care Coordination Example

## Matty

**Service Delivery:** Matty sees his new Primary Care Physician which the Care Coordinator helped him pick. Matty will have no co-payments for the check-up from an in-network doctor or any medications the doctor prescribes.

**Care Planning :** The Coordinators arrange for check-ups and help him to develop a nutrition and exercise program to help Matty prevent diabetes. Matty enjoys swimming so he joined a water aerobics class.



# Benefits of MI Health Link

## Each enrollee may

- Change or select the Care Coordinator assigned to them by the MI Health Link health plan
- Choose to have an existing supports coordinator or case manager to serve as his or her primary point of contact
  - In this situation, the Care Coordinator would work through this person to coordinate care and arrange supports and services



# Benefits of MI Health Link

## Each enrollee will have access to an Integrated Care Team

- The team will include doctors, other providers, and anyone else the enrollee would like to have on the team
- The team will work with the enrollee to identify goals and preferences for care and services





# Covered Services



# Covered Services

All health care covered by Medicare and Medicaid

- Medications (**without co-pays**)
- Dental and vision services
- Equipment and medical supplies
- Physicians and specialists
- Emergency and urgent care including emergency care when out of the demonstration region



# Covered Services

All health care covered by Medicare and Medicaid

- Hospital stays and surgeries
- Diagnostic testing and lab services
- Skilled nursing and rehabilitation services
- Home health services
- Transportation for medical emergencies and medical appointments



# Covered Services

## Long Term Supports and Services (LTSS)

- Personal care
- Equipment to help with activities of daily living
- Chore services
- Home modifications
- Adult day program
- Private duty nursing



# Covered Services

## Long Term Supports and Services (LTSS)

- Preventive nursing services
- Respite
- Home delivered meals
- Community transition services
- Fiscal intermediary services
- Personal emergency response system
- Nursing home care



# Covered Services

## Additional services offered by the health plan

- Health plans can offer services not covered by Medicare and Medicaid
- Health plans can enhance Medicare and Medicaid services
  - May cover supplies or services more often
  - May cover a higher dollar amount when there is a dollar limit on a service



# Covered Services

## Behavioral Health Services

- Provided to individuals who have a mental illness, intellectual/developmental disability and/or substance use disorder
- May be accessed by contacting the MI Health Link health plan, PIHP or local Community Mental Health Service Provider (CMHSP)



# Covered Services

## Behavioral Health Services

- If currently receiving services through the CMHSP, services will not change or be interrupted
- Personal care services previously provided through the Home Help program are the responsibility of the MI Health Link health plan



# Covered Services

Behavioral health services are medically necessary services, including these examples

- Individual, group, and/or family therapy
- Medication review
- Supported employment
- Community living supports (meal preparation, laundry, chores, food shopping)
- Substance use disorder services (assessment, treatment planning, stage-based interventions, referral and placement)



# Enrollee Protections



# Enrollee Protections

- MI Health Link follows the current grievance and appeal processes for Medicare and Medicaid services
- Enrollees are offered appropriate appeal rights
- With a timely appeal request, Medicare and Medicaid services will **continue** to be provided during the appeal
- The MI Health Link health plan and the PIHP will use the same notice which will direct enrollees to the entity they should contact if they wish to appeal an action



# Enrollee Protections

- A MI Health Link Ombudsman program will be available to help resolve problems and answer questions
- Health plans must offer a choice of providers and care coordinators
- Health plans must honor the continuity of care requirements per the three-way contract



# Continuity of Care

## The health plan must

- Allow enrollees to continue to see current doctors and other providers during the transition period
- Pay out-of-network doctors and other providers during the transition period at no cost to the enrollee



# Continuity of Care

## The health plan must

- Allow choice of personal care service providers including paying family members or friends to provide the service if the provider meets the criteria to enroll in the health plan's network
- Work to bring enrollees' current providers into the health plan's network
- Cover current prescriptions not on the plan's drug list



# Continuity of Care

## The health plan must

- Honor current authorizations for services
  - These can be reported to the health plan by the enrollee or provider
  - Personal Care authorization information is provided to the health plan by MDCH



# Continuity of Care

- Enrollees in nursing homes at the time of enrollment **are not** required to move to a nursing home in the health plan's network
- The MI Health Link health plan must enter into single-case agreements with out-of-network nursing homes for enrollees meeting the following criteria



# Continuity of Care

## Criteria

An enrollee has the right to live in an out-of-network nursing home for the life of the program if the enrollee

- Resides in the nursing home at the time of enrollment, **or**
- Residents in a bed not certified for both Medicare and Medicaid at the time of enrollment (applies to in-network and out-of-network providers)
- Has a family member or spouse that resides in the nursing home, **or**
- Requires nursing home care and resides in a retirement community that includes a nursing home which is not in the health plan's network



# Continuity of Care

## Timeframes

- Home Health and Personal Care Providers, Physician and Practitioners

For people receiving services from the PIHP Specialty Services and Supports Program or Habilitation Supports Waiver, the health plan must maintain current provider and level of services at the time of enrollment for 180 days



# Continuity of Care

## Timeframes

- Home Health and Personal Care Providers, Physician and Practitioners

For all other enrollees, the health plan must maintain current provider and level of services at the time of enrollment for 90 days



# Continuity of Care

## Timeframes

- Prescriptions
  - The health plan must cover at least a temporary 30-day supply of the drug for at least 90 days if
    - The enrollee is taking a drug that is not on the health plan's drug list, **or**
    - The health plan's rules do not cover the amount ordered by the prescriber, **or**
    - The drug requires prior approval by the health plan, **or**
    - The enrollee is taking a drug that is part of a step therapy restriction
  - The enrollee can ask the health plan to make an exception to cover a drug that is not on the drug list



# Continuity of Care

## Timeframes

- Prescriptions in a Nursing Facility
  - The health plan must refill prescriptions for enrollees in a nursing facility for a minimum of 91 days
  - The health plan must refill the drug multiple times during the first 90 days of enrollment, as needed
  - This gives the prescriber time to change the drugs to ones on the drug list or ask for an exception



# Continuity of Care

## Timeframes

- Scheduled Surgeries

The health plan must honor surgeries and the associated providers which were authorized within 180 days prior to enrollment

- Dialysis

The health plan must maintain current level of service and same provider at the time of enrollment for 180 days



# Continuity of Care

## Timeframes

- **Chemotherapy and Radiation**

Treatment initiated prior to enrollment must be authorized by the plan through the course of treatment with the specified provider

- **Organ, Bone Marrow, and Hematopoietic Stem Cell Transplant**

The health plan must honor specified provider, prior authorizations, and plans of care



# Continuity of Care

## Timeframes

- Durable Medical Equipment

The health plan must honor prior authorizations when the item has not been delivered and must review ongoing prior authorizations for medical necessity

- Dental and Vision

The health plan must honor prior authorization when an item has not been delivered



# Continuity of Care

## Timeframes

- MI Choice Home and Community Based Services (HCBS) Waiver services

For enrollees previously participating in the MI Choice HCBS waiver, the health plan must maintain the providers and level of services at the time of enrollment for 90 days

Applicable only to the MI Choice services which are also covered by the MI Health Link HCBS waiver



# What to consider when joining MI Health Link



# What to Consider

- Do current doctors and other providers participate in the MI Health Link health plan?
  - If not, would the provider consider joining the MI Health Link plan?
- Are current medications covered by the MI Health Link health plan?
  - Each plan offers its own list of covered medications



# What to Consider – MI Choice

- Participants have to leave the MI Choice program to join MI Health Link
- There are differences between the MI Choice and MI Health Link home and community based waiver services
  - For example, private duty nursing is limited to 16 hours/day in MI Health Link and not all MI Choice services are available in MI Health Link
- If the person wants to return to MI Choice, he or she may have to wait for an opening



# What to Consider – MI Choice

## When a MI Choice participant calls to enroll

- MDCH will take additional steps before enrollment to determine if the person will be eligible for MI Health Link HCBS waiver services
- MDCH will contact the person to explain options for the different programs and any impact MI Health Link enrollment could have on Medicaid eligibility before the person makes a final enrollment decision



# What to Consider – MI Choice

For MI Choice participants living in an adult foster care home or a home for aged

- This setting may not be approved under the new Home and Community Based Services rules applicable to the MI Health Link HBCS waiver
- Participants should discuss this issue with their current MI Choice supports coordinator



# What to Consider - PACE

## PACE integrates Medicare and Medicaid services

- Services are primarily provided in the PACE Center
- Participants must use the PACE primary care physicians in the PACE centers and other providers (such as hospitals) that are contracted with the PACE organization
- PACE provides social interaction in the PACE Center for participants



# What to Consider - PACE

- MI Health Link services are not centralized at a center like PACE and are primarily delivered at various provider offices or in the person's home
- If enrolling in MI Health Link, people must use the MI Health Link health plan provider network and not the PACE network
- Participants have to leave PACE to join MI Health Link
- If the person wants to return to PACE, he or she will have to reapply for PACE



# What to Consider – Home Help

- MI Health Link enrollees can use the same personal care provider they had in Home Help **if** the provider meets the MI Health Link health plan criteria, including a background check, to enroll as a network provider
- The personal care provider will need to contact the MI Health Link health plan to enroll in the provider network to receive payment for personal care services



# What to Consider – Home Help

- The MI Health Link health plan must provide the same amount of services until a new assessment is performed
- Personal care services will be provided through the MI Health Link health plans and not through the Home Help program
- If a person disenrolls from MI Health Link, there could be a delay in receiving personal care services while reapplying to the Home Help program



# What to Consider

People and their dependents with employer or union sponsored **Medicare** insurance plans who join MI Health Link may not be able to return to those insurance plans

- The individual should check with his or her retiree benefits management system or human resources for more information
- People's **private** employer or union sponsored insurance (as their primary insurance) will not be impacted by enrollment in MI Health Link



# What to Consider

Most people eligible for both Medicare and Medicaid who are enrolled in a Medicaid managed care plan and opt-out of MI Health Link will receive Medicaid services through original Medicaid and not a Medicaid Managed Care plan.

- Services will no longer be coordinated or arranged through a health plan.



# What to Consider – Habilitation Supports Waiver

- Habilitation Supports Waiver (Hab waiver) participants **do not** have to leave the Hab waiver to enroll in MI Health Link
- Medicaid behavioral health services **will not** be affected by enrolling in MI Health Link



# What to Consider – Habilitation Supports Waiver

- For people enrolled in the Hab waiver, the settings where people live and/or receive services do not have to be in compliance with the HCBS Final Rule waiver setting requirements until September 30, 2018.
- Hab waiver participants receiving personal care services through Home Help will receive this service from the MI Health Link health plan and not through the Home Help program



# Enrollment and Beyond



# Enrollment Periods

## UP and Southwest Michigan

- Opt-in enrollment
  - People can enroll no earlier than February 1, 2015
  - Services start no earlier than March 1, 2015
- Passive enrollment of eligible people if they do not opt-out
  - People will receive notices 60 days and 30 days before they are passively enrolled
  - Services start no earlier than May 1, 2015



# Enrollment Periods

## Wayne and Macomb counties

- Opt-in enrollment
  - People can enroll no earlier than April 1, 2015
  - Services start no earlier than May 1, 2015
- Passive enrollment of eligible people if they do not opt-out
  - People will receive notices 60 days and 30 days before they are passively enrolled
  - Services start no earlier than July 1, 2015



# Enrollment

People eligible for MI Health Link will receive a letter explaining

- How to enroll in a MI Health Link health plan
  - Michigan ENROLLS manages MI Health Link enrollment functions
- Whom to contact for help, including the Michigan Medicare/Medicaid Assistance Program (MMAP)
- How to opt-out if they do not want to be part of MI Health Link



# Enrollment

- People may change plans or opt-out at any time
  - Changes are effective on the first day of the month
- If people opt-out, the state can not automatically enroll them into a MI Health Link health plan
  - These people are still eligible to enroll if they wish



# Enrollment

## Selecting A Plan

- In regions in which there is more than one plan, people may compare drug formularies, extra services the plan offers, and other information to choose the best plan for them
- MMAP counselors and Michigan ENROLLS staff will be able to help people understand the differences between plans



# Enrollment

Michigan ENROLLS must ensure that enrollment decisions are only made by the individual or an authorized representative of the individual.

- The Department of Human Services records information on responsible parties in its system. This information authorizes family or others to assist with the Medicaid application process.
- Michigan ENROLLS may not use this authorization to assist with enrollment options for MI Health Link.



# Enrollment

- When calling Michigan ENROLLS, the customer service representative will ask the caller questions to verify his or her identity
- The beneficiary may give permission on the phone for the customer service representative to speak to another person who is also on the phone. This authorization is valid for that day only.
- If this authorized person calls back later in the day, Michigan ENROLLS will ask the caller to verify the beneficiary's information as well as the caller's information to be able to assist with enrollment options.



# Enrollment – Guardian or DPOA

- If the person calling is the beneficiary's legal representative through a court appointed guardianship or activated durable power of attorney (DPOA) for health care, Michigan ENROLLS will need to verify this in its system.
  - If this cannot be verified in the system, the letter of guardianship or DPOA with two physician letters confirming incapacity, can be submitted to MDCH.
  - MDCH will process this information, send a letter of confirmation to the guardian or DPOA, and transmit this information to Michigan ENROLLS.
  - The guardian or DPOA can then contact Michigan ENROLLS to discuss enrollment options for the beneficiary.



# Enrollment

- If the person calling does not have legal authority and the beneficiary cannot give verbal authorization on the phone, Michigan ENROLLS will send the MDCH 1183 form which can be completed and returned to authorize Michigan ENROLLS to speak to another person.
- Letters of Guardianship, DPOA with physician letters or the 1183 can be sent to MDCH at:

Michigan Department of Community Health  
P.O. Box 30479  
Lansing, Michigan 48909-7979

You can fax this information to (517) 241-8556.



# Enrollment

People calling to enroll will be asked simple questions during the call

- Nine “yes” or “no” questions to identify current services and immediate or unmet needs
- For people choosing not to answer on the phone, the health plan will work with them to complete the questions



# Passive Enrollment

- Phase I passive enrollment will be conducted over two months
- Phase II passive enrollment will be conducted over three months
- People on the same Medicaid case number who are eligible for MI Health Link will be assigned to the same plan unless they choose a different health plan



# Passive Enrollment

- Some people are eligible for MI Health Link but are excluded from passive enrollment.
  - MI Choice, PACE and Independence at Home (IAH) participants
  - People in Union or Employer sponsored **Medicare** health plans
  - Native Americans
  - People already passively enrolled in a health plan in the current calendar year
- These people will only receive the introductory letter #33 and would only be enrolled if they called to join MI Health Link.



# Passive Enrollment Notices

When people are passively enrolled in MI Health Link, they may receive multiple notices in the mail

- Michigan ENROLLS will send a 60-day enrollment letter including the name of the MI Health Link health plan in which the person will be enrolled
- If the person was in a Medicare Part D or Medicare Advantage plan, that plan will send a letter notifying the person that he/she is being disenrolled due to enrollment in another plan (MI Health Link)



# Passive Enrollment Notices

- These letters may arrive within days of one another
- The MI Health Link health plan becomes your new Medicare Part D plan. You cannot keep your current Part D plan and be enrolled into a MI Health Link health plan at the same time.
- There should be no gap in coverage between your prior Part D plan and your enrollment into your new MI Health Link health plan.



# Passive Enrollment Notices

- If a person receiving these letters opts out of MI Health Link prior to the enrollment effective date, the person's Part D Plan will be restored automatically.
- If a person enrolls in MI Health Link and then decides to opt-out, the person would need to call 1-800-MEDICARE to return to the previous Part D plan.



# What Happens After Enrollment?



# What Happens after Enrollment?

Enrollees receive a member packet from the health plan including

- A new MI Health Link card
- Provider directory
- Summary of benefits
- Member handbook
- Formulary
- Welcome letter



# What Happens after Enrollment?

## Proof of Insurance Coverage

- Enrollees can use the welcome letter to receive services for scheduled appointments or emergency services before the new MI Health Link card arrives
- Enrollees should take their Medicare and Medicaid cards to appointments until the MI Health Link card is received as these cards contain information that will help the provider confirm enrollment in MI Health Link



# What Happens after Enrollment?

## Level I Assessment

- A broad assessment used to identify and evaluate current health and functional needs
- Completed within 45 days of enrollment start date
- MI Health Link health plans are allowed to do this assessment 20 days before the enrollment start date, if the enrollee agrees
- Serves as the basis for further assessment
  - Triggers assessments for personal care services, nursing facility level of care and Level II assessments



# What Happens after Enrollment?

## Level II Assessment

- Completed within 15 days of the Level I Assessment for people identified with
  - Mental Health or Substance Use Disorder needs
  - Intellectual/developmental disabilities (I/DD) needs
  - Long term supports and services (LTSS) needs
- Health plans will collaborate with PIHPs and LTSS agencies
- Additional supports and services will be coordinated to meet the needs identified



# What Happens after Enrollment?

## Level II Assessment for people needing Nursing Home or Waiver Services

- The Michigan Nursing Facility Level of Care Determination tool will be completed to determine if the enrollee meets the requirements for these services
- The health plan will coordinate with long term supports and services providers to meet the enrollee's needs



# What Happens after Enrollment?

## Level II Assessment for people with Behavioral Health needs

- The health plan will make a referral to the PIHP
- The PIHP will complete a screen to determine mental health service needs and referral to a provider and/or complete Level II assessments



# Individual Integrated Care and Supports Plan (IICSP)



# Individual Integrated Care and Supports Plan (IICSP)

- Each enrollee will help develop his or her own Individual Integrated Care and Supports Plan
- Existing plans of care will be incorporated into the IICSP to avoid disruption of services
- The goal of the IICSP is to identify gaps in services to ensure the enrollee's needs are met



# Individual Integrated Care and Supports Plan (IICSP)

Each enrollee will choose the people to participate in the IICSP process

- Selected family, friends, and providers
- Invited integrated care team members
- Existing care coordinators or case managers



# Individual Integrated Care and Supports Plan (IICSP)

- Follows a person-centered planning process
- Is completed within 90 days of enrollment
- Is the single plan that coordinates care for all services and providers and includes the PIHP and LTSS service plans



# Individual Integrated Care and Supports Plan (IICSP)

- Plan for addressing concerns and goals, as well as measures for achieving them
- Identifies specific providers, supports and services including amount, scope and duration
- Lists the person responsible and time lines for specific interventions, monitoring and reassessment



# Ongoing Coordination

Care coordinators will maintain ongoing relationships with enrollees to assure

- Assessments and care plans are revisited and updated periodically
- Questions and concerns are answered and addressed
- Health issues get the attention they deserve
- **The enrollee is satisfied with MI Health Link**



# Hospice Services

## When a MI health Link enrollee decides to receive Hospice services

- The enrollee will be disenrolled from MI Health Link the first day of the month following Hospice election
- The Health plan will continue to pay for services not related to the terminal illness
- The Hospice agency will begin to provide Hospice services starting on the date of Hospice election
- **The enrollee does not have to wait to be disenrolled from MI Health Link to begin receiving Hospice services**



# Resources

[www.michigan.gov/mihealthlink](http://www.michigan.gov/mihealthlink)



[MDCH](#) > [PROVIDERS](#) > [MI HEALTH LINK](#)



## What is MI Health Link?

MI Health Link is a new health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid. The goal of MI Health Link is to provide seamless access to high quality care that reduces costs for those who are eligible. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet the individual needs of the enrollees.

People eligible for MI Health Link will receive services by joining a MI Health Link health plan. Each MI Health Link health plan has a network of doctors and other providers to care for its members. MI Health Link allows those enrolled to use one plan and one card to access services. They will also have a Care Coordinator, who will help get the supports and services needed to make it easier to receive care and live in the community.



Those who are eligible for both Medicare and Medicaid and qualify for MI Health Link will be given their enrollment options through a letter from Michigan ENROLLS.

## Spotlight

- [NEW - MI Health Link Timeline Change](#)
- [MI Health Link Brochure](#) 



# Resources

Visit the MI Health Link webpage to learn more about the program by clicking on

- Spotlight
- Beneficiaries
- Providers
- Other Resources



# Resources

[www.michigan.gov/mihealthlink](http://www.michigan.gov/mihealthlink)

 **Michigan**  
Department of Community Health

Search



Birth, Death, Marriage  
and Divorce Records

Physical Health &  
Prevention

Pregnant Women,  
Children & Families

Behavioral Health &  
Developmental  
Disability

Health Care Coverage

Statistics and Reports

Providers

High Utilizers

HIPAA

Health Professional  
Shortage Area

State Innovation  
Model

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## MI Health Link Information for Providers

MI Health Link is a new health care option for Michigan adults, age 21 or older, who are enrolled in both Medicare and Medicaid. Currently, these individuals navigate multiple sets of rules, benefits, insurance cards, and providers in accessing services covered by Medicare Parts A and B, Part D, and Medicaid. Many also have multiple or chronic conditions and will benefit from better [care coordination](#), [person-centered planning](#), and management of health and long term supports and services.

The goal of MI Health Link is to provide seamless access to high quality care through coordination of services currently covered separately by Medicare and Medicaid. MI Health Link offers a broad range of medical and behavioral health services, nursing home care, pharmacy and home and community based services through new managed care entities called Integrated Care Organizations (ICO) and Medicaid's existing [Pre-paid Inpatient Health Plans \(PIHP\)](#). ICOs, PIHPs and providers will be connected through the Care Bridge, a web-based platform for information exchange that is used to coordinate supports and services.

## Frequently Asked Questions for Providers



# Questions or comments?

If you have questions or comments about the MI Health Link program, please e-mail

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