



An Advocate's Guide to the MI Health Link Program

JANUARY 2018 | VERSION 1.9

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Produced with funding from the
Michigan Disability Rights Coalition

ADVOCATE'S GUIDE

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Revision Log

- **Version 1.9:** Revised health plan sections with up-to-date materials for 2018. More material will be added as updates are made available.
- **Version 1.8:** Updated health plan/Appeal & Grievance sections with Fidelis' new name, "Michigan Complete Health", and updated links to the new Michigan Complete Health website
- **Version 1.7:** Revised health plan sections with up-to-date materials for 2017. More material will be added as updates are made available
- **Version 1.6:** Added info on deeming, residential settings, and info from new Three-Way Contract, including new hospice rules and timelines for contacting new members
- **Version 1.5:** Added info on: home delivered meals, the MI Choice waiting list & MHL, passive enrollment & "disenrolling/opting out"
- **Version 1.4:** Added link to MHL section of Medicaid Provider Manual, added information on reassessments, added details on nursing home Patient Pay Amount and continuity of care
- **Version 1.3:** Revised health plan sections with up-to-date materials for 2016, added info on Medicaid redeterminations to Enrollment section
- **Version 1.2:** Added provider/pharmacy search links for each health plan, added Ombudsman contact information, added additional plan info for PIHPs
- **Version 1.1:** Formatting updates, small changes and revisions to Appeals and Grievances section

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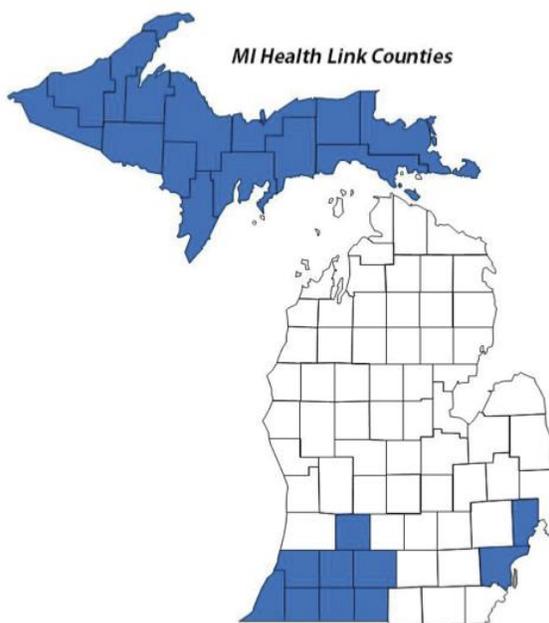
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Introduction

MI Health Link (MHL) is a new health care option for Michigan adults, age 21 or over, who are enrolled in both Medicare and Medicaid. MHL is available to these individuals if they are residents of the Upper Peninsula, Macomb or Wayne Counties, or one of eight counties in Southwest Michigan. MHL is Michigan's financial alignment demonstration program, launched in partnership with the Centers for Medicare and Medicaid Services (CMS). Advocates and service providers for eligible individuals should familiarize themselves with MHL and its range of services.

This Guide is intended to assist advocates in understanding MHL, including a description of the MHL program, covered services, eligibility and enrollment details, a detailed timeline, continuity of care requirements, and appeal rights. We will continue to update the Guide as MHL is implemented and there is more information to share about how it works and about challenges and opportunities for beneficiaries. We welcome feedback, questions, and information about beneficiaries' experiences in MHL. Please contact Dan Wojciak at dwojciak@meji.org with comments and suggestions.



What is MI Health Link?

MHL combines Medicare and Medicaid benefits, rules, and payments into one coordinated health care system. MHL is intended to integrate a broad range of health care services including acute care, primary care, behavioral health services, pharmacy services, dental and vision services, home and community-based services, and nursing home care into a single managed care plan designed to meet the individual needs of each enrollee. MHL will be available to residents age 21 or older who are eligible for both **full**¹ Medicaid and Medicare and live in one of four regions across the state: (1) the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren in

¹ Individuals with spend down or "deductible" Medicaid are not eligible for MHL.

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southwest Michigan; (2) any of the counties in the Upper Peninsula; (3) Macomb County; or (4) Wayne County. MHL is a demonstration program that will run through December 31, 2020.

The majority of MHL enrollees were automatically, or “passively,” enrolled into the demonstration. Eligible enrollees had the chance to voluntarily enroll, opt out, or disenroll from MHL during the enrollment period. If an eligible enrollee did not opt out and is eligible for passive enrollment, he or she was automatically enrolled in MHL. Any individual can choose to disenroll or change plans after enrollment, and can also re-enroll after disenrollment. See [“Enrollment”](#) below for more details.

The goal of MHL is to create a single program that can easily and effectively provide enrollees access to the full range of Medicare and Medicaid covered services. In addition to providing health care and long term and behavioral health supports and services, MHL offers each beneficiary a care coordinator, which is a key element of the plan’s focus on person-centered care and planning. MHL also intends to encourage home and community based living options for individuals who might otherwise have to live in institutional settings. To make access to health care easier, enrollees will only need one enrollment card to access services.² Moreover, MHL has **no** co-payments or deductibles for in-network services, **including medications**.³ A 24/7 Nurse Advice Line is available to answer beneficiaries’ questions.

Finally, an independent MI Health Link Ombudsman Program was established in December 2015. The goal of the Ombudsman is to serve as a confidential and conflict-free problem solver on behalf of all MHL enrollees. The Ombudsman has detailed knowledge of areas related to enrollee services, and will be skilled in negotiation and dispute resolution. In addition to providing information and helping to resolve individual concerns, the MHL Ombudsman also seeks to make systemic improvements in MHL by compiling data about consumer experiences with MHL, tracking systemic issues, bringing appropriate issues to the attention of the plans, PIHPs, and the state and engaging in other forms of advocacy to improve the program. The Ombudsman will also participate in the MHL Advisory Committee, which will allow enrollees, advocates, and providers to give guidance to MDHHS regarding MHL.

The new program will undoubtedly cause confusion and disruptions in care and services despite the state’s efforts to minimize these difficulties. However,

²**Advocacy Tip:** Enrollees should keep their Medicare and Medicaid enrollment cards in case they choose to disenroll from MHL and return to “original” Medicare and Medicaid fee-for-service. Having their cards will help smooth their transition back into these programs.

³ Nursing Home Patient Pay Amounts will still apply.

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because the response to a beneficiary's health, mental health, and long term care needs can have a profound impact on his or her physical, social, emotional and financial well-being, MHL also has the potential to make beneficiaries' lives better.

For example, if a beneficiary becomes light-headed while walking and fears falling, she may stop attending the church activities in which she has been very actively engaged. As a result, she may become isolated and depressed. She may also be more vulnerable to exploitation, more sedentary, and less intellectually engaged in the world around her. Ultimately, she may need to move to a nursing home, an experience that can be both deeply distressing for the beneficiary and costly for the state. But if the beneficiary's MHL care coordinator arranges appointments with appropriate providers to assess the beneficiary, the beneficiary's doctor may determine that the dizziness has been caused by a drug interaction or illness that can be successfully addressed. The care coordinator might also be able to help the beneficiary obtain a cane or walker to help her walk more safely and provide information on available door-to-door transportation.

Having a care coordinator marshaling the diagnostic, medical, and therapeutic services and supports available to a beneficiary to address his or her issues, preferences, and needs can ensure dignity, autonomy, and a vastly improved quality of life. When deciding whether to participate in MHL, beneficiaries will have to weigh the real risk of disruption and confusion in this new program with the significant potential advantages MHL may offer. Advocates will play an important role in addressing potential concerns and helping both beneficiaries and the state resolve concerns and improve service. As the program evolves, advocates and beneficiaries will have more opportunity to evaluate whether MHL realizes its laudable and ambitious goals.

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Eligibility



MI Health Link is available to Michigan adults, age 21 or over, who are enrolled in both Medicare and Medicaid.⁴ MHL is available to eligible individuals if they are residents of the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, and Wayne, or any county in the Upper Peninsula.⁵

Assuming they meet the above criteria, other eligible individuals include:

- People in nursing homes⁶
- People with Medigap (Medicare supplemental insurance) if they meet all other eligibility criteria⁷
- Money Follows the Person (Nursing Facility Transition) program enrollees.⁸

In addition to the above restrictions, the following populations are excluded from enrollment⁹:

- Individuals who are on spend down or “deductible” Medicaid
- Individuals currently enrolled in hospice care (unless they choose to disenroll from hospice)
- Individuals previously disenrolled due to Special Disenrollment from Medicaid managed care¹⁰
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals¹¹
- Individuals with Medicaid who reside in a State psychiatric hospital
- Individuals with commercial HMO coverage

⁴CONTRACT BETWEEN UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES IN PARTNERSHIP WITH THE STATE OF MICHIGAN(2014)

§ 2.3.2.

⁵MOU pg. 34.

⁶Slide 15.

⁷Slide 15.

⁸MOU pg. 6.

⁹Three-Way Contract § 2.3.2.2.

¹⁰Three-Way Contract § 2.3.2.2.2. As defined in 42 CFR 438.56. Refers to individuals that were disenrolled due to violent or threatening behavior towards the health plan staff, contracted providers, State staff, or contracted vendors. At this time they are excluded from enrollment, but do have coverage available through Fee-For-Service (FFS) Medicaid.

¹¹ Refers to individuals in the Medicare Specified Low-Income Medicare Beneficiary (SLMB) Program or Qualifying Individual (QI) Program

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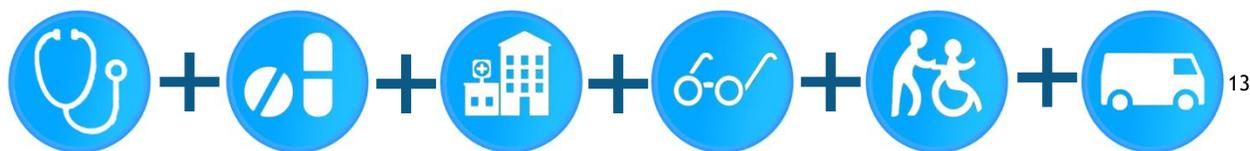
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Individuals enrolled in the Program for All-Inclusive Care for the Elderly (PACE) or MI Choice Home and Community-Based Services Waiver are eligible for MHL, **but they must leave that program before being enrolled in MHL.** If an individual disenrolls from a Money Follows the Person (MFP) program, PACE, or MI Choice to join MHL and then decides that he or she is not satisfied with the health plan, he or she is free to disenroll from MHL. However, **he or she will have to reapply for PACE or MI Choice.** MI Choice enrollees should be particularly careful when considering MHL, as there is a waiting list for MI Choice in many parts of the state. There is no guarantee that the individual will be able to promptly re-enroll in the program.

Enrolling in MHL should not affect an individual's spot on the MI Choice waiting list. That individual can keep his or her spot on the waiting list and stay in MHL, and once they get to the top of the list they can either disenroll from MHL and enter MI Choice, or decide to stay in MHL.¹²

Individuals who become eligible for MHL after the initial rollout dates **will** be allowed to enroll. And, as of June 1, 2016, the state is conducting new waves of passive enrollment each month on the 1st of each month. See the update in [Passive Enrollment, Opting Out, and Disenrollment](#) for more details.

Covered Services and Supports



Enrollees have access to [all](#) health care covered by Medicare and Medicaid. Covered services include:

- Medications (without co-pays)
- Dental services (cleaning, fillings, dentures, etc.)
- Vision services
- Durable medical equipment and medical supplies
- Physicians and specialists
- Emergency and urgent care
- Hospital stays and surgeries
- Diagnostic testing and lab services

¹² MDHHS Email, May 9, 2016.

¹³ Graphic design developed by the Los Angeles Aging Advocacy Coalition (LAAAC)

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- Nursing home services
- Home health services
- Long Term Supports and Services
- Transportation for medical emergencies, medical appointments, and to pharmacies

A complete list of required MHL services is available online at this [link](#). Because health plans may offer additional services, it is important to check the individual health plan's website (linked below) for formularies and more details on the specific MHL services they provide. The health plans have worked to improve the accuracy of their websites since their initial launch, and they are often updated to better reflect the available program services.

While most of these covered services were, at least theoretically, already available to beneficiaries, MHL participants may experience easier access to these services. For example, many Medicaid beneficiaries had great difficulty finding dentists who would accept Medicaid. In MHL, health plans had to demonstrate to the state and CMS in the readiness review process that they had adequate networks of providers, including dentists, who would agree to accept new patients. Even in the Upper Peninsula, most counties have at least one participating dentist who will accept MHL participants. Similarly, while transportation to medical appointments was supposed to be available to Medicaid beneficiaries statewide, many beneficiaries found that transportation services were spotty or practically non-existent. Health plans had to demonstrate that they had sufficient contracts in place to provide transportation to beneficiaries. In MHL, beneficiaries who might have previously struggled to find a participating dentist or figure out how to get to a dentist who would serve them can now have their care coordinators make the appointment and set up the transportation for them, thus ensuring beneficiaries have easy access to dental care¹⁴. If the MHL participant resides in a nursing home, the care coordinator will work with the nursing home to ensure the enrollee receives dental services, whether through an in-network or out-of-network provider.

Long Term Supports and Services

Long Term Supports and Services (LTSS) are also included in MHL. This includes a variety of supports and services that help older adults and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. LTSS can be provided over an extended period, in both homes and communities and in nursing facilities.

¹⁴ State Q&A May 26, 2015.

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Covered Long Term Supports and Services include services similar to those offered in the MI Choice Home and Community Based Waiver program:

- Personal care
- Equipment to assist with activities of daily living
- Chore services*
- Home modifications
- Adult day programs
- Private duty nursing*
- Preventive nursing services*
- Respite
- Home delivered meals*†
- Community transition services
- Fiscal intermediary services*
- Personal emergency response system
- Nursing home care

*Available to enrollees who meet level of care requirements.

† For many plans, home delivered meals are only available through the MI Health Link Waiver. However, plans can choose to make these waiver services available to its non-waiver beneficiaries if they meet medical necessity requirements. In 2016 AmeriHealth is offering all waiver services, including home delivered meals, to non-waiver enrollees (if they are medically necessary.)¹⁵

MHL health plans must ensure that enrollees have access to services and care in residential settings. The Three-Way Contract states¹⁶:

The ICO and its providers must comply with and apply the United States Supreme Court's *Olmstead* decision which requires that Enrollees be served in the most integrated setting appropriate to their needs. Any appropriate home and community-based service options must be exhausted prior to an Enrollee's admission into an institution. The ICO must have sufficient capacity to provide home and community-based services to meet the needs of Enrollees who choose to receive supports and services in community settings. This includes providing options for community living in places like adult foster care homes, assisted living facilities, homes for the aged, an individual's own home, etc., as desired by the individual, and in

¹⁵ AmeriHealth Caritas VIP Care Plus Member Handbook 2016 p 46.

¹⁶ Three-Way Contract 2.7.2.3.1

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compliance with requirements under the approved 1915(c) waiver for Enrollees participating in the 1915(c) waiver.

Some plans are also offering additional covered services, and enrollees should check individual plan websites (listed below) for more details on the above services.

IMPORTANT NOTE: private duty nursing is only available 16 hours a day under MHL. There are a very limited number of MI Choice beneficiaries, including some individuals who are ventilator-dependent, who currently require private duty nursing more than 16 hours each day. These individuals will not be automatically enrolled in MHL since they are MI Choice participants. It is extremely important that they do not voluntarily enroll in MHL because they will be unable to maintain their full private duty nursing hours.

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Behavioral Health

MHL also includes a range of behavioral health services. Behavioral health services are provided to individuals who have a mental illness, intellectual or developmental disability, and/or substance use disorder. These services can be accessed through the Health Plan, Prepaid Inpatient Health Plans (PIHPs) or a local Community Mental Health Services Providers (CMHSP). Mild to moderate behavioral health issues, such as depression, are covered by PIHPs, and a primary care doctor can refer an individual with no prior CMH connections to a CMHSP. However, an individual may choose to deny this referral and instead stay with his or her primary care doctor for these services. The enrollee's health plan will then cover these mild to moderate behavioral health issues, not the PIHP.¹⁸ If enrollees do go through with the referral, they will undergo an assessment to determine if they meet the necessary level of need for a case manager or supports coordinator.¹⁹ **Individuals already receiving services through the CMHSP will not have their services changed or interrupted after joining MHL, though it is possible that their current doctors, pharmacies, etc. may be changed if they are not participating in the ICO health plan.**

¹⁷ Three-way Contract Table A1

¹⁸ State Q&A May 26, 2015.

¹⁹ *Id.*

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Covered behavioral health services:

PIHPs will continue to provide the full array of Medicaid behavioral health, intellectual or developmental disability, and/or substance use disorder services, some of which include:

- Individual, group, 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).

Health Plans



Integrated Care Organization (ICOs)

MHL Health Plans, also known as ICOs, are responsible for acute and primary care, long term supports and services, medications, vision and dental, and most other health care services. Health Plan providers vary by region. When there are multiple plans in a region, enrollees may choose the plan that is best suited to their individual health needs.

Health Plans by Region

The links to provider information below also include information on pharmacies, unless a separate link for pharmacies is listed. **UPDATE: In April 2017, Fidelis SecureLife changed its name to “Michigan Complete Health.”**

Upper Peninsula (Region 1)

ICO:

- Upper Peninsula Health Plan MI Health Link ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([summary of benefits](#))

Southwest Michigan (Region 4)

ICOs:

- Aetna Better Health Premier Plan ([website/contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([summary of benefits](#))

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- Meridian Complete ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([formulary](#)) | ([provider & pharmacy directory](#)) | ([summary of benefits](#))

[Wayne County \(Region 7\)](#)

ICOs:

- Aetna Better Health Premier Plan ([website/contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([summary of benefits](#))
- AmeriHealth Caritas VIP Care Plus ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([provider & pharmacy directory](#)) | ([pharmacy search](#)) | ([summary of benefits](#))
- HAP Midwest MI Health Link ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([provider and pharmacy directory](#)) | ([summary of benefits](#))
- Michigan Complete Health Medicare-Medicaid Plan (Previously Fidelis SecureLife Medicare-Medicaid Plan (MMP)) ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([formulary](#)) | ([provider & pharmacy search](#)) | ([summary of benefits](#))
- Molina Dual Options MI Health Link ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([pharmacy search](#)) | ([summary of benefits](#))

[Macomb County \(Region 9\)](#)

ICOs:

- Aetna Better Health Premier Plan ([website/contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([summary of benefits](#))
- AmeriHealth Caritas VIP Care Plus ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([provider & pharmacy directory](#)) | ([pharmacy search](#)) | ([summary of benefits](#))
- HAP Midwest MI Health Link ([website](#)) | ([contact information](#)) | ([member handbook](#)) | ([annual notice of changes](#)) | ([formulary](#)) | ([formulary search](#)) | ([provider search](#)) | ([provider and pharmacy directory](#)) | ([summary of benefits](#))
- Michigan Complete Health Medicare-Medicaid Plan (Previously Fidelis SecureLife Medicare-Medicaid Plan (MMP)) ([website](#)) | ([contact](#))

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[information](#)) | [\(member handbook\)](#) | [\(formulary\)](#) | [\(provider & pharmacy search\)](#) | [\(summary of benefits\)](#)

- Molina Dual Options MI Health Link [\(website\)](#) | [\(contact information\)](#) | [\(member handbook\)](#) | [\(annual notice of changes\)](#) | [\(formulary\)](#) | [\(formulary search\)](#) | [\(provider search\)](#) | [\(pharmacy search\)](#) | [\(summary of benefits\)](#)

[Prepaid Inpatient Health Plans \(PIHPs\)](#)

PIHPs, through their network of Community Mental Health Services Providers (CMHSPs), provide behavioral health services such as mental health services, intellectual/developmental disabilities services and supports, and/or substance use disorder services. PIHPs will partner with ICOs to provide comprehensive support to MHL enrollees. As stated above, people already receiving these services from Community Mental Health will keep these same services without interruption upon enrollment in MHL.

PIHPs by Region

[Upper Peninsula \(Region 1\)](#)

- NorthCare Network [\(website - not MHL specific\)](#)

[Southwest Michigan \(Region 4\)](#)

- Southwest Michigan Behavioral Health [\(website\)](#)

[Macomb County \(Region 9\)](#)

- Macomb County CMH Services [\(website\)](#) | [\(member guidebook\)](#)

[Wayne County \(Region 7\)](#)

- Detroit-Wayne Mental Health Authority [\(website\)](#) | [\(member handbook\)](#) | [\(provider directory\)](#) | [\(provider resources\)](#)

[Timeline](#)



MHL was launched in two phases across four regions of the state. The three-year demonstration project will operate through December 2020. Phase 1 included beneficiaries eligible for both Medicare and Medicaid in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties in southwest Michigan as well as all those living in all the counties in the Upper Peninsula. Phase 2 included

beneficiaries eligible for both Medicare and Medicaid living in Macomb and Wayne counties.

Phase 1

Enrollment in the eight counties in southwest Michigan and each county in the Upper Peninsula began March 2015 and services for some individuals who voluntarily enrolled began March 1, 2015.²⁰ Services for the remaining enrollees were rolled out in three waves, with services for the first wave beginning on May 1, 2015. Individuals eligible during Phase 1 were permitted to opt into or out of the program beginning on February 1, 2015.

Phase 2

Enrollment in Macomb and Wayne counties began April 1, 2015, and services began on May 1, 2015 for individuals who voluntarily enrolled in a health plan.²¹ Services for the remaining enrollees are being rolled out in three waves, with services for the first wave beginning on July 1, 2015. Individuals eligible during Phase 2 could opt in to the program beginning on April 1, 2015. Passive enrollment for all eligible nursing home residents did not occur until September 1, 2015.

Beneficiary Enrollment Options

Beneficiaries have several choices:

- If they are eligible for MHL but not in one of the categories of people described above who will be passively enrolled, they can choose a health plan and participate in MHL.
- If they are among the vast majority of individuals who will be passively enrolled in a plan selected by the state, and they want to participate in MHL and accept their assignment, they need not do anything to remain in the program. Their enrollment will proceed automatically.

²⁰ There were multiple rollout waves within each phase, organized by enrollee Medicaid case numbers. Case numbers ending 0-4 were sent 60-day passive enrollment notices in February 2015 and 30-day passive enrollment notices in March 2015, with services beginning on May 1, 2015. The remaining case numbers ending 5-9 were sent 60-day passive enrollment notices in March 2015 and 30-day passive enrollment notices in April 2015, with services beginning on June 1, 2015.

²¹ There were multiple rollout waves within each phase, organized by enrollee Medicaid case numbers. Case numbers ending 0-3 were sent 60-day passive enrollment notices in April 2015 and 30-day passive enrollment notices were sent in mid-May 2015, with services beginning on July 1, 2015. Case numbers ending 4-6 were sent 60-day passive enrollment notices in mid-May 2015 and 30-day passive enrollment notices in mid-June 2015, with services beginning on August 1, 2015. The remaining case numbers ending 6-9 were sent 60-day passive enrollment notices in mid-June 2015 and 30-day passive enrollment notices in mid-July 2015, with services beginning on September 1, 2015. As mentioned above, all eligible nursing home residents were not passively enrolled until September 1, 2015.

- If they are going to be passively enrolled in one health plan but they wish to participate in a different health plan (in the three regions with multiple plans), they must call Michigan ENROLLS. In that case, they will be disenrolled in the health plan to which they have been assigned and voluntarily enrolled in the new plan they have selected.

Enrollment



Eligible individuals, or their responsible parties, should have received a welcome letter explaining how to enroll in a health plan or how to disenroll if they do not wish to join MHL.²² The envelope for this letter says “Michigan ENROLLS” and also states, “IMPORTANT - This envelope contains important information about your health insurance.” The letter explains whom to contact for help, including the contact information for the Michigan Medicare/Medicaid Assistance Program (MMAP). Unfortunately, it appears that many beneficiaries either did not receive the letter or did not open it, which could cause confusion down the road if this individual is later passively enrolled into a new health plan.

To enroll in, opt out, or disenroll of MHL, the eligible individual must **personally** contact Michigan ENROLLS. In addition, **the beneficiary must actually speak with a representative from Michigan ENROLLS to do so.** If an individual contacts Michigan ENROLLS after hours and leaves a message, a representative will return the call. But Michigan ENROLLS staff will not take any action based on a message requesting that the person be permitted to enroll or opt out/disenroll of MHL, or change health plans within MHL. The beneficiary must personally make the request over the phone to a Michigan ENROLLS representative.²³ The beneficiary is also permitted to give verbal authorization, over the phone, for the enrollment agent to speak to another person who is also on the phone. This authorization is valid for **that day only.**²⁴ If this authorized person calls back later in the day, he or she will have to verify the beneficiary’s information as well as verify his or her own identity before a Michigan ENROLLS representative can assist.

A legal representative of the beneficiary (through guardianship or power of attorney) is permitted to contact Michigan ENROLLS on behalf of the beneficiary **if the legal representative has properly filed documents with MDHHS that establish his or her authority.** Documents need to be filed with

²²“Letter 33” - see Appendix for sample letter.

²³ “Calling Michigan Enrolls” letter Question 6 - See Appendix.

²⁴MI Health Link Overview Slide 75.

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MDHHS, not Michigan ENROLLS. If MDHHS has not received and approved documentation that establishes legal authority over the beneficiary, the representative will not be able to opt in, choose a health plan, or opt out of MHL on behalf of the beneficiary. Individuals will need to submit the current court issued Letters of Guardianship, durable power of attorney, patient advocate designation or other necessary documents to MDHHS. The actual Letter of Guardianship from the court, not simply the guardianship order, must be submitted.

If the person calling on behalf of a beneficiary does not have legal authority and the beneficiary is incapable of giving verbal authorization over the phone, Michigan ENROLLS will send the form [DCH 1183](#) to the individual. Once the form is completed, returned to MDHHS and authorization is granted by MDHHS following its review of the DCH-1183, Michigan ENROLLS will permit the person identified in the DCH-1183 to speak on the beneficiary's behalf. Unfortunately, the DCH-1183 is a confusing form. For this reason, the state has also developed a sample form that demonstrates how to complete the DCH-1183. Even with that assistance, beneficiaries may be confused by the form. The state is reportedly developing a simpler form that will authorize informal decision-makers to act on behalf of beneficiaries. Individuals that lack the ability to sign their names may sign this form to the best of their ability.

It should be noted that some individuals reported considerable wait times when calling Michigan ENROLLS. This is not surprising because Michigan ENROLLS sometimes receives in excess of 10,000 calls per day for the many programs, including MHL, for which it serves as the enrollment broker. There is no voicemail service for Michigan ENROLLS; callers must remain on hold until they have the opportunity to speak with a representative. Michigan ENROLLS' capacity to handle calls has been a concern, particularly in Macomb and Wayne counties where it was anticipated there would be a higher volume of calls. Fortunately, Michigan Enrolls has now very significantly reduced wait times at most times of day and this no longer appears to be a huge barrier for beneficiaries. However, on some days Michigan ENROLLS still processes in excess of 10,000 calls, so there are still potential wait time issues that may arise.

The Michigan ENROLLS call center is open Monday through Friday 8AM-7PM ET. Individuals can contact Michigan ENROLLS toll-free at 1-800-975-7630. TTY users may call 1-888-263-5897. **The call center receives the highest volume of calls on Mondays and Tuesdays between 10AM and 2PM, so callers may wish to contact Michigan ENROLLS on Wednesday through Friday, or early in the**

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morning, later in the afternoon, or the evening, as the call center is open until 7PM ET.

Enrollees are free to change MHL health plans (if multiple plans are available) or to disenroll from MHL at any time after enrollment. The disenrollment or change of plans will be effective on the first day of the following month after the person calls.²⁵ For example, if an enrollee disenrolls from MHL on July 15th, he or she would keep his or her current MHL coverage until disenrollment on July 31st, and the new coverage would be effective on August 1st. **It is important to note that if an individual calls to change plans during the last five days of the month, his or her coverage under the new MHL plan will not be effective until first day of the month after next.** So, if an enrollee changes plans on July 27th, he or she would keep his or her current MHL coverage until August 31st, and the new plan would be effective on September 1st.

There is no limit on the number of times a beneficiary can change plans, enroll, or disenroll from MHL. While this is certainly helpful to assure maximum beneficiary choice and autonomy, it may also be confusing for providers who will need to check the beneficiary's enrollment status every month. It may also be disruptive for beneficiaries' health care since their providers may change frequently if they enroll, disenroll, or change plans repeatedly.

Members can also now be contacted by their health plans. The new Three Way Contract from November 2016 permits plans to reach out to members beginning **60 (sixty) days** prior to their passive enrollments.²⁶ This means members can expect to receive calls from plans at or around the time they received their first60-day passive enrollment notice.

During this call, the health plan may ask the enrollee to identify his or her current providers in order to ensure a smooth transition of services when the enrollee is passively enrolled into the plan. It is hoped that this will help identify existing Home Help/personal care providers so that these providers can enroll with the plan and continue providing services to the member, without a disruption in services or a delayed payment to the provider.

Passive enrollment, Opting Out, and Disenrollment

UPDATE - 2016:

²⁵MOU pg. 7.

²⁶ Three-Way Contract 2.3.6.5.1 (November 2016)

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*Passive enrollment began again on June 1, 2016 and continued on a monthly basis. 60-day notices were sent in late March 2016, with 30-day notices to follow. This enrollment did not occur by region, like in 2015's passive enrollments; instead, each region goes through passive enrollment at the same time. Individuals that were passively enrolled in 2015 and then opted out of MHL **will not be passively enrolled in these upcoming enrollments, nor any future passive enrollments.** This passive enrollment will affect individuals that have become dually eligible but missed last year's passive enrollments: individuals that have aged into the program, individuals who were recently enrolled into Medicaid, individuals that have moved into the demonstration region, etc. This passive enrollment may also catch enrollees who had been enrolled in a MHL health plan but lost that enrollment due to a missed Medicaid redetermination.*

It should be noted that individuals who were previously passively enrolled and then disenrolled before they entered MHL may still be caught in this next wave of enrollments if they did not also opt out of the program entirely when they disenrolled. As noted below, "disenrolling" will remove the individual from the current enrollment, and "opting out" will remove the individual from MHL entirely, including all future passive enrollments.

After this large wave of passive enrollment on June 1, passive enrollment will continue every month on the 1st of the month. These subsequent passive enrollments will be smaller than the June enrollment, but will target the same population.

The majority of MI Health Link participants were passively enrolled into the program. If an individual is eligible for MHL as outlined [above](#) and is a resident of one of the demonstration regions, he or she was or will be included in passive enrollment. Individuals eligible for Phase 1 began receiving introductory letters about the program on February 1, 2015²⁷ and individuals eligible for Phase 2 began receiving introductory letters no earlier than April 1, 2015.²⁸ These individuals will also receive or have received a 60-day notice²⁹ and a 30-day notice³⁰ before their passive enrollment in MHL becomes effective. Individuals can *opt out* after they get the introductory letter explaining MHL and before they are passively enrolled in a plan.

There has been some confusion about opting out and disenrolling for beneficiaries who do not want to participate in MHL. Once individuals get their

²⁷"Letter 33" - see Appendix for sample letter.

²⁸"Letter 33" - see Appendix for sample letter.

²⁹"Letter 31" - see Appendix for sample letter.

³⁰"Letter 5" - see Appendix for sample letter.

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60-day and 30-day letters advising them that they are being enrolled in an MHL health plan, **they should call Michigan ENROLLS to *disenroll and opt out* if they do not want to participate in MHL**, even though their coverage won't begin for 60 to 30 days. It is important that individuals request to disenroll, because once they receive a 60-day or 30-day notice they are technically enrolled in MHL. MHL coverage will not begin until the date on the enrollment letters, but they are enrolled. Additionally, the state has very specific definitions of "opt out" and "disenroll." Although intuitively it makes sense to think that opting out means an individual will avoid enrollment into a health plan, that is not necessarily the case.

This confusion regarding terminology has created issues when individuals have received a 60-day or 30-day letter and called to opt out of the program, only to find out later they were still enrolled in MHL. The problem arose because while the opt out request was processed, these individuals were only being opted out of *future passive enrollment into a health plan*, instead of being removed from the MHL program entirely. This is why it is very important to use "disenroll" **and** "opt out" if an individual wishes to avoid MHL altogether.

Michigan ENROLLS staff has received training on this issue, and if an individual calls to opt out, he or she is supposed to receive an explanation of what "opt out" really means. For example, if an individual calls Michigan ENROLLS and says he or she wants to opt out of the program, Michigan ENROLLS staff are supposed to ask whether the person means he or she wants to disenroll and completely avoid MHL or whether he or she wants to remain in MHL but choose a health plan himself or herself.

If neither the beneficiary nor the beneficiary's authorized representative calls Michigan ENROLLS to opt out or disenroll, the beneficiary's passive enrollment in a plan selected by the state will become effective. Any individual passively enrolled into MHL during Phase 1 began receiving services no earlier than May 1, 2015. Any individual passively enrolled into MHL during Phase 2 began receiving services no earlier than July 1, 2015.

Next Steps

Once an individual disenrolls from MI Health Link, he or she will then need to re-enroll in a Medicare Part D plan. The individual will also likely need to use the Limited Income Newly Eligible Transition program (LI NET) to cover medications while the individual is between plans. The Michigan Medicare/Medicaid Assistance Program (MMAP) is a fantastic resource to help navigate this process. MMAP counselors can help find the right Part D plan for

an individual's specific drug list, and can also walk beneficiaries through the entire process. MMAP can be reached at 1-800-803-7174, and counselors are available Monday through Friday from 8AM to 5PM ET.

Medicaid Redeterminations

Most individuals who qualify for Medicaid must have their eligibility renewed every year through a process called "redetermination." The redetermination is similar to the initial Medicaid application, and will examine a series of factors to determine if an individual is still eligible for Medicaid.

If an individual fails to complete a redetermination he or she will lose Medicaid coverage. Because MHL requires enrollment in both Medicare *and* Medicaid, this means the individual will also be disenrolled from his or her MHL plan. **If an individual loses Medicaid eligibility at any point, he or she will automatically be disenrolled from his or her plan.** If an individual loses Medicaid coverage there are steps that can be taken to get services restored, but it is important to note that even if the individual gets Medicaid services restored, he or she will **not** be automatically re-enrolled back into the old MHL plan. Instead the individual will go into traditional fee-for-service Medicaid. If an individual loses Medicaid for any reason, he or she will have to contact Michigan ENROLLS and re-enroll in a MHL plan once Medicaid services are restored.

Enrolling in MI Health Link does not mean that enrollees can skip doing their Medicaid redeterminations. If enrollees fail to do a redetermination they **will** lose their Medicaid and they **will** lose their MHL plan. They may also be forced to pay their own Medicare Part B premiums, as well as their own prescription drug plan, which could be quite expensive. Therefore, it is crucial for enrollees and advocates to be aware of the importance of these redeterminations. Care coordinators are required to assure that the redeterminations are completed in a timely manner, so MHL enrollees can contact their care coordinator if they need assistance with this process.³¹

Deeming

To help fix the problems caused by missed redeterminations, MDHHS has announced a deeming program for MHL enrollees.³² Under deeming, beneficiaries who fail to complete the redetermination process on time will be placed into deeming status for up to three months, and they will be allowed to stay enrolled in their MHL plans. Instead of being automatically disenrolled

³¹ Three-Way Contract § 2.5.3.2.2.18.

³² [MHL & Deeming Letter](#) - July 2016

from an MHL plan due to missed redeterminations, individuals will be placed into deeming status and will then have three additional months to complete the redetermination process. Beneficiaries should receive a letter from their health plans letting them know they are in deeming status, and their care coordinators should work with them to complete the redetermination paperwork.

Deeming status is not the same as being fully eligible for Medicaid. Beneficiaries in deeming status have been *deemed* eligible for Medicaid, and if they successfully complete their redeterminations they can once again be fully eligible for Medicaid. If the redetermination is not completed before the end of the three month period, or if the individual is found ineligible for Medicaid, then all Medicaid eligibility will end and the individual will be disenrolled from his or her MHL plan. The health plans have agreed to cover all costs during the deeming period, even if it turns out that a member was ineligible for Medicaid during the deeming process. If the member is found ineligible, the plan *cannot* ask the member to pay for any services they received during the deeming period.

Beneficiaries in deeming status will have access to the same Medicare benefits and almost the exact same Medicaid benefits. Medicaid services for behavioral health, intellectual/developmental disability, or substance use disorders are the only services not covered under deeming. Several PIHPs have stated they will try to find workarounds to ensure there are no gaps in services, but it could potentially be an issue for beneficiaries.

Special Enrollment Issues/What to Consider Before Enrolling



Individuals with Employer or Union Sponsored Insurance Plans³³

³³MI Health Link Program Overview Presentation March 4, 2015.

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Individuals and their dependents with Medicare health or drug coverage from an employer or union sponsored plan can leave that plan and enroll in MI Health Link if they desire. However, they or their dependents could lose that employer or union coverage and ***not get it back*** if they join MHL. It is **strongly recommended** that potential enrollees first contact their retiree benefits manager and discuss their plans **before** they decide to enroll in MHL.

There has been confusion about what kinds of plans exempt beneficiaries from passive enrollment. If an individual believes he or she had an employer or union sponsored plan and was mistakenly enrolled in MHL, he or she should contact IntegratedCare@michigan.gov immediately to determine if MHL staff can confirm the beneficiary's enrollment status and, if necessary, assist the beneficiary in regaining his or her previous coverage.

Hospice

Hospice services are the only Medicare/Medicaid health care services not covered by MHL. Individuals currently **receiving hospice services are not eligible to enroll in MHL unless they disenroll from hospice.**³⁴ The updated Three-Way contract from November 2016 changed the rules for individuals currently in MI Health Link plans. Previously, if an individual enrolled in an MHL plan chose to receive hospice services, that person would be disenrolled from MHL after they entered hospice. Now, under the new contract, current MHL enrollees who select hospice services can **stay enrolled** in their current MHL plan.³⁵

The period between when a MHL participant chooses to begin hospice services and the last day of the month in which that individual elects hospice services is the only time a beneficiary can receive both MHL covered services and services that are not covered by MHL, though it is important to reiterate that hospice services **are not** covered by MHL. For example, if a beneficiary determines he or she needs hospice care on April 6, he or she can begin receiving hospice services immediately and disenroll from his or her health plan effective April 30. From April 6 until April 30, Medicare (not the health plan) will pay the hospice agency to provide hospice services. If during the remainder of April, however, the beneficiary develops a very painful dental problem unrelated to his or her end of life care, the MHL health plan will pay the dental provider to serve the beneficiary. As of May 1, when the beneficiary is no longer enrolled in MHL, the beneficiary will receive hospice services from Medicare and any

³⁴MOU pg. 6.

³⁵ Three Way Contract 2.3.2.3 (November 2016)

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other necessary services not covered by Medicare from traditional Medicaid instead of from the MHL health plan.

“The beneficiary is still responsible for paying the Patient Pay Amount (PPA). For the days before to the hospice election, the nursing facility will collect the PPA. Any remaining PPA is paid to the hospice provider for days starting with the hospice election and in turn is paid to the nursing facility.

The ICO may not limit the beneficiary's choice of hospice providers. The ICO may execute a single case agreement with the hospice provider or include the hospice provider in the ICO's provider network in order to reimburse the hospice provider for the Medicaid nursing facility room and board.”³⁶

Habilitation Supports Waiver

Habilitation Supports Waiver (HSW) participants may continue to participate in the HSW and enroll in MHL. Medicaid behavioral health services will not be affected by enrolling in MHL.³⁷

Health plans must maintain the current provider and level of services at the time of enrollment for **180 days** for individuals receiving services from the HSW. See “Continuity of Care” below for more information. HSW participants receiving personal care services through the Home Help program will continue to receive these services through MHL, not the Home Help program.³⁸

It is important to note that the locations where HSW waiver participants live or receive services do not have to be in compliance with the new Home and Community Based Services (HCBS) Final Rule waiver setting requirements until March 16, 2019.³⁹

MI Choice/PACE

Individuals enrolled in MI Choice or PACE will **not** be passively enrolled into MI Health Link. As referenced above, these individuals will have to disenroll from MI Choice or PACE before they can enroll in MHL. If an individual is scheduled for a future passive enrollment date and then chooses to join MI Choice or PACE, his or her passive enrollment into MHL **may not always be cancelled**. If that occurs, these individuals can contact IntegratedCare@michigan.gov for assistance with this issue.

³⁶MI Health Link Guidance email - January 22, 106

³⁷MI Health Link Program Overview Presentation March 4, 2015.

³⁸*id.*

³⁹MI Health Link Program Overview Presentation March 4, 2015.

Also noted above: private duty nursing is only available 16 hours a day under MHL.⁴⁰ Individuals in MI Choice who currently require private duty nursing more than 16 hours/day **should not opt into MHL**. It is **extremely important** that these individuals remain in MI Choice where the full extent of their need for private duty nursing can be met.

MI Choice participants should also realize that their Level of Care coding will change if they enter a nursing home or hospital, which may lead to their being passively enrolled into MHL.⁴¹ Beneficiaries are generally not aware of level of care coding, so it is important that advocates address this issue. In order for the nursing home to receive Medicaid reimbursement for the individual's care, the MI Choice participant's level of care code must be changed to LOC 02. This code change is what makes the individual eligible for passive enrollment since nursing home residents, unlike MI Choice participants, are eligible for passive enrollment.⁴² If an enrollee wants to return to the MI Choice program after a nursing home stay, it is very important that he or she disenroll from MHL after admission to the nursing home. Enrollees can contact MI Choice waiver agents to discuss their options once they begin their nursing home stay.

Hospital stays could also result in passive enrollment into MHL. MI Choice enrollees admitted for a hospital stay may remain on the MI Choice waiver for up to 30 days. If an individual stays in the hospital for more than 30 days, he or she will be disenrolled from MI Choice per MI Choice rules.⁴³ Once this occurs, the individual will lose his or her MI Choice level of care code (LOC 22) and then may become eligible for passive enrollment into MHL. At this point the enrollee should disenroll MHL if he or she wants to return to MI Choice once the hospital stay is complete. Enrollees can contact MI Choice waiver agents to discuss their options once they begin their hospital stay.

If a MI Choice agency discovers that a participant is passively enrolled into MHL, staff should help the beneficiary contact MHL at MSA-MHL-enrollment@michigan.gov to resolve the issue. Personal information must be sent via encrypted e-mail, or via password protected file attachment with the password to follow in a separate email.⁴⁴

[Nursing Facility Residents](#)

⁴⁰ Three-way Contract Table A1

⁴¹ MI Choice Participants and MI Health Link Q&A Letter March 2015

⁴² *Id.*

⁴³ [Medicaid Provider Manual](#) at 1056.

⁴⁴ *Id.*

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Nursing facility residents should consider a number of factors when deciding whether enrolling in MHL is advantageous for them. First, for individuals in poor quality nursing facilities, it may be beneficial to have an MHL care coordinator involved in their lives. The care coordinator may be able to arrange for services such as dental care or visits to a specialist that the nursing home has neglected to provide, or make suggestions regarding care planning and person-centered care. While nursing facility staff may not be receptive to these efforts, the fact that an outside entity is tracking what happens in the nursing home may create an incentive for substandard facilities to improve their services or serve as another way to identify abuse or neglect in the facility. The involvement of a care coordinator may be particularly helpful for beneficiaries in nursing facilities who lack family or other advocates and are unable to advocate for themselves.

Another important advantage of MHL for nursing facility residents or potential residents is that MHL does not require a three day hospital stay prior to the nursing home admission to qualify for up to 100 days of Medicare skilled nursing or therapy/rehabilitation services.⁴⁵ Individuals in traditional Medicaid and Medicare are required to have a three day hospital stay to qualify for skilled services. This requirement in traditional Medicare poses a problem for some beneficiaries who enter the nursing facility from the community, instead of from a hospital, or who are admitted from a hospital but have either not been in the hospital for the requisite three nights or have been on “observation status” which does not qualify them to receive skilled services in the nursing facility. When individuals in MHL or traditional Medicare qualify for Medicare skilled services, they will likely receive more intensive rehabilitation services and will not be required to pay a patient pay amount for the initial 20 days of their nursing facility stay if they receive skilled services during that period.⁴⁶ Therefore, MHL’s elimination of the three day hospital stay requirement can result in both therapeutic and financial benefits for nursing facility residents.

An issue that may be a concern for some residents is the Level of Care Determination (LOCD) that is required to ensure the beneficiary qualifies for nursing home level of care. Eventually, this assessment will be performed by an independent entity but until this “conflict-free LOCD” process is established, the health plans must conduct an LOCD within 90 days of a nursing facility resident’s enrollment in MHL.⁴⁷ Although the plans must use the same assessment tool as the nursing facilities, they may assess a resident differently than the facility and may have different incentives or understanding of the

⁴⁵ Nursing Facilities Webinar 7/14/15 Chat Q & A, pg. 5, Nursing Facility Guide to MI Health Link, pg. 5

⁴⁶ See Nursing Facilities Webinar 7/14/15 Chat Q & A, pg. 5.

⁴⁷ Nursing Facility Guide to MI Health Link pg. 5

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LOCD process. Residents who fail to pass the LOCD (and do not successfully appeal that determination) cannot continue to receive Medicaid funding for their nursing home stay. Therefore, individuals who wish to stay in the facility but fear they may not pass the LOCD if assessed by their health plan may choose to disenroll from MHL.

In addition, although there are generous continuity of care provisions ([described below](#)) that permit nursing facility residents to remain in out-of-network facilities when they enroll in MHL, there may be complications with other providers who have provided services to beneficiaries in the facility but are not in the health plan's provider network. For example, a nursing facility could contract with or utilize doctors, therapists, pharmacies, durable medical providers, and other health care providers who are not in-network providers for the plans in which residents are enrolled. While facilities have been encouraged to suggest these ancillary providers join MHL provider networks, beneficiaries in nursing facilities may have to change some of their providers. Finding alternate providers can be challenging for nursing home residents.

Some nursing facilities have sought to discourage beneficiaries from participating in MHL because the program poses additional administrative burdens on facilities. Moreover, nursing homes have struggled to understand how they will be paid under MHL and to establish relationships with representatives of the health plans. However, nursing facilities are not permitted to attempt to influence beneficiaries to disenroll for the convenience of the facility.

[Medicare Part D Drug Plans](#)

MI Health Link enrollees cannot keep their current Medicare

Part D drug plans. However, MHL coverage includes **all** Medicare and Medicaid services, **including** Part D drug plans, so enrollees should not experience a disruption of their Part D Services.⁴⁸ If an individual calls to enroll in MHL or receives a passive enrollment letter stating he or she will soon be auto-enrolled in MHL, then that individual will also be disenrolled from his or her Part D plan.⁴⁹ Beneficiaries should expect to receive a letter from the Part D plan informing them that they will be disenrolled from their current coverage. This may alarm some enrollees, but it is important to remember that MHL will be covering **all** services currently provided by the Part D plan, and that disenrollment from a Part D plan **should not** result in a disruption in drug



⁴⁸ Part D and MI Health Link Letter - rev. 3/2015.

⁴⁹*Id.*

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coverage, because Part D services will instead be covered by MHL. To be sure, however, the beneficiary needs to confirm whether current medications are covered in the formulary of the health plan.

Individuals passively enrolled into MHL will keep their Part D plans until the date specified in their 60-day and 30-day passive enrollment letters.⁵⁰ If individuals want to [keep](#) their Part D plan, it is very important that they contact Michigan ENROLLS and disenroll from MHL [before](#) the date listed on their enrollment letters. In that case, there should not be any change to their current Part D plan. Once an individual disenrolls from his or her passively assigned MHL plan, the Part D plan will be notified and told to continue the current coverage. Individuals who disenroll should receive a letter confirming their disenrollment and the desire to keep their current Part D plan.⁵¹

If an individual chooses to disenroll from MHL once he or she is officially enrolled in the program (i.e. any time after the effective date listed in the passive enrollment letter) he or she will be disenrolled on the last day of the current month.⁵² These individuals can then re-enroll in their old Part D plan or select a new plan. If they do not request to return to their old or another plan, they will be assigned a new Part D plan.⁵³ To return to their old or another plan, individuals can call 1-800-MEDICARE or go online [here](#) to enroll in the Part D plan.

Each health plan must cover a minimum number of drugs, including Part D drugs and Medicaid drugs not covered by Part D.⁵⁴ Individuals have several options to see which drugs are covered by which plans. The health plans' websites list their drug formularies, and some include a search function. Links to these formularies can be found [above](#). The Medicare Plan Finder also has a list of formularies for each plan, and can be accessed [here](#). Finally, enrollees can speak with a counselor from the Michigan Medicare/Medicaid Assistance Program (MMAP) by calling 1-800-803-7174. MMAP counselors are available Monday through Friday from 8AM to 5PM ET.

Assessments



Each voluntary enrollee will complete a brief initial screening over the phone at the time of enrollment in MHL. Individuals calling to enroll in MHL will be asked nine simple “yes” or “no” questions during the phone call as part of the initial

⁵⁰*Id.*
⁵³*Id.*
⁵⁴*Id.*

assessment process. These questions will help identify current services as well as immediate or unmet needs. Enrollees are not required to answer these questions over the phone, and if they choose not to do so, the health plans will work with them to complete the questions. Enrollees are also free to not answer specific questions on any assessment, or to not participate in an assessment at all.⁵⁵ If they choose not to participate, the health plan will note that decision in the Integrated Care Bridge Record as well as the Individual Integrated Care and Supports Plan (IICSP).

Following this initial screening, enrollees will complete a Level I assessment and, depending on the level of care or services they require, additional assessments.

Level I Assessment

This is a broad assessment used to identify and evaluate current health and functional needs, and also serves as the basis in determining need for further assessment. This assessment is to be completed within **forty-five (45) days** of the enrollment start date. Enrollees identified with immediate needs or as having high risk should have their assessments completed earlier than forty-five (45) calendar days from Enrollment, “as appropriate,” and these assessments should be done in person.⁵⁶ In other states, health plans had difficulty meeting deadlines to complete assessments. However, MDHHS and CMS closely monitor the completion of these assessments, and each plan has a reporting requirement.

Reassessments must be completed within **twelve (12) months** of the last Level 1 assessment.⁵⁷ However, reassessments may need to be completed even sooner, as warranted by the beneficiary’s condition. A new assessment must be completed when there is a change in the beneficiary’s health status or needs, or a new assessment may be requested by the beneficiary, his or her authorized representative or caregiver, or his or her provider.⁵⁸ Additionally, there must be a reassessment if any of the following events occur⁵⁹:

- A hospital admission
- Transition between care settings
- Change in functional status
- Loss or change in circumstances of a caregiver so that the individual supports or services are affected

⁵⁵ State Q&A May 26, 2015

⁵⁶ Three-Way Contract § 2.6.1.3.9.2.

⁵⁷ Medicaid Provider Manual: MI Health Link p. 50.

⁵⁸ Medicaid Provider Manual: MI Health Link p. 50.

⁵⁹ *Id.*

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- Change in diagnosis
- As requested by a member of the ICT who observes a change that requires further investigation.

The health plan is encouraged to conduct these reassessments in person.

Other Assessments

After the Level I Assessment, there may also be a Nursing Facility Level of Care Determination (NFLOCD) as well as a Personal Care Services Assessment, which is done for both personal care services and the Personal Care Supplement.

Level II Assessment

Enrollees identified as having behavioral health needs, intellectual developmental disabilities (I/DD) needs, or long term supports and services (LTSS) needs in the Level I Assessment will also undergo a Level II Assessment. This assessment is supposed to be completed within **fifteen (15) days** of the referral to the entity conducting the Level II Assessment.

Individual Integrated Care and Supports Plan



After enrollment, each enrollee will be asked to help create his or her Individual Integrated Care and Supports Plan (IICSP) with his or her care coordinator. This is a key element of the person-centered planning process of MHL, and is designed to honor the enrollee's preferences and decisions. The enrollee can also choose additional people to participate in this process. This planning process is supposed to be completed within **ninety (90) days** of the enrollment start date.⁶⁰

The Integrated Care Team (ICT), made up of the beneficiary, care coordinator, providers, and any other members the beneficiary wishes to include, must develop a "comprehensive, person-centered, [and] written" IICSP for each beneficiary. This must be conducted in-person, unless the beneficiary chooses otherwise. A beneficiary may choose not to participate, and this refusal must be marked in the IICSP and the Integrated Care Bridge Record (ICBR).

The IICSP must:

- Focus on supporting the individual to achieve personally defined goals in the most integrated setting;

⁶⁰ Three-Way Contract 2.6.2.3.

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- Be developed following MDHHS principles for person-centered planning;
- Include the individual's preferences for care, services, and supports;
- Include the individual's prioritized list of concerns, goals and objectives, and strengths;
- Include specific providers, supports and services including amount, scope, and duration;
- Include a summary of the individual's health status;
- Include the plan for addressing concerns or goals and measures for achieving the goals; and
- Include person(s) responsible for specific interventions, monitoring, and reassessment

Care Bridge

Integrated Care Organizations (ICOs) and Prepaid Inpatient Health Plans (PIHPs) will coordinate services for MHL enrollees through what the state is calling the Care Bridge (ICB). This is a secure electronic platform which allows for the exchange of information to support the coordination of care for all enrollees. The web-based portal is to be accessible by the enrollee, his or her approved representatives, and care team members including the PIHP.

Care Coordination



As a part of its person-centered focus, each MHL enrollee will be assigned a care coordinator. This care coordinator is charged with working alongside the enrollee to create a personalized care plan that is tailored to the enrollee's health needs and goals. The care coordinator's role is to advocate for the enrollee, help answer questions and concerns, connect the enrollee to necessary supports and services, and try to ensure the enrollee's health needs are being met. Beneficiaries will initially be assigned a care coordinator, but if they wish to select a new care coordinator they will be able to select from a pool of qualified candidates. However, they will likely have only limited information about the available staff. Coordinators must be a Michigan licensed registered nurse, a licensed nurse practitioner, a licensed physician's assistant, a licensed Bachelor's prepared social worker, a limited license Master's prepared social worker, or a licensed Master's prepared social worker.⁶¹

The presence of a care coordinator is the heart of the MHL project. Many of the anticipated benefits of the program arise from the ability of the

⁶¹Three-Way Contract § 2.5.3.1.3.

coordinator to identify needs, improve access to services and supports, troubleshoot problems, and empower the beneficiary to take charge of his or her healthcare. In addition to the above requirements, each care coordinator must also participate in in-person training on both person-centered planning and self-determination, as well as online training on multiple topics.⁶²

However, advocates are concerned that care coordinators may not have manageable caseloads that will enable them to offer the full range of services the state anticipates. Each health plan determines how many care coordinators to hire and how to assign caseloads (e.g., care coordinators with significant numbers of beneficiaries with complex needs should have lower caseloads than care coordinators who manage the care of beneficiaries who need only occasional healthcare services). The state has not yet mandated any caseload limitations, and it is not clear what remedies the state has if care coordinators are overburdened and not all of the benefits of care coordination can be realized. However, CMS and MDHHS are monitoring current enrollment, enrollee to care coordinator ratios, and anticipated hires to fulfill care coordination requirements. Once the state sets a limit, plans will not be permitted to staff beyond that level

Person Centered Planning must occur in person unless the individual refuses. Staff from one plan reported they anticipate doing almost all of their care coordination over the telephone. This practice would certainly create barriers for some beneficiaries and eliminate the many benefits of having the care coordinator actually see the beneficiary. Different health plans may have different protocols and beneficiaries may have different preferences. Some beneficiaries will prefer the convenience of interacting with their care coordinator over the telephone; others will find telephone communication challenging or unsatisfactory. It is also not yet clear how health plans will respond when they have difficulty making contact with beneficiaries to perform the assessments, develop the care plan, ensure Medicaid redeterminations and other paperwork is completed, or complete other tasks. This issue is being monitored by CMS and MDHHS, however, health plans are taking steps to locate enrollees. Care coordinators will also face challenges with beneficiaries who may appear to lack capacity but who do not have an authorized representative.

Individuals currently receiving behavioral health services from a Community Mental Health Services Provider (CMHSP) can retain their CMH supports coordinator (for HSW Supports or I/DD services) or care manager (other behavioral health services). This supports coordinator is supposed to work alongside the beneficiary's MHL care coordinator, and while the supports

⁶²Three-Way Contract §§ 2.5.3.1.4.1., 2.5.3.1.4.1.

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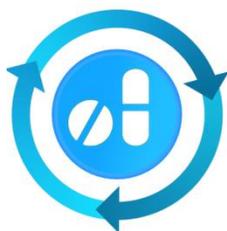
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coordinator cannot perform all the functions of the care coordinator, the beneficiary **can** designate the supports coordinator as the primary point of contact.⁶³ This would allow a beneficiary to maintain a strong connection with his or her current supports coordinator. In this scenario, the beneficiary would likely have limited contact with the MHL care coordinator and would instead speak primarily with his or her supports coordinator. The supports coordinator would then pass along the necessary information to the care coordinator and work with that person to ensure the beneficiary's full range of needs and preferences are met.

The care coordinator is required to maintain ongoing relationships with enrollees. In addition to the above services, care coordinators will periodically conduct new assessments and, when necessary, will help revise care plans. Care coordinators are also responsible for ensuring enrollees are satisfied with the services they are receiving from MHL. Care coordinators are required to maintain contact with enrollees "as frequently as appropriate."⁶⁴

Enrollees have several options if they are unhappy with their care coordinator. First, they can contact the beneficiary help line for their specific health plan, and they will then be guided through the process. Second, they can contact the Medicaid Beneficiary Helpline at 1-800-642-3195 (TTY 1-866-501-5656). Finally, they can contact the MHL Ombudsman at 1-888-746-6456 or at help@MHLO.org.

Each enrollee will also have access to an Integrated Care Team (ICT) that is designed to work alongside the enrollee to establish individual preferences for care and required services. Along with the care coordinator, the ICT may include doctors, nurses, counselors, and any other members the enrollee wishes to include. The ICT is supposed to work with each enrollee to establish goals and preferences for care and services, though some advocates are concerned that many of these providers will not have the time to participate significantly in the ICT. Indeed, in a busy medical practice that may have dozens or hundreds of patients enrolled in MHL, it is difficult to imagine how providers will make time to participate in each beneficiary's ICT. High caseloads and limited resources may prevent some providers from effectively contributing to this process, but providers **are required** to be part of the ICT. CMS and MDHHS are monitoring this issue, however, and health plans in turn are developing solutions to encourage provider participation.



Continuity of Care

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MI Health Link enrollees can continue to see doctors and providers who are not part of the MHL health plan network for a period of time after enrolling in MHL. This “Continuity of Care” period is designed to ease the transition into MHL and is supposed to ensure enrollees, at least temporarily, maintain access to the same providers and services to which they currently have access. An enrollee’s primary care physician, specialists, hospitals, clinics, dentists, personal care provider and other providers are covered by continuity of care requirements.⁶⁵ It is important to note that pharmacies are **not** covered by the continuity of care provisions although there are requirements to ensure beneficiaries have continued access, during the transition period, to the medications they have been taking. Therefore, while beneficiaries will be able to continue obtaining their medications, as described below, they will have to get those medications from pharmacies that participate in the plan to which they have been assigned or in which they have chosen to enroll as soon as their enrollment in MHL is effective.

CMS and MDHHS require ICOs to ensure enrollees have continued access to medically necessary items, services, medications and medical and long-term supports and service providers for the transition period. This includes paying out-of-network doctors and providers during the transition period at **no cost** to the enrollee.⁶⁶ MHL health plans are required to ask enrollees about any upcoming appointments to guarantee that agreements are in place with out-of-network providers during the transition period, but enrollees should also be sure to discuss any upcoming appointments with their care coordinator, if possible.⁶⁷ It will be important to ensure that these mechanisms work effectively to avoid chaotic interruptions of service and confusion.

MHL health plans must cover services during the continuity of care period for providers that do not have documented quality of care concerns that would normally cause the MHL health plan to exclude that provider based on state or federal requirements.⁶⁸

In addition to pharmacies, as mentioned above, durable medical equipment (DME) providers and ancillary service providers, such as medical suppliers and laboratories, are not covered in the continuity of care period.⁶⁹ Nevertheless, MHL health plans still must ensure a continuity of care for **services**. MHL health plans are responsible for finding an in-network provider that can deliver the

⁶⁵ MDCH Continuity of Care Letter - 02/2015

⁶⁶ MI Health Link Program Overview March 4, 2015 - Slide 42.

⁶⁷ MDCH Continuity of Care Letter - 02/2015

⁶⁸ *Id.*

⁶⁹ *Id.*

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services offered by these uncovered providers without disruption to the enrollee.⁷⁰

If an enrollee's current provider is not part of the MHL network, the MHL health plan is supposed to work to bring that provider into the network.⁷¹ Health plans also have an ongoing obligation to contact out-of-network providers "as appropriate" and present information on how to become a certified, in-network provider, though it is not clear from the Three-Way Contract how frequently Health Plans actually have to contact these providers.⁷²

Health plans have an obligation **during** the continuity of care period to alert enrollees and providers if the services being offered or received will no longer be covered after the transition period ends.⁷³ Therefore, enrollees are supposed to be alerted to the services and providers that will lose in-network coverage **before** that coverage is actually lost. At least one health plan has notified many beneficiaries that certain medications they are taking will no longer be covered after the continuity of care period ends. It should be noted that enrollees have the right to request exceptions.

Advocates are concerned that decisions about eliminating or changing medications should be made only after consultation with and assessment by a doctor, but these letters and eliminations do in fact comply with federal regulations. Some of the beneficiaries who have received these notices have not yet been assigned a care coordinator and have not had a chance to discuss the consequences of changing medications with a doctor. Individuals with immediate concerns about medication changes or terminations should contact their health plans immediately. If the problem cannot be resolved with the health plan, individuals may contact IntegratedCare@michigan.gov or the MHL Ombudsman at 1-888-746-6456 or at help@MHLO.org.

Continuity of care requires more than simply covering services and providers during the MHL transition period. It may also require that an enrollee maintain a continuity of *participation* throughout the entire demonstration period, which in turn means that an enrollee will have to maintain his or her eligibility and enrollment in Medicaid. This means that health plans must also promote continuity of care by assisting enrollees during redeterminations of eligibility if

⁷⁰*Id.*

⁷¹*Id.*

⁷²Three-Way Contract § 2.6.4.3.3.

⁷³*Id.*

they need help with paperwork, verification, or other steps to maintain their eligibility for, and enrollment in, Medicaid.⁷⁴

Prior Relationship

An enrollee must have an existing relationship with a provider to receive coverage during the continuity of care period.⁷⁵ An existing relationship will be found in the following circumstances:

- **Primary Care Provider:** The enrollee must have seen the primary care provider at least *twice*, for a nonemergency visit, within the twelve months prior to enrollment into a MHL health plan.
- **Specialists:** The enrollee must have seen the specialist at least *once*, for a nonemergency visit, within the twelve months prior to enrollment into a MHL health plan.
- **Other Covered Providers:** The enrollee must have received services from other providers within the twelve months prior to enrollment into a MHL health plan.⁷⁶

MHL health plans are required to review Medicare and Medicaid utilization data from CMS and MDHHS to determine which providers have prior relationships with enrollees. Continuity of care is supposed to be **automatic** if a prior relationship is found through this data.⁷⁷

A simple statement that the provider relationship exists is **not sufficient** to receive coverage. The MHL health plan must be able to verify the existing relationship based on the available data. If the health plan cannot verify the relationship through data it is supposed to ask both the provider and the enrollee to provide documentation of the visit. This can include the medical record or proof of payment that establishes the relationship.⁷⁸

Requesting Coverage

The enrollee, his or her appointed representative, power of attorney, guardian, or conservator may request continuity of care. The enrollee's out-of-network provider may also request continuity of care on behalf of the enrollee. Requests should be made by contacting the health plan's member services department or the enrollee's Care Coordinator. Requests can be made verbally

⁷⁴*Id.*

⁷⁵MDCH Continuity of Care Letter - 02/2015

⁷⁶*Id.*

⁷⁷*Id.*

⁷⁸*Id.*

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or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the health plan.⁷⁹

MHL plans are supposed to start processing a continuity of care request within **five (5) working days** after receiving the request, though the plans have a maximum of thirty (30) days to actually complete the request. However, if an enrollee has an upcoming appointment or a medical condition that requires immediate attention, the health plans must complete the request within **fifteen (15) days**.⁸⁰ If the enrollee would have to **reschedule an appointment** or there is a **risk of harm** then the request must be processed within **three (3) days**.⁸¹

The health plan may verbally approve a continuity of care request with the requester and should record such approval in the enrollee's record.

Out-of-network providers can be **reimbursed retroactively** for services provided without an approved continuity of care request. Assuming the "prior relationship" requirement outlined above is satisfied, out-of-network providers can be reimbursed if they submit requests for payment within **thirty (30) days** of the first date of service.⁸²

Personal Care Providers

Health plans must allow enrollees to choose personal care providers (also known as "Home Help" providers in traditional Medicaid) to provide services, including paying family members or friends, if the non-agency providers meet the criteria to enroll in the health plan's network. Health plans may enter into an agreement with non-agency personal care providers when a permissible exclusion is identified through a background check.⁸³ Health plans **cannot** enter into an agreement if it is discovered the personal care provider falls under the mandatory exclusion policy from providing personal care services.⁸⁴

Health plans may allow beneficiaries to utilize personal care providers who have criminal backgrounds that fall in the permissible exclusion category if the enrollee is **informed of the details and agrees, in writing**, to allow the person to provide personal care to him or her during the continuity of care period. If the health plan will not continue this agreement beyond the required

⁷⁹*Id.*

⁸⁰ MDCH Continuity of Care Letter - 02/2015

⁸¹*Id.*

⁸²*Id.*

⁸³ See [here](#) for mandatory exclusions and permissible exclusions.

⁸⁴*Id.*

continuity of care period, the enrollee can use that period to seek personal care providers.⁸⁵

In other states' financial alignment demonstration projects, the enrollment of personal care providers has been very problematic. Providers were unaware how to enroll as a provider and how to get paid for the services they provided. In Michigan, state staff are aware of the challenges of enrolling this provider population and sensitive to the concerns regarding accountability of personal care providers that were raised in a recent audit of the state's Medicaid Home Help program. Beneficiaries or providers with questions about enrolling or paying personal care providers should contact their health plans or submit questions to IntegratedCare@michigan.gov. Providers can also contact the state Medicaid Provider Hotline. The MHL Ombudsman program can also assist beneficiaries with concerns about retaining or obtaining personal care providers.

Continuity of Care Period

During the transition period, a change from an existing provider can only occur in the following three ways:⁸⁶

1. The enrollee requests a change;
2. The provider chooses to discontinue services to an enrollee as currently permitted by Medicare or Medicaid; or
3. The Health plan, CMS, or MDHHS identifies provider performance issues that affect an enrollee's health and welfare and therefore requires the beneficiary to obtain services from a different provider.

A change of provider for any other reason is impermissible during the continuity of care period.

The timeline of the continuity of care period will vary depending on the enrollee and the service. The following table shows the continuity of care periods for enrollees, grouped by Habilitation and Supports Waiver (HSW) enrollees and enrollees receiving services from the PIHP Specialty Services and Supports Program on the left, and all other enrollees on the right.

⁸⁵*Id.*

⁸⁶MOU pg. 84.

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Transition Requirements	Habilitation Supports Waiver Enrollees and Enrollees Receiving Specialty Services and Supports Program through the PIHP	All Other MHL Enrollees
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 180 days or continue with single case agreements. (Health plan must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner.)	Maintain current provider at the time of enrollment for 90 days or continue with single case agreements. (Health Plan must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner.)
Prescriptions	See note at end of table.	See note at end of table.
Durable Medical Equipment (DME)	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.	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 days of enrollment.	Must honor specified provider and PAs for surgeries scheduled within 180 days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider. Course of treatment is defined as a prescribed regimen to be followed for a specific period of time based on current treatment standards.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider. Course of treatment is defined as a prescribed regimen to be followed for a specific period of time based on current treatment standards.
Organ, Bone	Must honor specified	Must honor specified provider,

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Transition Requirements	Habilitation Supports Waiver Enrollees and Enrollees Receiving Specialty Services and Supports Program through the PIHP	All Other MHL Enrollees
Marrow, Hematopoietic Stem Cell Transplant	provider, PAs and plans of care.	PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 days .	Maintain current level of service and same provider at the time of enrollment for 180 days .
Vision and Dental	Must honor PAs when an item has not been delivered.	Must honor PAs when an item has not been delivered.
Home Health	Maintain current level of service and same provider at the time of enrollment for 180 days .	Maintain current level of service and same provider at the time of enrollment for 90 days .
Medicaid Nursing Facility Services**	N/A	Enrollee may remain at the facility through contract with the health plan 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	N/A - current providers and level of services will remain unchanged unless changed during the person-centered planning process.	N/A *MI Choice HCBS waiver enrollees: Maintain current providers and level of services at the time of enrollment for 90 days unless changed during the person-centered planning process.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 180 days .	Maintain current provider and level of services at the time of enrollment for 90 days . The Individual Integrated Care and

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Transition Requirements	Habilitation Supports Waiver Enrollees and Enrollees Receiving Specialty Services and Supports Program through the PIHP	All Other MHL Enrollees
	The Individual Integrated Care and Supports Plan (IICSP) must be reviewed and updated and providers secured within 180 days of enrollment.	Supports Plan (IICSP) must be reviewed and updated and providers secured within 90 days of enrollment. *Not applicable for MI Choice HCBS waiver enrollees

Enrollees residing in an out-of-network nursing facility at the time of enrollment into the MHL health plan will not have to move from the facility.⁸⁷ An enrollee has the right to live in an out-of-network nursing home **for the life of the MHL program if the enrollee⁸⁸:

- Resides in the nursing home at the time of enrollment in MI Health Link, **or**
- Resides in a bed not certified for both Medicare and Medicaid (applicable to both in network and out of network providers) at the time of enrollment in MI Health Link, **or**
- Requires nursing home care and has a family member or spouse that resides in an out of network 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 - so long as the facility beds are certified for Medicaid and Medicare.

This continuity of care protection is available as long as the enrollee resides in the nursing facility. Continuity of care in a nursing facility is automatic. The enrollee does not have to make a request for continuity of care.

The MHL health plan must enter into a single-case agreement with the nursing facility and reimburse the nursing facility as an in-network provider. Single-case agreements are effective as long as the resident requires nursing facility care.

Prescriptions

⁸⁷ MDCH Continuity of Care Letter - 02/2015

⁸⁸*Id.*



The MHL health plan must cover at least one temporary thirty (30) day supply of the drug if:

- The enrollee is taking a drug that is not on the MHL Health plan's drug list, **or**
- The MHL health plan's rules do not cover the amount Ordered by the prescriber, **or**
- The drug requires prior approval by the MHL health plan, **or**
- The enrollee is taking a drug that is part of a step therapy restriction

The enrollee can ask the MHL health plan to make an exception to cover a drug that is not on the drug list, though it is important that this is done in a **timely manner** to avoid disruption of the medication.

Prescriptions in a Nursing Facility

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

Nursing Facilities/Patient Pay

Nursing facility residents must be mindful of the continuity of care period/out-of-network providers. If a nursing home resident does not receive prior authorization for a Medicaid covered service provided by an out-of-network provider, the cost of this service **cannot** be offset from the Patient Pay Amount (PPA) if the continuity of care period has ended. If the continuity of care period has ended, the beneficiary is responsible for following the procedure of either: 1, using an in-network provider, or 2. receiving prior authorization. If the beneficiary does not follow one of these procedures, the health plan will not be responsible for covering the cost of the service, **and** the beneficiary will be unable to offset this cost from his or her PPA.⁸⁹

Troubleshooting Resources



The [Michigan Medicare/Medicaid Assistance Program](#) (MMAP) is an excellent resource for questions related to MHL. Trained counselors are available to discuss enrollment options and

Pay Amount Clarification email - January 22, 2016.

answer questions. MMAP is open Monday through Friday from 8AM-5PM ET and can be reached at 1-800-803-7174.

MDHHS has also created a webpage called the [MI Health Link Resources Toolkit](#) that provides a tremendous wealth of resources related to MI Health Link. Many questions related to MHL can likely be answered by a document in this toolkit, and the state continues to update its materials frequently. Most, if not all, of the documents in this toolkit can also be found in the appendix of this guide.

Finally, as noted previously, the MI Health Link Ombudsman was established in December 2015. The goal of the Ombudsman is to serve as a confidential and conflict-free problem solver on behalf of all MHL enrollees. The Ombudsman has detailed knowledge of areas related to enrollee services, and is skilled in negotiation and dispute resolution. The Ombudsman responds to both telephone inquiries and questions submitted electronically. It also maintains a website with information for consumers at www.MHLO.org. The purpose of the program is to help resolve individual concerns, compile data about consumer experiences with MHL, track systemic issues with the program, and bring appropriate issues to the attention of the plans, PIHPs, and the state. The MI Health Link Ombudsman can be contacted at 1-888-746-6456 Monday-Friday 8am - 5pm or anytime at help@MHLO.org.

The MHL Ombudsman works collaboratively with the State Long Term Care Ombudsman Program (SLTCOP). Unlike the SLTCOP, however, due to limited resources and the nature of the MHL program, the vast majority of communication with the MHL ombudsman will be over the telephone. This may pose challenges for individuals who have trouble communicating over the phone or have limited minutes on their telephone plan. In rare cases, in-person visits may be arranged.

Notice and Appeal Rights



Each health plan's website and member handbook should contain detailed information about the appeal and grievance process. The information contained in these guides is lengthy and cannot be properly summarized or reproduced here, so it is strongly recommended you consult the plan-specific materials [linked below](#) when navigating the appeal process. Most of these plan materials are straightforward and easy to understand, and should be very helpful in navigating the appeals process. While

this section of the guide will not cover every precise step of the appeal process, it will attempt to highlight some of the more important details.

If beneficiaries require additional assistance with appeals or grievances, they can contact their local legal services providers or the MHL Ombudsman. Since beneficiaries are eligible for Medicaid, they are also automatically eligible for free legal assistance and legal services providers have significant experience with public benefits appeals. A list of legal services providers in the four demonstration regions is included in the Appendix. Due to very heavy caseloads and demand, legal services staff may not have the capacity to accept all requests for assistance.

Requesting Coverage

Each health plan's member handbook should contain information on how to request a coverage determination, which can be made when an enrollee believes that the health plan should cover a medical service or other supports and services that the enrollee is not currently receiving. Enrollees or their representatives should be able to call, fax, or write in a request for a coverage determination. Health plans are required to authorize services in accordance with 42 C.F.R. § 438.210.⁹⁰ Health plans must also ensure that a health plan representative and a behavioral health provider are available twenty-four (24) hours a day for the timely authorization of medically necessary services.⁹¹

For a standard authorization decision, health plans must provide notice of the authorization as quickly as the requesting enrollee's health condition requires, and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) calendar days.⁹²

Expedited service authorization decisions can be made when a provider indicates or a health plan determines that the timeline outlined above could seriously endanger the enrollee's life, health, or ability to function. Health plans must make a decision and provide notice as quickly as the requesting enrollee's health condition requires, and no later than seventy-two (72) hours after receipt of the request for expedited service, with the possible extension not to exceed fourteen (14) calendar days.⁹³ This expedited determination is only available for services or items an enrollee has not yet received.⁹⁴ If the enrollee's provider tells the health plan the enrollee needs an expedited

⁹⁰Three-way Contract § 2.8.3.1.

⁹¹Three-way Contract § 2.8.3.3.

⁹²Three-way Contract § 2.8.3.7.1.

⁹³Three-way Contract § 2.8.3.7.2.

⁹⁴MI Handbook § 5.2.

determination, the health plan is supposed to automatically grant such a determination.⁹⁵ Note: the health plan has to grant the request for an expedited determination, not necessarily the coverage requested in the determination.

If the requested coverage is denied the enrollee can make an appeal. See [“Internal Appeals”](#) below for further discussion.

[Notice of Adverse Action](#)

An adverse action is an action, or lack of action, by an entity (ICOs or PIHPs) that may be appealed. An entity must give enrollees written notice of any adverse action.⁹⁶ This notice must be provided at least ten (10) calendar days before the adverse action will occur, in accordance with federal regulations.⁹⁷ An enrollee, a provider, or authorized representative acting on behalf of an enrollee and with the enrollee's written consent may appeal the entity's decision to deny, terminate, suspend, or reduce services.⁹⁸ An enrollee, a provider, or authorized representative acting on behalf of an enrollee and with the enrollee's written consent may also appeal the entity's delay in providing or arranging for a covered service or in failing to respond to an enrollee's request for prior authorization for a service.⁹⁹

[Internal Appeals](#)



Internal appeals, also known as Level 1 appeals, are made to the entity taking the action against the enrollee. This can be an appeal of a coverage determination, a proposed reduction or termination, or Medicare service denials.¹⁰⁰ If a health plan is the entity reducing services, for example, a Level 1 appeal would be made to the health plan. Enrollees, authorized representatives, and providers can make either a standard appeal or an expedited appeal to the entity by phone or in writing. Internal appeals must be filed within **sixty (60) calendar days** following the date of the adverse action notice.¹⁰¹ If the appeal regards a service that is being changed

⁹⁵*Id.*

⁹⁶42 C.F.R. §§ 438.404, 422.570.

⁹⁷Three-way Contract §2.11.2.1., 42 C.F.R. § 438.404.

⁹⁸Three-way Contract § 2.11.2.1.

⁹⁹*Id.*, 42 C.F.R. §§ 438.402, 422.574.

¹⁰⁰Three-way Contract § 2.11.2.7.1.

¹⁰¹Three-way Contract § 2.11.3.4.

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or terminated, and the enrollee wishes to **keep** that service pending the appeal, then the appeal must be filed within **twelve (12) calendar days** of the adverse action notice or prior to the date the service is scheduled to be changed or terminated.¹⁰²

It is also important to note that if the enrollee loses the appeal he or she may be responsible for the costs of the services provided by the entity while the appeal was being processed. If the covered services were provided solely because of a timely twelve (12) day appeal, the entity may recover the costs of services provided during the appeal period.¹⁰³

The internal appeal process **must be completed** before an enrollee can pursue an external appeal for Medicare services.¹⁰⁴

Appeals for Medicaid services can be filed concurrently with both the health plan and the Michigan Administrative Hearing System (MAHS). An appeal to MAHS, known as a Fair Hearing, can be requested before, during, after, or instead of their internal appeal to the entity, and must be made within **ninety (90) calendar days** of the adverse action notice.¹⁰⁵ If an entity affirms its decision after an appeal the enrollee will receive a Medicaid service denial and the covered services in question will change or end, but this denial will **not** be automatically sent to MAHS for further consideration. Therefore, it is up to the enrollee or authorized representative to file a separate appeal with MAHS, if he or she has not done so already, as long as it is still within **ninety (90) calendar days** of the adverse action notice.¹⁰⁶

Every appeal must be resolved as quickly as the enrollee's condition requires. A standard appeal must be resolved within **thirty (30) calendar days** after the request, and an expedited appeal must be resolved within **seventy-two (72) hours** after the request, though there is a possibility the entity could extend this deadline by **fourteen (14) calendar days**.¹⁰⁷ Standard Medicare Part D appeals must be resolved within **seven (7) calendar days**, and expedited appeals will be resolved in **seventy-two (72) hours**.¹⁰⁸ If a Part D appeal is not resolved within the above time periods then the appeal will be automatically sent to an Independent Review Entity (IRE) for an external/Level 2 appeal ([see below](#)).¹⁰⁹

¹⁰² Three-way Contract § 2.11.3.6.4.3.2.

¹⁰³ 42 CFR 438.420(d).

¹⁰⁴ Three-way Contract § 2.11.3.1.

¹⁰⁵ Three-way Contract § 2.11.2.7.2.

¹⁰⁶ Three-way Contract § 2.11.2.7.3.

¹⁰⁷ Three-way Contract §§ 2.11.2.7.6., 2.11.2.7.6.1.

¹⁰⁸ State Member Handbook at 31.

¹⁰⁹ *Id.*

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Health plans are supposed to ensure that the individuals who decide both standard and expedited appeals were not involved in any level of the decision-making process for the original coverage determination.¹¹⁰

External Appeals



External appeals, also known as Level 2 appeals, are the next level following the initial internal appeal. These appeals are handled by an independent organization, not the health plans. Medicare's external appeals are handled by an Independent Review Entity (IRE). Medicaid external appeals are handled by the Michigan Administrative Hearings System (MAHS) via a Fair Hearing or through the Michigan Department of Insurance and Financial Services (DIFS) via an External Review.

Medicare

There are different appeal protocols depending on whether the appeal concerns Part D Medicare drugs or other Medicare services or benefits. The health plan must continue to provide all non-Part D benefits and services throughout the appeal process. If a health plan does not fully rule in favor of an enrollee's internal appeal for **non-Part D Medicare drugs and services**, an external appeal will **automatically** be sent to the IRE.¹¹¹ It is important to remember that enrollees must file an internal appeal and exhaust the health plan's internal appeal process before they can pursue an external appeal to Medicare.¹¹²

Both standard and expedited Part D appeals will also be automatically forwarded to the IRE **if no decision is rendered by the entity by the required deadline**.¹¹³ If an entity denies an appeal for Part D drugs by the required deadline (see above), an external appeal will **not** be automatically sent to the IRE. Therefore, if enrollees receive a decision denying their **Part D** internal appeal it will be up to the enrollee to file a subsequent external appeal with the IRE, and they will have **sixty (60) calendar days** to file this appeal.¹¹⁴

For standard appeals, the IRE will respond within **thirty (30) calendar days** after it receives the case from the entity, though there is the possibility of a **fourteen (14) calendar day** extension of this deadline.¹¹⁵ Expedited appeals

¹¹⁰Three-way Contract § 2.11.3.5.1.2., 2.11.3.6.2.

¹¹¹Three-Way Contract § 2.11.2.7.1.1.

¹¹²Three-Way Contract § 2.11.3.1.

¹¹³State Member Handbook at 31.

¹¹⁴State Member Handbook at 32.

¹¹⁵Three-Way Contract § 2.11.4.1.2.

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must be answered within **seventy-two (72) hours**, with another possible extension of fourteen (14) calendar days.¹¹⁶ If the IRE rules in favor of the enrollee and reverses the entity's decision, the entity must authorize the disputed service as quickly as the enrollee's health condition requires, and no later than **seventy-two (72) hours** after the entity receives the notice reversing its decision.¹¹⁷

The IRE may confirm the decision of the entity and rule against the enrollee's appeal. If this happens, the enrollee can make a Level 3 appeal and request a hearing with an administrative law judge in the Office of Medicare Hearings and Appeals (OMHA).¹¹⁸

Medicaid

Appeals for Medicaid services can be filed through either MAHS or DIFS.

Enrollees can file an external appeal through MAHS by requesting what is called a **Fair Hearing**. This Fair Hearing is an impartial review conducted by an administrative law judge at MAHS.¹¹⁹ As mentioned above, Fair Hearings can be requested before, during, after, or instead of the internal appeal to the entity, and must be made within **ninety (90) calendar days** of the date on the adverse action notice.¹²⁰

IMPORTANT: If an enrollee requests a Fair Hearing (and does not file an internal appeal) because a covered service he or she receives is being changed or stopped, the timeline changes if he or she wishes to *keep the covered service throughout the appeals process*. In that case, a Fair Hearing must be requested within twelve (12) calendar days of the adverse action notice OR before the date the covered service is scheduled to change. If a Fair Hearing is not requested within twelve (12) calendar days the service will be changed or stopped as of the day listed on the adverse action notice. It is possible this action could be reversed and the service restored if the Fair Hearing is successful, but the enrollee will not have access to the service during the appeal process without a timely 12-day appeal.

¹²¹, ¹²²

¹¹⁶Three-Way Contract § 2.11.4.1.3.

¹¹⁷Three-Way Contract § 2.11.4.1.3.

¹¹⁸Three-Way Contract § 2.11.2.7.1.2.

¹¹⁹Three-Way Contract § 1.117.

¹²⁰Three-way Contract § 2.11.2.7.2.

¹²¹Three-Way Contract § 2.11.2.8.2.

¹²²42 CFR 438.420(d).

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Enrollees can ask for a Fair Hearing by submitting a “[Request for Hearing](#)” form. This form should be included along with the plan’s coverage decision.

Enrollees can also make an external appeal via an **External Review** through DIFS under the [Patient's Right to Independent Review Act](#) (PRIRA) by completing a “[Health Care Request for External Review Form](#).” Enrollees should receive this form from their health plans in the Internal Appeal decision letter. Unlike an external appeal with the MAHS system which, as noted above, can be filed before, during, or after an internal appeal, an External Review through DIFS can only be filed after the health plan’s internal appeal process is exhausted.¹²³ The request should also include a copy of the final adverse determination from the health plan along with other information and documentation to support the patient's position. The request must be submitted within **sixty (60) days** of the enrollee's receipt of the final adverse determination/Internal Appeal decision letter.¹²⁴

IMPORTANT: As with the Fair Hearing above, the External Review application timeline changes if an enrollee wishes to keep the disputed service during the External Review. If an enrollee qualified for continuation of benefits during the Internal Appeal, he or she can keep the disputed service during the External Review if the request for External Review is submitted within twelve (12) calendar days of the Internal Appeal denial.

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Overlapping Medicare & Medicaid Services

If the service of item could be covered by both Medicare and Medicaid, enrollees may file an appeal through either the Medicare or Medicaid appeals process, or both.¹²⁶ Internal appeals will be automatically forwarded to the Independent Review Entity (IRE) by the health plan. The enrollee may also file a request for a Fair Hearing with MAHS. If an appeal is filed with both the IRA and MAHS, any determination in favor of the enrollee will bind the health plan and will require payment for the service or item in question which is closest to the enrollee’s relief requested in the appeal.¹²⁷

Integrated Notice

¹²³Three-Way Contract § 2.11.3.2.

¹²⁴*Health Coverage Grievances and Appeals*, MICHIGAN.GOV, http://www.michigan.gov/difs/0,5269,7-303-12902_35510-263250--00.html (last visited Sep. 2 2015)

¹²⁵Three-way Contract § 2.11.2.8.2.1.

¹²⁶Three-way Contract § 2.11.2.7.5.

¹²⁷*Id.*

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Each health plan offers specific information on appeals, but beneficiaries retain all the appeal rights they had in traditional Medicaid and Medicare in addition to appeal rights within the health plan. Of course, an essential element of individuals' appeal rights is receiving adequate notice of the health plan's or provider's intended actions. The three-way contract requires that an entity provide enrollees notice of decisions regarding services or coverage, and enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single Integrated Notice.¹²⁸ Enrollees must be notified at least **twelve (12) calendar days** in advance of the effective date of the action. The notice must explain¹²⁹:

- The action the entity has taken or intends to take;
- The reasons for the action explained in simple and appropriate terms for the enrollee to understand;
- The citation to the regulations supporting such action;
- The enrollee's right to file an internal appeal with the entity, explaining that exhaustion of the entity's internal appeal processes is a prerequisite to filing an external appeal to **Medicare for a Medicare service** or filing an external review with the Michigan Department of Insurance and Financial Services(DIFS) for a Medicaid service;
- The enrollee's or authorized representative's right to file an external appeal for Medicaid services with the Michigan Administrative Hearings System (MAHS) simultaneously with an internal appeal to the entity.
- Procedures for exercising the enrollee's rights to appeal;
- The enrollee's right to request a State Fair Hearing in accordance with federal and state Medicaid law;
- The enrollee's right to request an independent review of a Medicaid service with DIFS in the implementation of PRIRA, MCL 550.1901-1929; and
- If applicable, the enrollee's rights to have benefits continue during the time the appeal is being decided, and the circumstances when the enrollee may be required to pay the costs of these services.

The above information is supposed to be available in alternate formats for individuals with special needs, as well as additional languages, and enrollees should be provided information on how to access these additional materials.¹³⁰

¹²⁸Three-way Contract § 2.11.2.6.1.

¹²⁹*Id.*

¹³⁰Three-way Contract §§ 2.11.2.6.2., 2.11.2.6.3, 2.11.2.6.4.

Grievances



Grievances are complaints made about certain types of problems with a health plan or provider. In some materials grievances may be referred to as “complaints.” Possible grievances include issues with quality of care, privacy, accessibility, wait times, cleanliness of facilities, language access, and complaints about the timeliness of responses to coverage decisions or appeals. Enrollees can file an internal or external grievance.

Internal Grievances



Internal grievances can be filed with the health plan or with a provider, who must then forward the grievance to the health plan.¹³¹ For complaints related to Part D coverage, the grievance must be filed within **sixty (60) calendar days** of the event that triggered the complaint.¹³² For all other Medicare complaints the grievance must be filed within **ninety (90) calendar days** of the event that triggered the complaint.¹³³

Enrollees and authorized representatives can contact the health plan’s Member Services if they wish to file a grievance. A grievance can be filed over the phone, and Member Services should assist in the process.

Enrollees can also file a grievance in writing, and the plan will respond to the complaint in writing. Health plans must respond to a grievance within **thirty (30) calendar days** after receiving the complaint, though there is the possibility this may be extended by **fourteen (14) calendar days** in select circumstances.¹³⁴ Health plans should also provide a timely acknowledgement of the receipt of each enrollee grievance.¹³⁵

Enrollees can also file **expedited grievances**. If a health plan denies an expedited appeal or an expedited service authorization (outlined above) then an enrollee may file an expedited grievance. Health plans must respond to an expedited grievance within **twenty-four (24) hours** of receipt of the grievance.¹³⁶

¹³¹Three-Way Contract § 2.10.1.1.

¹³² 42 C.F.R. § 423.564 (d)(2).

¹³³Three-way Contract § 2.10.1.1.

¹³⁴Three-Way Contract § 2.10.2.1.3.3.

¹³⁵Three-Way Contract § 2.10.2.1.3.1.

¹³⁶Three-way Contract § 2.10.2.1.3.4.

External Grievances



There are a number of external grievance options available to enrollees.¹³⁷

Complaints About Disability Access or Language Assistance

Enrollees can file a complaint with the Office of Civil Rights at the United States Department of Health and Human Services at:

233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-800-368-1019
Fax: 312-886-1807
TDD: 1-800-537-7697

Enrollees can also contact the Michigan Department of Civil Rights at:

110 W. Michigan Ave., Suite 800
Lansing, MI 48933
Phone: 517-335-3165
Fax: 517-241-0546
TTY: 517-241-1965

In addition, recipients of public mental health services can file complaints with the MDHHS Office of Recipient Rights:

Michigan Department of Health and Human Services
Office of Recipient Rights
Lewis Cass Building-Garden Level
Lansing, MI 48933
Phone: 1-800-854-9090
Relay Center (for hearing impaired individuals): 800-649-3777 or 3711

Or contact their county Office of Recipient Rights (see [this link](#) for information about how to contact the county offices).

¹³⁷MI Handbook §§ 10.1-10.8.

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Beneficiaries who live in nursing facilities, adult foster care facilities, or homes for the aged may contact the State Long Term Care Ombudsman Program by calling 1-866-485-9393. The call will be routed to the local long-term care ombudsman. For more information on the State Long Term Care Ombudsman program, see [this link](#).

Beneficiaries who want to file a complaint about a nursing facility may contact:

Department of Licensing & Regulatory Affairs
Bureau of Health Care Services - Health Facility Complaints
PO Box 30664
Lansing, MI 48909
Phone: 1-800-882-6006 or 1-517-241-4712
Fax: 1-517-241-2635 (to submit the BHCS-361 Complaint Form only)

For more information about filing a complaint with the Bureau of Health Care Services, see [this link](#).

Complaints About Quality of Care

Enrollees can file quality of care grievances with the Quality Improvement Organization (QIO), a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. These quality of care grievances can either be made strictly to the QIO (and *not* to the health plan) or to both the QIO *and* the health plan.

The QIO can be contacted at 1-855-408-8557 (TTY: 1-855-843-4776).

As noted above, nursing facility residents concerned about quality of care can contact the Michigan State Long Term Care Ombudsman at 1-866-485-9393. In addition, complaints can be filed against nursing homes and other licensed health care facilities by contacting the Department of Licensing and Regulatory Affairs (LARA) at 1-800-882-6006.

Contact the State of Michigan with Provider Complaints

Complaints against individual licensed health care providers can be filed with LARA at:

The Department of Licensing and Regulatory Affairs
Bureau of Health Care Services

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Enforcement Division, Allegation Section
PO Box 30454
Lansing, MI 48909
Phone: 1-517-373-9196
Fax: 1-517-241-2389
Email: BHCSHelp@michigan.gov

Contact the State of Michigan with Health Plan Complaints

Enrollees may contact the state if they have issues with their health plan. Enrollees should call the Michigan Department of Insurance and Financial Services (DIFS) toll free at 1-877-999-6442, Monday through Friday from 8AM to 5PM, ET or via email at: difs-HICAP@michigan.gov.

Contact Medicare Directly

Enrollees can send grievances directly to Medicare. Enrollees should file the Medicare Complaint Form available [here](#). Medicare can also be reached at 1-800-MEDICARE (1-800-633-4227)(TTY 1-877-486-2048).

Contact Medicaid Directly

Enrollees can also contact Medicaid directly. They should contact the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656), open Monday through Friday from 8AM to 7PM ET.

Contact the MI Health Link Ombudsman

The MI Health Link Ombudsman is available Monday through Friday from 8AM to 5PM ET at 1-888-746-6456. Beneficiaries can also email the Ombudsman at help@MHLO.org.

Health Plan Grievance and Appeals Information

See below for information on each health plan's grievance and appeal process:

Upper Peninsula

ICO:

- Upper Peninsula Health Plan MI Health Link ([website](#))

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Southwest Michigan

ICOs:

- Aetna Better Health Premier Plan ([Part D appeals](#)) | ([Non-Part D appeals](#))
- Meridian Complete ([website](#))

Macomb County

ICOs:

- Aetna Better Health Premier Plan ([Part D appeals](#)) | ([Non-Part D appeals](#))
- AmeriHealth Caritas VIP Care Plus ([appeals](#)) | ([grievances](#))
- HAP Midwest MI Health Link ([website](#))
- Michigan Complete Health ([website](#)) | ([Part C appeals](#)) | ([Part D appeals](#)) | ([grievances](#))
- Molina Dual Options MI Health Link ([website](#))

Wayne County

ICOs:

- Aetna Better Health Premier Plan ([Part D appeals](#)) | ([Non-Part D appeals](#))
- AmeriHealth Caritas VIP Care Plus ([appeals](#)) | ([grievances](#))
- HAP Midwest MI Health Link ([website](#))
- Michigan Complete Health ([website](#)) | ([Part C appeals](#)) | ([Part D appeals](#)) | ([grievances](#))
- Molina Dual Options MI Health Link ([website](#))

Glossary



Adverse Action - (i) The denial or limited authorization of a service authorization request, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; or denial in whole or in part of payment for a covered service for Enrollee; (iv) the failure by the health plan to render a decision within the required

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timeframes; or (v) solely with respect to a health plan that is the only plan serving a rural area, the denial of Enrollee's request to obtain services outside of the Contracting Area.¹³⁸

AFC-Adult Foster Care. A licensed residential facility that provides foster care to adults¹³⁹[HFA/AFC Lookup](#). [License Lookup](#).

Bridges - The [computer system](#) used by MDHHS to conduct and track enrollment in Medicaid and other public benefits.

Care Bridge - The framework for MI Health Link's integrated care program. Through the Care Bridge, members of the enrollee's Integrated Care Team (ICT) will coordinate services and supports as part of the enrollee's person-centered care plan. The Care Bridge includes an electronic Care Coordination platform, which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the ICT.

Care Coordinator - A designated person to help MI Health Link enrollees with coordination of Medicare and Medicaid services. The Care Coordinator will be a Michigan licensed registered nurse, nurse practitioner, physician's assistant, or Bachelor's or Master's prepared social worker employed or contracted with the health plan. He or she will be accountable for providing Care Coordination services and trained in person-centered planning techniques.¹⁴⁰

CHAMPS - Community Health Automated Medicaid Processing System. The Medicaid provider enrollment and payment system run by MDHHS.

CMH/CMHSP - Community Mental Health/Community Mental Health Services Provider. An agency or entity responsible for directly providing behavioral health services in MHL. CMHs/CMHSPs are managed by Prepaid Inpatient Health Plans (PIHPs).¹⁴¹

CMS - Centers for Medicare and Medicaid Services, the federal agency within the United States Department of Health and Human Services that administers Medicare and Medicaid.

DHHS - the Michigan Department of Health and Human Services. The new Michigan Department of Health and Human Services (MDHHS) which was established by Governor Snyder on April 10, 2015 and encompasses both the

¹³⁸ Three-way Contract § 1.2

¹³⁹ MCL § 400.703(4).

¹⁴⁰ Three-Way Contract § 1.54.

¹⁴¹ [Behavioral Health Services and MI Health Link Letter](#)

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former Michigan Department of Community Health and the Michigan Department of Human Services.¹⁴²

DIFS - Michigan Department of Insurance and Financial Services (DIFS). It handles external appeals for Medicaid services.

Disenroll - term used by the MDHHS for when an individual wants to be **completely removed** from MI Health Link. If an enrollee is scheduled for passive enrollment, simply requesting to “opt out” of MHL will **not** remove him or her from the program. The word “disenroll” must be used.

DME - durable medical equipment such as wheelchairs, walkers, air fluidized beds or other equipment to prevent skin breakdown, oxygen equipment, lifts, and hospital beds.

Fair Hearing - The process for handling an external appeal for Medicaid services. Run by the Michigan Administrative Hearings System (MAHS).

HCBS/ED - Home and Community Based Services for the Elderly and Disabled. Authorized in § 1915(c) of the Social Security Act.¹⁴³ See MI Choice Home and Community Based Waiver below.

HCBS rules - Home and Community Based Service Rules. Available [here](#).

HFA - Homes for the Aged. A licensed residential setting for older adults.¹⁴⁴ [HFA/AFC Lookup](#). [License Lookup](#).

HSW - Habilitation Supports Waiver. 1915(c) home and community based services waiver that provides intensive habilitation and support services to assist individuals with intellectual/developmental disabilities to live independently in the community.¹⁴⁵ Enrolling in MI Health Link will not impact enrollment in the Habilitation Supports Waiver program.

ICBR - Integrated Care Bridge Record. An individualized record generated and maintained within the electronic Care Coordination platform. It allows secure access for enrollees and the ICT to use and (where appropriate) update information. These records are electronic, but a paper version must be made available if the enrollee requests one. Each plan has a platform accessible

¹⁴²[Executive Order No. 2015-4](#).

¹⁴³42 U.S.C. § 1396n.

¹⁴⁴MCL § 400.701 et seq.

¹⁴⁵42 U.S.C. § 1396n.

through a web portal, and MDHHS and CMS track these platforms on bi-weekly calls with the plans.

ICO - Integrated Care Organization. A health insurance-based organization contractually responsible and accountable for providing integrated care to people eligible for both Medicare and Medicaid. ICOs are responsible for providing Physical Health services and long-term care.¹⁴⁶ ICOs are the health plans in each region that are referred to throughout this Guide.

IICSP - Individual Integrated Care and Supports Plan. Each enrollee will help develop his/her own care and supports plan with his/her care coordinator and will choose the people to participate in the process to identify the supports and services that will best help enrollees meet their needs and care goals.

ICTs - Integrated Care Teams. These teams will help manage and coordinate care for enrollees by participating in the person-center planning process. ICTs are lead by an ICO Care Coordinator.

I/DD - Intellectual and/or developmental disabilities.

IRE - Independent Review Entity, responsible for handling Medicare external appeals.

LOCD - Level of Care Determination. The process is used to determine if an individual needs nursing home level of care. Eventually, MI Health Link will use a conflict free LOCD process, in which an entity with no interest in the outcome of the assessment (financial or otherwise) makes the determination if the individual qualifies for the necessary level of care. However, because the State has not yet identified the contractor that will perform the conflict free assessments, initially, the plans will be conducting their own Level of Care Determinations. [LOCD Form](#). [MDHHS website](#).

LTSS - Long Term Supports and Services. A variety of supports and services that help older adults and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.¹⁴⁷

MAHS - Michigan Administrative Hearings System. Handles external appeals for Medicaid via Fair Hearings.

¹⁴⁶[MI Health Link Glossary](#)

¹⁴⁷Three-Way Contract § 1.66.

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MI Choice - MI Choice Home and Community Based Waiver Program. Allows eligible adults to receive Medicaid covered services, like those provided in nursing homes as well as other services to support beneficiaries in the community, while staying in their own homes or other residential settings. Participants must leave MI Choice before they can join MI Health Link. See [Medicaid Provider Manual](#) at 1049.

MHL - MI Health Link, the managed health care plan that is the subject of this guide.

MMAP - Michigan Medicare/Medicaid Assistance Program. Michigan's State Health Insurance Program (SHIP) that assists individuals in understanding the Medicare and Medicaid programs and provides Enrollment assistance to persons seeking guidance on health care options. Hours: M-F 8AM-5PM. Phone: 1-800-803-7174. [Website](#).

MFP - Money Follows the Person. Helps states rebalance their Medicaid long-term care system by transitioning individuals from institutions back into the community. More information [here](#).

MOU - Memorandum of Understanding. For this guide the MOU refers to the agreement entered into between MDCH and CMS on April 3, 2014, authorizing MI Health Link.

MSA - [Medical Services Administration](#). An administration within the Michigan Department of Health and Human Services that oversees the Medicaid program and MHL.

Opt out - Language used by the state to indicate an individual wants to opt out of being passively enrolled into a pre-selected health **and instead wants to select his or her own health plan**. If an individual is scheduled for passive enrollment and calls Michigan ENROLLS to "opt out" he or she might not be actually removed from MI Health Link. Instead, opting out means the individual wants to choose a health plan themselves, instead of being assigned one by the state. If an individual wants to completely remove themselves from MHL they must use the word "disenroll" and **not** "opt out."

PA - Prior Authorization - required to obtain some services.

PACE - Program of All-Inclusive Care for the Elderly. Provides services to individuals 55 years of age and older. Allows a member to live at home while

receiving social and medical services in an adult day health center rather than living in a nursing home.¹⁴⁸¹⁴⁹ Participants must leave PACE before they can join MI Health Link.

Passive Enrollment - The process where an eligible beneficiary is automatically enrolled by the state into MI Health Link. If the eligible beneficiary does not affirmatively opt out of MHL before being enrolled in a plan or disenroll after being assigned to a plan, he or she will eventually be passively enrolled into the program and that enrollment will become effective. Before the enrollment becomes effective, beneficiaries will receive a 60-day notice that includes the plan selection and a 30 day notice. These notices will also give enrollees the opportunity to select a different health plan or disenroll from the health plan to which he or she has been assigned prior to the effective date of passive enrollment. Individuals can also disenroll or change plans at any time after their passive enrollment becomes effective.

PIHP - Prepaid Inpatient Health Plan. Organizations that the Department of Health and Human Services contracts with to administer the Medicaid covered community mental health benefit. PIHPs are responsible for managing behavioral health services - mental health services, intellectual/developmental disabilities services and supports, and/or substance use disorder services. See [MDHHS behavioral health website](#) for more information.

PRIRA - Patient's Right to Independent Review Act. Allows an enrollee to file an external appeal to the Michigan Department of Insurance and Financial Services (DIFS) for Medicaid services.

Provider - health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance use providers, nursing home providers, LTSS providers, pharmacy providers, and other acute care providers.

SNF - Skilled Nursing Facility

SNP - Dual-Special Needs Plan

¹⁴⁸[Medicaid Provider Manual](#) at 1,537.

¹⁴⁹[MDHHS Information](#) on MI PACE Programs.

Appendix

Websites

- [MDHHS MI Health Link Website](#)
- [MDHHS MI Health Link Resources Toolkit](#)

MHL Letters

- [Introductory Letter #33 \(Southwest Region/Upper Peninsula\)](#)
- [Introductory Letter #33 \(Wayne and Macomb\)](#)
- [60-Day Passive Enrollment \(Letter #31\)](#)
- [30-Day Passive Enrollment \(Letter #5\)](#)
- [60-Day Passive Enrollment \(2016\)](#)
- [30-Day Passive Enrollment \(2016\)](#)

General Information

- [Calling Michigan ENROLLS](#)
- [List of Required MI Health Link Services](#)
- [Hospice and MI Health Link](#)
- [MI Health Link for MI Choice Participants](#)
- [MI Health Link and Medicare Part D Plans](#)
- [Personal Care Supplement Guide](#)
- [Comparison of Home and Community Based Long-Term Care Programs](#)
- [Behavioral Health Services and MI Health Link](#)
- [Care Coordinator Responsibilities and Expectations](#)
- [Enrollee Protections](#)
- [Assessments Overview](#)
- [MI Health Link Brochure](#)
- [MI Health Link Flyer](#)
- [Eligibility Redetermination and Deeming for MI Health Link Q&A](#)

Consent Forms

- [Form DCH-1183: Authorization to Disclose Protected Health Information \(PDF\)](#)
- [Form DCH-1183: Authorization to Disclose Protected Health Information \(MS Word\)](#)
 - [Sample form DCH-1183](#)
- [Form DCH-3927: Behavioral Consent Form \(MS Word\)](#)
 - [Behavioral Consent Form Handout](#)
 - [Behavioral Consent Form Background Information](#)

Miscellaneous

- [Memorandum of Understanding Between CMS and Michigan Department of Community Health](#)
- [Three Way Contract - Updated November 2016](#)
- [CMS Website for Michigan Demonstration](#)
- [Medicaid Provider Manual - MI Health Link](#)
- [Deeming Information for Providers](#)
- [Deeming Presentation Materials](#)