Michigan MI Health Link Demonstration

(MI Health Link)

This contract was re-executed on November 1, 2016 to:

- Add a two-year extension to the contract, for a new demonstration end date of December 31, 2020, as agreed upon by CMS and MDHHS. The contract also includes the policies applicable to the two-year extension throughout the contract in relevant sections, including savings percentages for demonstration years 4 and 5 (see 4.1.2), and applicable quality withhold measures (see 4.4.4.8).
- Perform general clean-up and make technical changes to streamline provisions across all three-way contracts for the capitated model demonstrations under the Medicare-Medicaid Financial Alignment Initiative. These changes include:
    - Adding policies and procedures related to discretionary involuntary disenrollments, such as clarifying when an MMP may disenroll an enrollee due to disruptive behavior, and adding procedures that MMPs must complete before effectuating the disenrollment (see 2.3.7.5);
    - Adding requirements related to model of care submissions (see 2.5.1.);
    - Clarifying out-of-network reimbursement rules, including clarifying reimbursement for emergent or urgent care (see 2.4.1.9, 2.8.8.2) and policies regarding when plans may not pay for items or services (see 2.7.4.3, 2.7.3.5);
    - Clarifying and updating requirements regarding Indians and Indian Health Care Providers (1.57, 1.58, 2.3.5.1.1, 2.7.3.9.5, 2.7.3.9.7, 5.1.9.1); and
    - Updating marketing requirements to align with national Medicare Marketing Guidelines, Medicare-Medicaid marketing guidance, and state-specific marketing guidance (see 2.3.6, 2.9.2, 2.9.3, 2.14).
- Clarify requirements related to the provision of provision of Medicaid behavioral health services in the event there is no contract between the ICO and the Prepaid Inpatient Health Plan (PIHP) (see 2.4.1.7, 2.5.3, 2.5.4.4.1.4, 2.5.5.1.2, 2.6.3.6, 2.7.4.2, 2.3.7.8.1.1, 2.7.4.2, 2.11.1.3, 2.13.9.4.3)
- Clarify expectations regarding care coordination and person-centered planning. These changes include:
    - Clarifying that the person-centered planning process is conducted in person unless declined by the enrollee (see 1.96);
    - Clarifying referrals through the OBRA PASARR program for Nursing Facility residents (see 2.6.3.6.1.1);
    - Prohibiting Level I Assessment tools to be mailed to enrollees unless the mailing process has been approved by the CMT (2.6.3.10);
    - Clarifying the Personal Care Assessment, the Michigan Medicaid Nursing Facility Level of Care (NFLOC) Determination, and the Level II Assessment requirements (see 2.6.4, 2.6.5 and 2.6.6), clarify Level II Assessment adoption (see 2.6.6.5.1) and clarify Level II Assessment referral timing (see 2.6.6.6);
    - Clarifying the responsibility for the ICO to develop a reassessment strategy (2.6.7.4);
    - Clarifying the reassessment timing for NFLOC redeterminations (2.6.7.8); and

    - Clarifying the definition of the Individual Integrated Care and Supports Plan (IICSP) and that the expectation that the IICSP be completed in person, and reviewed and updated based on enrollee stratification (see 1.59, 2.6.8).
- Allow beneficiaries who are already enrolled in an ICO to elect hospice services and remain enrolled with their plan (see 2.3.2.3, 4.2.2.2.5).
- Allow for ICOs to make outreach calls to passive enrollees beginning 60 days prior to the effective date of coverage (see 2.3.6.5).
- Update quality withhold requirements. These changes include:
    - Aligning the QW DY1 measures with the Michigan MOU (The CAHPS measure "percent of best possible score the plans earned on how easy it is to get information and help when needed" measure was previously moved to DY2 based on measure collection timing when DY1 aligned with CY2015. The change in demonstration years from original contract signing allows this measure to be collected in DY1.) (see 4.4.4, Exhibit 6); and
    - Allowing for alternative QW measures to be used for DY2-5 if an ICO has low enrollment or an inability to meet reporting criteria (see 4.4.4.8.3).
- Clarify appeals provisions. These updates include:
    - Provide for continuing benefits through IRE review for previously authorized non-Part D benefits (see 2.11.2.8.2);
    - Clarify the requirement for a written confirmation for an oral appeal request (see 2.11.3.5.2); and
    - Add information regarding the appeals process for non-contracted providers (see 2.12.4).
- Clarify eligibility and enrollment provisions. These changes include:
    - Clarifying demonstration ineligibility (see 2.3.2.2), and passive enrollment ineligibility (see 2.3.5.1);
    - Clarify the distinction between demonstration disenrollment, opt-out, and cancelation of passive enrollment (throughout).
- Update references with regards to the consolidation of state agencies into the Michigan Department of Health and Human Services (MDHHS).