Highlights of Michigan's Memorandum of Understanding with CMS
For the Michigan Demonstration to Integrate Care for Dual Eligible Beneficiaries
"MI Health Link"

Scope

- Individuals eligible for the demonstration include full benefit Medicare-Medicaid enrollees aged 21 or older. Approximately 100,000 Medicare-Medicaid enrollees will be eligible to participate in the demonstration.
- Excluded populations from this demonstration include, but are not limited to the following: individuals under the age of 21, individuals previously disenrolled due to special disenrollment from Medicaid managed care, individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals status, individuals without full Medicaid coverage, individuals with Medicaid who reside in a State psychiatric hospital, individuals with commercial HMO coverage, and individuals with hospice services.
- Individuals enrolled in the MI Choice waiver program (a 1915(c) waiver) and related Money Follows the Person (MFP) program or the Program for All-inclusive Care for the Elderly (PACE) may choose to participate in the Integrated Care Program, but only if they elect to disenroll from MI Choice, MFP, or PACE. These individuals, along with persons enrolled in employer-sponsored Medicare Advantage health plans, will be excluded from passive enrollment.
- The demonstration will be implemented in twenty-five counties of the State grouped into four regions and will run from January 1, 2015 to December 31, 2017.

Contracting and Rates

- CMS and the State will enter into a joint rate-setting process as described in Appendix 6 of the MOU.
- CMS will develop baseline spending (costs absent the demonstration) and payment rates for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the participants using a blend of Medicare Advantage projected payment rates and Medicare Fee-for-Service (FFS) standardized county rates. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year.
- Subject to CMS approval, the State and its actuaries will determine the baseline spending for Medicaid services under the demonstration based on historical State data and trend rates and a blend of Medicaid fee-for-service claims for services to be covered in the demonstration and also capitation payments associated with eligible individuals currently in Medicaid managed care. Medicaid actuarial soundness principles will apply to payments to health plans.
- Rates for each demonstration year will incorporate projected savings: Year 1, 1%; Year 2, 2%; and Year 3, 4%.
- CMS-HCC risk adjustment methodology will be applied to the Medicare Part A/B portion of the rate and Part D RxHCC will be applied to the Part D portion. The Medicaid portion of the blended rate paid to health plans will include a tiered rate cell structure risk adjustment based on the level of care.
- Because most enrollees will come from Medicare FFS, in calendar year 2015, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In calendar year 2016, CMS will apply an appropriate coding intensity adjustment reflective of all demonstration enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of demonstration enrollees in calendar year 2016 with prior Medicare Advantage experience and/or demonstration experience based on the demonstration's enrollment phase-in as of September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all enrollees.
- Beginning in the second year of the demonstration, each participating plan will be required to meet a Minimum Medical Loss Ratio (MMLR) of 85%. If a plan has an MMLR below 85%, the plan must remit the amount by which the 85% threshold exceeds the plan's actual MMLR multiplied by the total applicable revenue of the contract. The three-way contracts will include additional specifications on the MMLR.

Enrollment

- The State will conduct phased-in enrollment periods for opt-in and passive enrollment, including two phased opt-in periods and two passive enrollment phase-in periods by region. Passive enrollment is effective no sooner than 60 days after participant notification of the right to select a participating plan, referred to as an Integrated Care Organization (ICO). ICOs will be required to accept opt-in enrollments no earlier than 30-days prior to the initial effective date. No enrollments will be accepted within 6 months of the end of the demonstration.
- The State is developing an "assignment" algorithm for passive enrollment. The algorithm will, at a minimum, consider beneficiaries' previous managed care enrollment, in both Medicare Advantage plans and Medicaid managed care, and enrollments of people who share a common case number for Medicaid eligibility.
- Requests to disenroll from an ICO, opt out, or enroll in a different ICO will be accepted at any point after an individual's initial enrollment occurs and are effective on the first of the month following receipt of request.

Care Model and Assessments

- All ICOs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care. Michigan's comprehensive care coordination requirements are summarized in Section IV of Appendix 7 of the MOU will also apply and be further outlined in the three-way contract.
- ICOs will ensure the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services (LTSS). CMS, the State, and ICOs shall ensure that care is person-centered, outcome-based, and consistent with CMS MOC and Medicare and Medicaid requirements and guidance.
- ICOs will develop and implement a strategy that uses a combination of initial screenings, assessments, health risk assessment tools, functional assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of care coordination needed by each enrollee. Care coordination services will be available to all ICO enrollees.
- ICOs will be required to contract with Prepaid Inpatient Health Plans (PIHP) to jointly coordinate and manage care for enrollees with behavioral health, substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD) needs. The ICO-PIHP contract will be monitored by the State to ensure ICOs meet all delivery system requirements of the demonstration and all enrollees receive the appropriate care coordination services.
- The ICOs and PIHPs will be connected through the Care Bridge, a care coordination model and framework that requires the coordination of services and supports between the two entities and involved providers. The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record (ICBR) to facilitate timely and effective information flow between the members of the care and supports team. Through the Care Bridge, the members of the enrollee's care and supports team facilitate access to formal and informal services and supports identified in the enrollee's Individual Integrated Care and Supports Plan (IISCP), which will be developed in consultation with the enrollee through a person-centered planning process by the enrollee's ICO Care Coordinator and the enrollee's Integrated Care Team (ICT). This plan must focus on supporting the enrollee to achieve personally defined goals in the most integrated setting.
- The ICO Care Coordinator must 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 ICO who is accountable for providing care coordination services. The ICO Care Coordinator will conduct at a minimum the Level I Assessment, assure the person-centered planning process is complete, prepare the IICSP, coordinate care transitions, and lead the ICT. Care Coordinators must coordinate these activities with the PIHP Supports Coordinator/Case Manager or LTSS Supports Coordinator and ICT members as appropriate.
- The Integrated Care Team will include the enrollee, enrollee's chosen associates, or legal representative, Primary Care Physician, ICO Care Coordinator, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed. The ICT works with the enrollee to develop, implement, and maintain the IICSP and to coordinate the delivery of services and benefits as needed for each enrollee.
- The assessment process includes three steps: 1) Initial Screening (at the time of enrollment or within 15 calendar days of enrollment) using specified screening questions at the time of enrollment; 2) completion of the Level I Assessment (within 45 calendar days of enrollment) using an approved tool; and 3) the Level II Assessment (within 15 calendar days of completion of Level I Assessment) for enrollees identified as having needs related to LTSS, BH, SUD, or I/DD services or complex medical needs. The assessment process must be completed for all persons who enroll in the demonstration. Existing assessments and person-centered service plans or plans of care can be incorporated into the assessment and IICSP.

Consumer Protections

- CMS, the State, and ICOs shall ensure that all medically necessary covered benefits are provided to participants and are provided in a manner that is sensitive to the participant's functional and cognitive needs, language and culture, allows for involvement of the participant and caregivers, and is in a care setting appropriate to the participant's needs, with a preference for the home and the community.
- The State and CMS will require ICOs and their providers to communicate with their participants in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for participants with cognitive limitations, and interpreters for those who do not speak English.
- The State will provide Medicaid-Medicare participants with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will work with an independent Enrollment Broker to ensure ongoing outreach, education, and support to individuals eligible for the demonstration.
- The State will establish an Integrated Care Ombudsman Program for this demonstration independent and external to the ICOs. The purpose of this new program is to advocate on behalf of all enrolled individuals.
- CMS and MDCH agree to utilize a unified set of requirements for ICO grievances and internal appeals processes that incorporate relevant Medicare Advantage, and Medicaid managed care requirements, to create a more enrollee-

friendly and easily navigable system, which is discussed in further detail in Appendix 7 and will be specified in the three-way contract. Part D appeals and grievances will continue to be managed under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by Michigan Medicaid. PIHPs will use integrated notices and forms specific to the demonstration, but the grievance and appeals processes for PIHP related issues will remain the same. CMS and Michigan Medicaid will work to continue to coordinate grievances and appeals for all services.

- Enrollees and treating providers will have access to all the information in the Integrated Care Bridge Record (ICBR). It is the Enrollee's right to determine the appropriate involvement of other members of the ICT in accordance with applicable privacy standards. An enrollee with extensive service needs may warrant periodic meetings with all team members. An enrollee with less intense needs may warrant fewer meetings with selected members of the ICT.
- Quality withhold measures will be applied to the demonstration for Medicare Parts A and B and Medicaid. The percentage withhold will be 1%, 2%, and 3% in each of the three demonstration years, respectively.

Continuity of Care

- With some exceptions that are detailed in Table 7-C in Appendix 7, ICOs must allow enrollees to maintain current providers and service levels at the time of enrollment for 90 days or continue with single case agreements. (ICOs must also honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner). For nursing facility services, enrollees may remain at the facilities through contracts with the ICOs 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.
- In an emergent or urgent situation, ICOs must reimburse an out-of-network provider of emergent or urgent care at the Medicare or Medicaid FFS payment amount applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. ICOs may authorize other out-of-network services to promote access to and continuity of care. When out-of-network services are authorized and where the service would traditionally be covered under Medicare FFS, the ICO will pay out-of-network providers at least the lesser of the providers' charges or the Medicare FFS payment amount. When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, the ICO will pay out-of-network providers paid at established Medicaid fees in effect on the date of service. If Michigan Medicaid has not established a specific rate for the covered service, the Contractor must follow Medicaid policy for the determination of the correct payment amount.
- On an ongoing basis, and as appropriate, ICOs must also contact providers not already members of their network with information on becoming credentialed as in-network providers.

Evaluation

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the financial alignment models, including the Michigan capitated demonstration, on participant experience of care, quality, utilization, and cost. The evaluator will also explore how the Michigan initiative operates, how it transforms and evolves over time, and participants' perspectives and experiences.
- The evaluator will design a State-specific evaluation plan for the Michigan demonstration, and will also conduct a meta-analysis that will look at the State demonstrations overall. In addition to the topics above, the Michigan evaluation will focus on issues associated with the PIHP and Care Bridge arrangements, including to beneficiary experiences, administrative issues, cost shifting, and access to care, especially for mental health services, treatment for substance use disorders, and other services coordinated through the PIHPs
- The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and ICOs must submit all required data for the monitoring and evaluation of this demonstration, according to the data and timeframe requirements to be listed in the three-way contract.