Michigan Memorandum of Understanding: What Advocates Need to Know

Introduction

The Michigan Department of Community Health (MDCH) and the Centers for Medicare and Medicaid Services (CMS) entered into a Memorandum of Understanding[1] (MOU) in April 2014 to pursue a dual eligible demonstration project, *MI Health Link*. The MOU outlines the terms of what will eventually be a three-way contract between the federal government, the state and selected health plans[2] that will provide integrated Medicare- and Medicaid-covered benefits to dually eligible individuals. The demonstration will run in four regions of the state, in which approximately 100,000 dually eligible beneficiaries reside: the Upper Peninsula; Southwest Michigan; and Wayne and Macomb counties. Unique to Michigan, the health plans, termed Integrated Care Organizations (ICOs), will contract with existing Michigan Prepaid Inpatient Health Plans (PHIPs) to provide behavioral health services.

This fact sheet provides consumer advocates with the basics on the MOU and key issues to watch.

Enrollment

Highlights

- Enrollment into the *MI Health Link* demonstration program will launch with two phases of voluntary enrollment, followed by two phases of passive enrollment, for each region.

	Voluntary enrollment	Passive Enrollment
Upper Peninsula region	October 1, 2014 (effective January 1, 2015)	April 1, 2015
Southwest region	October 1, 2014 (effective January 1, 2015)	April 1, 2015
Wayne County	March 1, 2015 (effective May 1, 2015)	July 1, 2015
Macomb County	March 1, 2015 (effective May 1, 2015)	July 1, 2015

- ICOs designated as low-performing plans by CMS will not be eligible for passive enrollments. United Healthcare Community Plan, Inc. is one of the contracted health plans and has been designated with a low-performing icon. United will be serving Wayne and Macomb counties.

[1] See MOU: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIMOU.pdf
[2] MLTSS Weekly Update, page 6: http://mltssnetwork.org/wp-content/uploads/2014/04/MLTSS-Weekly-Update-4-17-2014.pdf

- In addition to the state's enrollment broker, the Michigan Medicare-Medicaid Assistance Program (MMAP), a free benefit counseling service,[3] will work with enrollees and stakeholders on outreach and education, options counseling and peer-to-peer options counseling. MMAP will do this by building upon its partnership with Michigan's Area Agencies on Aging and entities like senior centers and Centers for Independent Living.

Long Term Services and Supports

Highlights

- ICOs will be required to offer a self-determination option as part of their long-term services and supports (LTSS) benefit package.[4]
- The LTSS Supports Coordination services will be provided by the ICO either directly or contractually. An LTSS Supports Coordinator will be offered to all enrollees that meet the state's Medicaid Nursing Facility Level of Care and will take part in the assessment process.[5] Each assessment will take into account individual preferences and goals, functional needs, social supports, behavioral and substance use disorder risk status, LTSS needs and quality of life.
- The ICO is responsible for providing directly, or contractually, a range of LTSS Supports Coordination services.[6]
- MDCH has developed transition requirements that detail the continuation of existing providers for LTSS.[7] For example, ICOs must allow certain waiver enrollees to maintain their personal care services providers at the current level for 180 days. Enrollees receiving Medicaid Nursing Facility services can stay at their facility if it contracts with the ICO. Alternatively, the ICO could execute a single case agreement with the facility or pay it on an out-of-network basis for the duration of the Demonstration.

Care Coordination

Highlights

- ICOs will conduct a three-step assessment process: initial screening, a level one assessment and a level two assessment.[8] ICOs will be required to submit policies and procedures as part of the readiness review process on their three-step assessment process.
- All enrollees will have access to care coordination services through a care coordinator and will have an integrated care team (ICT). Through the ICT, the enrollee will develop a personalized care plan. ICT members will be trained in the person-centered planning process.
- ICOs will be required to contract with PIHPs to coordinate and manage care for those with behavioral health, substance use disorders and/or intellectual/developmental disabilities needs.
- The ICT will include an LTSS Supports Coordinator and/or a PIHP Supports Coordinator[9] depending on the primary needs of the enrollees; if the enrollee has both LTSS and behavioral

[3] Learn more about MMAP at http://mmapinc.org/
[4] See MOU Appendix 7 page 74
[5] See MOU Appendix 7 page 64 & 70
[6] See MOU Appendix 7 page 70
[7] See MOU Appendix 7 Table 7-C page. 82
[8] All enrollees will receive an initial screening at the time of enrollment and a level 1 assessment. The level two assessment is for enrollees identified as having needs related to LTSS, behavioral health, substance use disorder, or intellectual/developmental disabilities or complex medical needs. See MOU Appendix 7 page 63-65

health needs, the ICO care coordinator will collaborate with both the LTSS Supports Coordinator and/or a PIHP Supports Coordinator.

- A "Care Bridge"[10] function will allow the ICT to facilitate access to the care plan and support the flow of information between members of the care team. The Care Bridge is the care coordination framework by which the enrollees care and care team will facilitate services and supports. This function includes an electronic database which will maintain an "Integrated Care Bridge Record" to facilitate the flow of information between each enrollee and her or his care team.

Benefits and Provider Networks

Highlights

- Through the demonstration, enrollees will have access to all Medicare and Medicaid benefits. In addition to the Medicare and Medicaid benefits, ICOs will be required to provide services in the 1915 (b) and (c) waivers.[11] ICOs will have discretion to offer flexible benefits based upon an enrollee's care plan to address specific needs.
- The PIHPs will offer services related to behavioral health, substance use disorders and/or intellectual/developmental disabilities. The State will contract directly with PIHPs for the Medicaid services and the ICOs will be required to contract with PIHPs for the Medicare funded behavioral health services.[12]
- The ICOs are required to ensure adequate provider networks and a choice of providers. This includes contracting with independent providers of the enrollee's choice.
- The ICOs must adhere to Medicare requirements for network standards. This includes elements such as time, distance and/or minimum number of providers or facilities.

Consumer Engagement

Highlights

- ICOs are required to have one consumer advisory board and a process for that board to provide input to the governing board. A member of the governing board will sit on the advisory board and serve as a liaison to the governing board.
- The consumer advisory board must reflect the diversity of the population served. There should be a mix of enrollees, caregivers and local representatives from the community, e.g., advocacy groups, faith-based organizations, etc. In addition, at least one-third of the consumer advisory board must be enrollees.
- ICOs must have written policies and procedures for consumer advisory board elections; this includes how the board will be elected, term length, filling of vacancies, and procedures for notifying enrollees.
- The consumer advisory board will meet quarterly and keep a record of its meetings. The ICOs must accommodate and support the board, e.g., provide transportation, appropriate communications and interpretation services, and other relevant measures that encourage fully representative participation.

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[9] See MOU Appendix 7 page 70-71
[10] See MOU Appendix 7 page 62
[11] See MOU Appendix 7 page 79-81
[12] See MOU Appendix 7 page 80

Financing and Payment

Highlights

- The demonstration is expected to achieve savings of 1 percent in Year One, 2 percent in Year Two and 4 percent in Year Three. If at least one-third of the ICOs have Year One losses exceeding 3 percent of revenue, the Year Three savings percentage will be reduced to 3 percent.
- The Medicaid portion of the capitated rate is determined by assigning each enrollee to a rating category. Medicaid will be using three rating categories:
    - People living in nursing facilities
    - People requiring a nursing facility level of care, but living in the community and enrolled in the 1915(c) waiver
    - All other beneficiaries
- To provide an incentive for community-based care over nursing facility care, ICOs will receive a temporary higher "transition rate" for beneficiaries who are moving out of a nursing facility and into community settings. Conversely, ICOs will receive a temporary lower transition rate for beneficiaries moving into a nursing facility.
- To limit ICO gains or losses and thereby reduce the risk to beneficiaries, the state and CMS will use risk corridors in Year One of the demonstration. The first corridor will put ICOs at full risk if expenses are in the range from 3 percent below to 3 percent above the capitation rate. In the second corridor, the ICO and CMS/State will share the risk 50-50 for the next 6 percent. The third corridor again assigns ICOs full risk for costs beyond 9 percent above or below the capitation rate.
- Starting in Year Two, ICOs will be held to a Medical Loss Ratio (MLR) of 85 percent.
- CMS and the State will review the rates and payment parameters if two or more ICOs show MLRs below 90 percent over all regions in which those plans participate, or in the event that two or more ICOs show annual losses exceeding 5 percent over all regions in which those plans participate.

Cultural Competency & ADA Compliance

Highlights

- ICOs and providers must be in compliance with the Americans with Disabilities Act (ADA) and the Olmstead decision. This means ICOS must contract with providers that demonstrate the ability to offer physical access and flexible scheduling.
- As a part of readiness review, each ICO will have to develop training on cultural competency and disability for its staff. In addition, providers in ICO networks must participate in disability training.
- ICOs and providers must communicate with their enrollees in ways that accommodate their needs. This includes providing accommodations for those with hearing impairments, and interpreters to those for whom English is not the primary language.
- All materials developed should be sensitive to the needs of the enrollees; this includes individuals with disabilities, those individuals with functional limitations and those with limited English proficiency.

Key Issues to Watch

- The State is working on an intelligent assignment process for passive enrollment, but does not offer details on how this will be implemented. The three-way contract should specify that the State will take into account previous provider relationships and LTSS needs and usage in assigning enrollees to ICOs.
- The readiness review process will be critical to monitor in order to ensure that the ICOs have the capacity and competency to provide LTSS, particularly the self-determination option and how they will provide supports to consumers to facilitate self-direction.
- The language on materials translation is broad, and it will be important to urge the state and CMS to provide details on which languages materials will be provided in translation and ensure that enrollees will have access to them as needed.
- There are several concerns related to the financing and payment mechanisms[13] .
    - There is no backup evidence for the expected savings amounts[14].
    - The Medicaid rating categories are too broad. At the very least the number of rating categories should be expanded in order to better account for the complexity of beneficiaries' needs and the costs associated with those needs.
    - The three-way contract should provide further detail on how long the transition rate will apply for those moving from the community to a nursing facility[15]. The rate for people moving into the community is similarly vague.
    - One year is an insufficient amount time to apply risk corridors given the large costs associated with start-up and the fact that enrollees coming into the demonstration will have been previously underserved.
- The language in the MOU related to cultural competency and ADA compliance is positive, but details are lacking. Advocates must continue to push CMS and the state to ensure that during readiness review and in three-way contracts, ICOs truly demonstrate their ability to provide services in a manner that is preferred by the beneficiary.

An overarching point advocates must remember and push is that the details matter in this demonstration. Readiness review is the next important milestone in the demonstration and ICOs must show the capacity and competency to take on this new population. The three-way contracts must provide a concrete roadmap to ensure consumer protections are not sacrificed.

Authored by,
LEENA SHARMA
State Advocacy Manager, *Voices for Better Health*

[13] Risky Business: Capitated Financing in the Dual Eligible Demonstration Projects, Community Catalyst. Available: http://www.communitycatalyst.org/doc-store/publications/risky-business_capitated-model.pdf
[14] Community Catalyst Letter to HHS on Savings Expectations. Available: http://www.communitycatalyst.org/doc-store/publications/Sebelius_duals_demo_projects_savings_letter_July2012.pdf
[15] See MOU Appendix 6 page 47