MI Health Link Demonstration

This contract was re-executed on January 1, 2018 to:

- Revise throughout to reflect the new Medicaid managed care regulations, such as updating citations, adding in definitions of new terms, and aligning appeal and grievance procedures.
- 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:
    - Clarifying and updating requirements regarding primary care providers as well as in and out-of-network Indian Health Care Providers that Indian Enrollees can see (1.59, 2.7.3.9);
    - Updating provider network requirements to highlight additional services and items Medicare-Medicaid Plans (MMPs) are prohibited to pay for based on federal regulations (see 2.7.3.5.1.1).
    - Updating provider network requirements to clarify that CMS and MDHHS may take corrective action if the MMPs or Providers fail to comply with timely access requirements (see 2.7.1.6.4)
    - Clarifying that FQHC Reimbursement provisions also apply to rural health clinics (2.7.4.5)
    - Updating the Enrollee Access to Services section to clarify that when a service authorization decision is not reached within the timeframe for standard or expedited requests, the MMP must provide notice on the date that the timeframe expires (2.8.3.7.3.1)
    - Updating marketing requirements to reflect updates to federal regulations (throughout 2.14), including clarifying communicating beneficiary access to online formularies (2.3.6.1.2, 2.3.6.3.1, 2.14.4.1.5), clarifying circumstances under which MMP can make telephone calls to current enrollees (2.4.1.1.9), add requirements regarding including non-English taglines in mailings to alert beneficiaries of the availability of other language services, (2.14.2.1.3-5).
    - Updating provider and pharmacy directory requirements to include updates regarding notices on how beneficiaries can access and/or request the provider and pharmacy directory, updates regarding the timeframe a MMP must notify beneficiaries of any significant changes to the network, and updates on how frequently the internet directory must be updated (2.14.4.1.3, 2.14.5.1.2-4)
    - Updating model of care requirements to specify the MMP abide by the care delivery model described within the contract and eliminate previous model of care MMP submission requirements (2.5.1.4, 2.5.1.8.1)
    - Updating the Medical Loss Ratio refund requirements and adding medical loss ratio calculation requirements (4.3.2.3, 4.3.2.9)
    - Adding final Medicare reconciliation and settlement language regarding an MMP that terminates or non-renews, and how the CMS final settlement phase for terminating contracts applies to MMPs (4.6.3.2)
- Revise care coordination requirements. These changes include:

    - Adding requirements that ICO Care coordinators have knowledge of state plan personal care services, waiver services and MI Health Link Minimum Operating Standards, (2.5.3.2.3-4)
    - Adding requirement that the ICO notify beneficiaries or their designees in writing when there is a change in care coordinator (2.5.3.3.5)
    - Clarifying that Level I Assessments be utilized to determine appropriate acuity and risk stratification, as well as to determine need for a Level II Assessment (2.6.3.5)
    - Clarifying that the Level I and Level II Assessment are to be used to develop the IICSP (2.6.3.6)
    - Allow for additional Level II Assessments as may be approved by MDHHS (2.6.6.3.5, 2.6.7.6)
    - Adding the requirement that the ICO provide information to Enrollees regarding how to contact their Care Coordinator (2.5.3.2.1, 2.14.4.1.1.25, B.2.10.14)
- Update the state provider network review timeframes to annually (2.7.1.2, 2.7.1.4)
- Clean up state statute references and add additional definitions (throughout).
- Revise the state's timeframe for the nursing facility transition rate payment from 6 months to 90 consecutive days. (4.5.1.3, A.6)