MI HEALTH LINK PROVIDER NEWSFLASH

General Questions
Q1. Do you have the final versions of the Bio Psychosocial, Detailed Flow from Level I to Level II, MDCH Behavioral Health consent documents? A1. The Final version of the above documents are on www.dwmha.com under Provider Information-MI Health Link
Q2. When will we get the member handbooks to give the consumers? A2. The Member Handbooks are available and have been delivered to the contracted providers. If you have not received the member handbooks, please contact Bonnie Herndon, bherndon@dwmha.com
Q3. A small group from Behavioral Health Services participated in your March 31 virtual training. At that time I submitted a couple of questions and was asked to provide my e-mail address. I am not finding a response. I recall one issue was to confirm transportation services to Behavioral Health appointments would be provided. A3. To answer you first question, for behavioral health services, the transportation process is still as is. Logisticare is the transportation vendor. The DWMHA is investigating other options. That may be available later in the year.
Q4. In reviewing the contract for MI Health Link on page 13, bullet point c describes the licensure requirements for case managers and supports coordinators. I cannot find similar requirements for therapists, peers and nurses. For these professionals and the services they deliver we are uncertain if we should be following the Medicare guidelines or the Medicaid guidelines for credentialing. A4. Please see Medicare Guidelines for handling Mental Health Services on www.dwmha.com.
Q32. If consumers opt out are they at risk for a gap in Medicare Part D? A32. NO. Please refer to www.michigan.gov/mihealthlink
Q33. What are rates for Partial and Intensive Crisis Stabilization? A33. Those service providers are contracted directly through authority and must be prior approved.

Q35. If an enrollee opts in/opts out, loses Medicaid/regains Medicaid, or changes ICOs, when will these changes in enrollments in the MI Health Link program go into effect?

A35. Enrollment into a MI Health Link health plan is effective the first day of the next month if you call before the last five days of the month. For example, if you call on May 15 to enroll in a MI Health Link health plan, your enrollment will be effective on June 1.
If you call within the last five days of the month, your enrollment in a MI Health Link work plan will be delayed for a month due to the time needed to process your enrollment. For example, if you call on May 28 to enroll, your enrollment will be effective on July 1.

Q37. When someone is passively enrolled in MI Health Link, how is their health plan determined?

A37. The MDCH uses a complicated formula to determine which passively enrolled consumers receive each plan. This formula is in part constituted by the consumer's provider history and address, but is affected by many other factors. MI Health Link enrollees can switch between participating health plans at any time.

Q42. What is the process for a person who declines BH services?

A42. In this case, the Level I/II Tracking Sheet should be used. This document can be found at www.dwmha.com under Provider Info., MI Health Link. This tracking sheet should be sent to the ICO as progress is made.

Q43. What is the process to terminate/discharge a consumer from BH services?

A43. Each provider should follow their own organization's guidelines for consumer discharge. This update in consumer care should be recorded in MH-WIN. Also note that discharge from a specific BH provider does not mean discharge from the MI Health Link program.

Q44. Are there plans to allow for waitlists if the demand for services goes beyond system capacity?

A44. No, there will be no waitlists for MI Health Link enrollees. New providers will be contracted if need be.

Q45. Is there a limit to the number of visits for mild/moderate consumers?

A45. There are no appointment limits under the MI Health Link program. Specifics regarding this will be fleshed out in the Utilization Management Guidelines, which are currently being developed. Additional training regarding these guidelines will be available soon.

Q56. When MDHS terminates ILS on the basis that a dual eligible consumer has an ICO, and issues an advance action notice, why is it that MHWIN does not show that the consumer has an ICO? What is the lag time between the issuance of the advance action notice and MHWIN showing the consumer as being ICO?

A56. Generally, it indicates that the enrollee is going to become active with the MI Health Link Program/ICO the first of the next month. The MDHHS has to issue this advance action to the enrollee within a specific timeframe prior to the action taking effect. Hence, MHWIN, will not have that the person is active with MI Health Link until the month that the enrollee is active.

Q57. When MDHS issues an advance action notice to a dual eligible consumer who is enrolled with an ICO and was receiving ILS services, does the service(s) that are the subject of the advance action notice get terminated after a 90 day period, or immediately - 30 days or less?

A57. The current authorization is effective until the date indicated on the Advance Action Notice. The MI Health Link Enrollee should contact their ICO Care Coordinator to ensure that the services are authorized with the ICO. The ICOs are working diligently to identify these enrollees and ensure there are no gaps in authorization and/or payment for the service provider.

Staff Qualifications

Q36. Can a bachelor level social worker or a limited license master level social worker complete an annual assessment (H0031) with a dual eligible consumer? Prior to the dual eligible project, they were able to do this since we billed the H0031 to the MCPN's.

A36. For the MI Health Link enrollees. The Case Manager has to be in compliance with the credentialing guidelines. The Case Manager could be a different person than the person completing the Annual Assessment.

H0031 - Assessment by non-physician is not a Medicare covered service code, so it will be paid by Medicaid (**HCPCS Manual 2015**). Each of the BSW (who is licensed) or LLMSW must practice within the scope of their license. (**H0031: Mental Health Professional, QMHP, or QIDP if within their licensure scope of practice - MDCH Provider Qualifications 3/11/15)**.

(**Michigan Social Worker Licensing Board, 2015**). The BSW (who is licensed) and LLMSW must be licensed and receive the supervision of a LMSW to conduct **assessments** - which is a Medicaid covered service code (**this code is not a Medicare covered code - HCPCS Manual 2015)**. The BSW (who is licensed) is unable to diagnose.

Hence, BSW's who are supervised by an LMSW can complete assessments on the MI Health Link enrollees, because the enrollee has Medicaid as well as Medicare, and Medicaid allows it so the DWMHA will allow reimburse the provider for it.

Q41. Who can fill out the Level I/II Tracking Sheet?

A41. This document can be completed by anyone involved in the consumer's MI Health Link program coordination and care. This includes providers, Access Center staff, etc.

Q54. What credentials do staff need to have in order to complete Level II Assessments and/or serve as a MI Health Link case manager/supports coordinator?

A54. The credential level to complete the Biopsychosocial and LOCUS is what is covered in the Medicaid manual. The credentials for case manager /supports coordinator for the MI Health Link Program are those specified in the contract, which can be found at dwmha.com under Provider Info, MI Health Link. Limited License BSW can be supervised by Licensed MSW to provide Supports Coordination for MI Health Link consumers. Individuals with Registered Social Service Tech license cannot provide services to this population.

MHWIN

Q49. Who should be identified in the "referred by" section in MH-WIN under Utilization Management?

A49. The "referred by" individual should be the person from CMH entering the request. This may be the provider biller or clerk or clinical staff.

Q59. What if I have a client's whose new ICO is shown in MHWIN, but they have not had their Level 1 Assessment completed, no Pioneer appointment set and no Level 2 Assessment completed thus far?

A59. This reflects someone in service, but that has not had a Level I. Please ensure the authorizations are in the system. Update the Bio psychosocial, LOCUS, and BH Consent form; provide the MI Health Link Member Handbook; and explain the program. When the Level I referral comes over

simply attach the documents to the referral. Reach out to the ICO Care Coordinator to facilitate the ICT meeting.

Billing of Services for Opt In or Opt Out

Q5. For those who opt out of MI Health Link, will providers receive notice when we should start billing the Authority or do we do so automatically October 1st?

A5. Pursuant to the MI Health Link Services Description, providers should start billing DWMHA for PIHP managed services effective October 1, 2015, for dual eligible person who opt out. MHWIN will eligibility will indicate those members who are eligible but have opted out.

Q6. When can we expect a list of which consumers have opted in/out?

A6. DWMHA will send information to providers of those persons who have opt in to the MI Health Link program as we get updated information from the 270/271 file. DWMHA will also send information to providers of those persons who have opt in to the MI Health Link program as we are made aware from the ICOs. We have started to send this information to providers.

Q7. I know we were told that we bill Clubhouse to the MCPN's – what about if a dual consumer has opted in – do we bill the MCPN"s for the clubhouse services and all others to the Authority?

A7. Please bill the Authority in accordance with the MI Health Link Services Description. This document can be found at www.dwmha.com, under Provider Information tab, and MI Health Link.

Q8. If a dual eligible consumer opts out of the program do we bill as we have been or only to the Authority?

A8. The dual eligible consumer who opts out of the program should bill the Authority for PIHP services pursuant to the MI Health Link Service Description document, starting October 1, 2015.

Q9. How will we know that consumer has opted in or out?

A9. MHWIN Eligibility Verification will provide this information.

Q10. Does the outpatient rate represent 100% of what Behavioral Health Services (BHS) at a Provider will be paid, or is there a secondary portion that is not paid that reduces the actual rate paid.

A10. Yes, the outpatient fee schedule for the MI Health Link Program, represents 100% for Medicare and Medicaid. There is no secondary portion.
Q26. On the fee schedule there is a rate for intake assessment (include psychosocial) with the TF modifier. What is the definition of the TF modifier? A26. The TF modifier is used as a level in the standard of care. This modifier is only appropriate when the member has "mid range" or intermediate level of care needs. (HCPCS Manual 2015)
Q27. What is the billing schedule? A27. Providers can submit weekly batches through the claims system. Claims will be processed and paid every two weeks.
Q28. What are the billing rules? A28. Medicaid establishes the billing rules. Providers should reference the Medicaid Manual. For Medicare services, please refer to the document "Medicare Guidelines for Mental Health" on the DWMHA website.
Q29. If a consumer loses their Medicaid do their providers continue to bill the Authority for Medicare? A29. If consumer loses Medicaid they will be ineligible for MI Health Link. Providers should verify insurance eligibility prior to service delivery. Providers will need to bill Medicare for services. It is imperative that case managers/supports coordinators managed Medicaid re-enrollment periods.
Q30. If they lose Medicaid will they revert to the Authority's GF benefit plan for 90 days while getting Medicaid reinstated? A30. See above. Also depends on consumer. If mild/mod then, the provider bills Medicare fee for service. If consumer is smi/idd then provider will use Benefit Grid and Utilization Management guidelines on a case base care review.
Q38. How do Adult Foster Care (AFC) providers receive reimbursement for services provided to MI Health Link enrollees? A38. These services will be billed through the MCPN that the MI Health Link enrollee is enrolled with.

Q47. How are Supports Coordination fees meant to be billed?

A47. Supports Coordination is billed at $70.00 per 15 minutes with a monthly limit. It is expected that the majority of Supports Coordination- at least 75%- will be community based. There is not a separate rate for office based Supports Coordination.

Q50. Is there an instruction guide regarding authorization and claims available?

A50. A step by step instruction guide is being developed and can be expected to be found through the MHWIN help icon within the next two weeks.

Q51. What is the function of the Utilization Management grid?

A51. Although every MI Health Link service needs to be authorized, the UM grid allows providers to enter services identified per the individual standardized assessment scores, i.e., LOCUS or SIS and/or ASAM as well outcomes from the Bio-Psychosocial Assessment. The provider will request services through MH-WIN and as long as the services request fit within the guidelines, the services will be automatically authorized. If the services request go beyond the UM guidelines, the UM staff will review for Medical Necessity Criteria (MNC) and authorize services requested.

Claims are submitted to claims processing staff that review services authorized by UM, adjudicate and pay claims.

Q52. How quick will the turnaround be for service authorizations – (which result in a billable claim) need approval by the DWMHA UM team?

A52. The UM grid guidelines were made to be generous and therefore service authorization decisions – (which result in a billable claim) that require DWMHA UM team approval should be infrequent. The UM team operates on regular business hours, so when service authorization require approval, the process will begin on the same or next business day of the request for services and allow providers to file a claim.

Q53. When submitting claims in MHWIN, I noticed a contract called “Dual Eligible.” Is this the MI Health Link contract?

A53. Yes. The MI Health Link contract is named “Dual Eligible” within MHWIN.

Q58. If a consumer was admitted in June with Medicare, and transition to MI HL starting today – do we split bill the stay or bill Medicare for the entire stay including the dates that they are in MIHL?

A58. If you have patients who are now MI Health Link effective July 1, 2015, you should contact the Utilization Management area to provide appropriate clinical information and obtain authorization. The Utilization Management number, Monday - Friday, 8:30am - 4:30pm is 313-344-9035 . The number to contact after those business hours is 1800-241-4949.

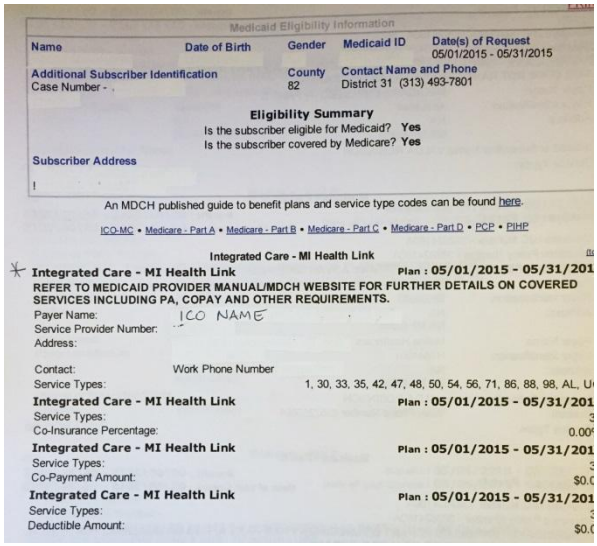
MI Health Link Eligibility

Q11. What happens if a consumer loses their Medicaid – are they out of the program?

A11. To be eligible for the MI Health Link, a person must have both Medicare and the full scope of Medicaid benefits. If the person loses Medicaid, they will no longer be eligible for the MI Health Link program.

Q12. How will it look in MH-WIN if someone is enrolled into the MI Health Link Program?

A12.



Medicaid Eligibility Information

Name	Date of Birth	Gender	Medicaid ID	Date(s) of Request
				05/01/2015 - 05/31/2015

Additional Subscriber Identification
Case Number - ,

County
82

Contact Name and Phone
District 31 (313) 493-7801

Eligibility Summary
Is the subscriber eligible for Medicaid? **Yes**
Is the subscriber covered by Medicare? **Yes**

Subscriber Address

An MDCH published guide to benefit plans and service type codes can be found here.

ICO-MC • Medicare - Part A • Medicare - Part B • Medicare - Part C • Medicare - Part D • PCP • PIHP

Integrated Care - MI Health Link

Integrated Care - MI Health Link **Plan : 05/01/2015 - 05/31/201**
REFER TO MEDICAID PROVIDER MANUAL/MDCH WEBSITE FOR FURTHER DETAILS ON COVERED SERVICES INCLUDING PA, COPAY AND OTHER REQUIREMENTS.
Payer Name: ICO NAME
Service Provider Number:
Address:

Contact: Work Phone Number
Service Types: 1, 30, 33, 35, 42, 47, 48, 50, 54, 56, 71, 86, 88, 98, AL, U

Integrated Care - MI Health Link **Plan : 05/01/2015 - 05/31/201**
Service Types:
Co-Insurance Percentage: 0.00

Integrated Care - MI Health Link **Plan : 05/01/2015 - 05/31/201**
Service Types:
Co-Payment Amount: $0.

Integrated Care - MI Health Link **Plan : 05/01/2015 - 05/31/201**
Service Types:
Deductible Amount: $0.

Coordination of Care

Q13. If a consumer is in the program, but doesn't want all the coordination, no communication with the ICO – is there anything we should be sure to document that states this, other than our normal documentation?

A13. Enrollees in the MI Health Link program are to be managed using person centered planning, and choice principles. The provider should document this information as normal.

Q14. Who is responsible to arrange, schedule and invite participants (including the person) to the IICSP, is it the ICO care coordinator or the Supports Coordinator? A14. If the SMI or I/DD consumer the Provider Level Case Manager/Supports Coordinator should take the responsibility for coordinating the IPOS/IISCP meeting.
Q16. Even though an individual we serve today has not had an ICO HRA and has not gone through the Level-II referral process, EVERY service they have, starting May 1st is attributed to and funded through the MH-Link System correct? A16. Yes, even if the enrollee has not gone through the level I or II process, they are active with our contracted PIHP providers. And based on them checking eligibility, I'd they are Mi Health Link DWMHA is the responsible payor.
Q25. Can the provider level case manager/supports coordinator bill for the Integrated Care Team meeting (ICT) along with the ICO Care Coordinator? A.25. Yes the provider level case manager/supports coordinator can bill for the ICT meeting. The ICO Care Coordinator is an employee of the managed care organization. The managed care organization is not a provider of services in accordance with the Medicaid policy.
Q48. Can a consumer be enrolled with Healthy Michigan and still be eligible for MI Health Link? A48. No. Even if a consumer has Medicare coverage in addition to Healthy Michigan, they must disenroll from Healthy Michigan before enrolling with MI Health Link.
Q60. We have IDD clients opting out due to their nursing services and medications not being paid by the ICO that they opted into. What information can you provide to us so that the IDD client's contracted services can be maintained under the ICO they opted into? A60. The ICO has to honor the relationship with any existing provider for at least 90 days and any authorizations for at least 180 days. The ICO is working with the enrollee to get their care giver set up in their system. You should contact the enrollees ICO Care Coordinator to provide the

enrollee's concerns and get the facts from the ICO on the status of the nursing and medication situation.
Level I & Level II Assessment
Q15. Our bio psychosocial is not the exact template of the one in MH Win. Although pertinent data is there and can be migrated- if this doc is current can it be used? A15. The current bio psychosocial can be used.
Q17. Level 1 is completed by ICO-then the Provider will have 14 days to get both our bio psychosocial and SIS done? What if both are current within our system? A17. Use the current SIS and bio psychosocial Assessment completed within the last 12 months.
Q18. The SIS assessment questions continue to come up. Please help me understand how it will be handled. A18. I/DD Enrollees in the MI Health Link program will need a Level II Assessment. The SIS assessment is required as part of the Level II assessment. The MCPN will continue to be responsible for assuring I/DD enrollees have access to SIS assessors.
Q19. If the consumer is in Healthy MI, is the MCPN required to do a SIS Assessment? A19. Irrespective of the insurance type, the SIS is the standard assessment expected to be completed on persons with intellectual and developmental disabilities.
Q20. Also, please be aware that SIS Assessments are good for three years and all the Provider Meetings thus far have indicated an assessment would have to be completed at Level II if one had not been completed in the past year. A20. Yes, we are aware that the SIS Assessment is good for three years. When we speak about the Level II and the reassessment, we are speaking generally. It is understood that the SIS is good every three years, or when the health status changes.

Q39. What kind of documentation needs to be provided for someone who doesn't show for a Level I/II Assessment appointment? A39. A solution to this issue is being developed for MH-WIN, but until that is completed, the Level I/II Tracking Sheet should be used. This document can be found at www.dwmha.com under Provider Info., MI Health Link. This tracking sheet should be sent to the ICO as progress is made.
Q40. Where do we get the Level I Assessment if the assigned person only has a screening from the Access Center? A40. The Level I Assessment is usually attached to the referral notification. If it is not, the consumer may be one that is coming in for regular services. The Level I Assessment can also be found in the MI Health Link Level II Documents Queue in MH-WIN.
Q46. If someone doesn't require ongoing Psychiatric Services, would an Annual Psych Evaluation be required? A46. An Annual Psych Evaluation would not be required in this case, but the IICSP for each MI Health Link enrollee must be updated at least once per year.
MCPN Questions
Q21. Does the MCPN continue to do a SIS Assessment for dual eligible that are assigned to their MCPN? Our standing is that yes the MCPN would continue. A21. Your understanding that the MCPN will continue to cover the SIS, even for person with MI health Link is my understanding also. Per the document reviewed at the last MCPN Partnership meeting.
Q22. I have another question regarding the consumers in SILP (Supervised Independent Living) and other Dual Eligible consumers requiring CLS 1:1 Staffing Services, would like to know if they will remain with MCPN's along with the consumers living in Specialized Residential Homes. A22. Yes.
Q23. I have had MCPNs ask me how their capitation will be adjusted on the back end to remove overfunding for the claims we pay in this program. Any word on that? They are looking for specifics.

A23. The adjustments to the MCPNs will likely be retrospective through the end of FY15 and likely be the lesser of actual claims paid or risk score value for each month, but this is not finalized. We will be regrouping on this at CUSC and then with Milliman.
Q31. Please distinguish the services that appear to be identical for payment by the Authority and MCPN. A31. The services that are both allowed by the authority and MCPN are because the specific service might be tied to another benefit provided by either entity. For example peer services could occur at any location/provider. It might make sense, based on how providers are funded to have that paid by mcpn. If stand alone service then authority would pay. Case managers need to manage.
Q34. Currently MCPNs authorizes level of care for AFC homes will that now be driven by the LOCUS? A34. No, MCPNw will continue to authorize based on their guidelines.
Grievances and Appeals
Q55. If the consumer's IPOS contains an authorization for a service that the PIHP declines to approve, who is responsible for giving the advance action notice to the consumer? A55. The PIHP is responsible for authorizing services not the case manager or service provider therefore the PIHP would be responsible for giving the advance action notice to the consumer.
Critical Incident Reporting
Q24. Who do I contact at DWMHA for guidance if I suspect an enrollee has had any of the following: exploitation, illegal activity in the home with potential to cause serious or major negative event, neglect, physical abuse, provider no shows, sexual abuse, theft, verbal abuse, worker consuming drugs on the job, suspicious or unexpected death, and medication errors. A24. Mary Allix, mallix@dwmha.com, (313) 833- 4198.