POLICY

Please see historical policy for MI Health Link (MHL) information. MI Health Link enrollees will transition automatically to MICH with no break in coverage.

The MI Coordinated Health (MICH) program is a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) launching on January 1, 2026.

It replaces the MI Health Link program and is designed to provide integrated care for individuals eligible for both Medicare and Medicaid.

The goals of the program are to improve coordination of support and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

This category is available to waiver clients who are aged (65 or older), blind or disabled. See BEM 106 for the definition of waiver clients. Gross income cannot exceed 300 percent of the SSI federal benefit rate; see RFT 248.

All eligibility factors in this item must be met in the calendar month being tested

INTERGRATED CARE ORGANIZATIONS (ICO)

MDHHS and the Center for Medicaid and Medicare Services (CMS) contracts with managed care entities called MI Coordinated Health (MICH) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental and Long Term Supports and Services (nursing facility and home and community-based services). In addition to all Medicare Parts A, B, and D, and Medicaid State-plan services (except those covered through contracts between the State and the Michigan Pre-Paid Inpatient Health Plans), Mich is required to provide supplemental benefits and other supports and services as defined in the approved 1915(b) and 1915(c) waivers and other supporting documentation, or rules, provided by CMS or MDHHS. See Exhibit I in this item for a list of MICH names and service areas.

The PIHPs are responsible for managing Medicaid Specialty Services and Supports in specified geographic regions, under contract with the Michigan Department of Health and Human Services (MDHHS) consistent with the Michigan Mental Health Code (MMHC). The MICH and PIHPs coordinate and manage care for jointly served enrollees.

ELIGIBILITY

MI Coordinated Health (MICH) is a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) for Michigan residents that:

- Age 21 or older at the time of enrollment including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program.
- Are enrolled in both Medicare and Medicaid. Entitled to Medicare Part A, Medicare Part B, and Medicare Part D.
- Receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount).
- Do not live in a state-operated veteran's home.
- Are not currently enrolled in hospice care.
- Live in Michigan in the following regions/counties:
  - Region 1: Upper Peninsula (except Chippewa, Gogebic, and Menominee).
  - Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren.
  - Region 10: Macomb.
  - Region 12: Wayne.
- It is allowable for an Enrollee residing in a MI Coordinated Health region to be admitted to a Nursing Facility outside the HIDE-SNP region for a service that cannot be obtained in the HIDE-SNP region (and replacement is not based on the family

or social situation of the Enrollee). This is allowable for up to 6 consecutive months.

INELIGIBLE POPULATION

Populations ineligible for the MI Coordinated Health Program are:

- Individuals under the age of 21.
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 C.F.R. § 438.56.
- Individuals not living in a HIDE SNP Service Area.
- Individuals who are eligible for partial Medicaid coverage through the following eligibility groups: Additional Low Income Medicare Beneficiary (ALMB), Qualified Individual (QI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Disabled and Working Individuals (QDWI).
- Individuals without full Medicaid coverage (including those with spenddowns or deductibles).
- Individuals with Medicaid who reside in a State psychiatric hospital.
- Individuals with other comprehensive health coverage including commercial HMO coverage.
- Individuals who elected hospice services prior to HIDE SNP enrollment:
    - If an existing HIDE SNP Enrollee elects to receive hospice services, the Enrollee may remain enrolled in the HIDE SNP and will only be disenrolled at the Enrollee's request.
- Individuals who are incarcerated.
- Individuals with presumptive eligibility.
- Individuals not eligible for Medicaid due to divestment.
- Individuals residing in designated State sanction Veterans' Homes.

Note: Individuals enrolled in MI Choice, PACE, MI Care Team, Independence at Home, and CSHCS are eligible but must leave their programs before joining MI Coordinated Health. MI Coordinated Health members cannot be simultaneously enrolled in MI Choice, PACE, or Home Help; see ASM 126 for information on Home Help referrals from MI Coordinated Health.

MICH ENROLLMENT PROCESS

Enrollment in the MI Coordinated Health program occurs through voluntary enrollment.

Voluntary Enrollment

All enrollments must be voluntary. There are several ways to enroll in MICH.

Enrolling, Disenrolling, or Cancelling Automatic Enrollment

HIDE-SNPs will manage enrollment processes with the allowance of agents and brokers.

Beneficiaries may enroll in HIDE-SNPs by:

1. Contacting the plan, they want to enroll in.
2. Contacting an insurance agent or Broker.
3. Contacting 1-800-MEDICARE (1-800-633-4227, TTY: 1-800-486-2048).
4. Using Medicare's online official Plan Finder tool.

There are no open enrollment periods. Eligible individuals can enroll, disenroll, and change plans at any time.

Note: Enrollment and disenrollment elections will be active the first day of the month following the date the request is processed.

MICH COORDINATED INFORMATION AND SUPPORT

To learn more about MI Coordinated Health, individuals should contact the following:

- The MI Options Program:

  MI Options Program provides resources to help individuals navigate Medicare options. To contact MMAP, individuals may call 1-800-803-7174. Office hours vary by location. Open Monday through Friday.

  Individuals actively enrolled in MI Coordinated Health with questions or concerns related to their care may contact the following:

- The MI Community, Home, and Health Ombudsman (MI CHHO):

  MI CHHO is an independent program that serves as an advocate and problem-solver for beneficiaries enrolled in MI Coordinated Health. All services are free and confidential. To contact MI CHHO, members may call toll-free at 1-888-746-6456 Monday through Friday 8 AM to 5 PM. Written correspondence can go through email at: MI-CHHO@meji.org or mailed to 15851 S. US 27, Suite 73 Lansing, MI 48906.

MICH 1915 (B) AND (C) WAIVERS

The Behavioral and Physical Health and Aging Services Administration (BPHASA) MI Coordinated Health Program offers comprehensive Medicare and Medicaid managed care, as well as a Home and Community Based Services (HCBS) Waiver through a single managed care organization called Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP). The MI Coordinated Health 1915(b) Waiver program allows Michigan to passively (automatically) enroll individuals eligible for both full Medicare and full Medicaid into a contracted HIDE on a monthly basis. MDHHS contracts with several Plans throughout the state of Michigan, known as Health Delivery Entities (HDEs). Individuals enrolled in an HDE who are eligible for 1915(c) Home and Community Based Services (HCBS) can access them through their HDE without being disenrolled from MI Coordinated Health. Individuals receiving HCBS in MI Coordinated Health's 1915(c) waiver would, absent the waiver, require services in a nursing facility.

This means an individual enrolled in MI Coordinated Health is receiving comprehensive managed care and HCBS concurrently through their HDE.

Note: The MI Coordinated Health Waiver is not an MA category, but there are special eligibility rules for people approved for the waiver; see Financial Eligibility Factors in this item.

1915 (C) WAIVER ADMINISTRATION

MI Coordinated Health administers the HCBS Waiver through contracts with Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP).

1915 (C) Waiver Eligibility

To be eligible for the MI Coordinated Health HCBS waiver, an individual must do all of the following:

- Be enrolled in the MI Coordinated Health program.
- Meet nursing facility level of care as determined by Michigan's Medicaid Nursing Facility Level of Care Determination tool.
- Have a need for one or more of the Waiver services listed in the MI Coordinated Health waiver application.

Enrollees must receive at least one waiver service each month to remain enrolled in the MI Health Link HCBS Waiver.

1915(C) Waiver Enrollment Process

The HCBS waiver enrollment process includes:

Assessment

HDE and/or the HDE’s contracted vendor are responsible for completing an assessment to verify a member’s medical and functional eligibility for the Waiver. Once all Waiver enrollment materials are complete, the HDE must enter the HCBS Waiver enrollment in CHAMPS and upload an enrollment packet for MDHHS to review. Additionally, HDEs must complete new Waiver assessments and submit to MDHHS at least annually. The MDHHS local office is still responsible for financial eligibility determination.

Plan of Service

A written plan of services, also known as an "Individualized Care Plan (ICP)" is developed by the HDE and the Waiver participant if the assessment confirms medical and functional eligibility for the HCBS Waiver. The participant may choose to receive home and community-based services from the HDE.

At a minimum, the plan of services includes all of the following:

- Types of services to be furnished.
- The amount, frequency, and duration of each service.
- The type of provider to furnish each service.
- Participant goals, preferences, and outcomes.
- Participant approval of the plan.
- The signature of the care coordinator assisting with developing the plan.

Care Coordination

Through care coordination, a person employed by the HDE, (known as a *care coordinator*) or a team, (known as an *integrated care team*), assists MICH enrollees in accessing Medicare and Medicaid services, including medical services and supplies, behavioral health, substance use disorder and/or intellectual developmental disabilities, pharmacy, and Long Term Supports and Services (LTSS), to promote quality, effectiveness, and integration of care.

The Enrollee's HDE is responsible for arranging for planned services to be provided. In addition to coordinating with MDHHS-contracted PIHPs for the delivery of Medicaid behavioral health services, HDEs may contract with downstream providers for delivery of covered services.

APPROVED FOR THE 1915 (C) WAIVER

Approved for the HCBS waiver means all of the following:

- The HDE conducted the assessment.
- A person-centered plan of service has been developed.
- The participant has been approved for an available Waiver slot.

- The participant has at least one ongoing service need per month and is receiving at least one service from the ICO per month to remain on the waiver.
- The HDE submitted an assessment, a care plan, and other required documentation to MDHHS.
- The HDE reviewed documentation and determined medical and functional Waiver eligibility and enrolled into the HCBS Waiver.

The participant's Waiver documentation has not been deemed incomplete or deficient through ongoing MDHHS monitoring and auditing processes.

Approval and Termination Dates

The HDE determines the Waiver effective date and termination date based on the participants' needs. The HDE is responsible for advising the appropriate local Michigan Department of Health and Human Services (MDHHS) office of these dates by entering the information into CHAMPS.

Waiver enrollment automatically terminates when the participant enters a Long-Term Care (LTC) facility; see BEM 547 for instructions.

Note: An HCBS Waiver Notice is sent from CHAMPS to Bridges to notify caseworkers when an individual is newly enrolled in the waiver, which qualifies them for expanded financial eligibility. The HCBS Waiver Notice appears as an Admission/Discharge Notice in Bridges and is sometimes misinterpreted as a Nursing Facility Admission. Page one of the notice specifies in the SMA Approval Type field that the individual is in an HDE, meets Nursing Facility Level of Care Determination, and is in the community (formerly LOC 03 now HDE-HCBS or HDE-HOSW).

MDHHS LOCAL OFFICE RESPONSIBILITIES

The local MDHHS office is responsible for completing an initial asset assessment (IAA) and determining MA eligibility for potential waiver participants.

Waiver Participant Defined

A waiver participant is a person who is approved to receive or receives waiver services based on medical and functional and financial eligibility.

Waiver Month Defined

A waiver month is a calendar month containing at least one day that the participant is (or was) receiving Waiver services. HDEs enter Waiver enrollment into CHAMPS for either the current or the following month, dependent on service start date. The enrollment would be effective the first of the month.

For purposes of MA eligibility, a month remains a waiver month even if the Waiver participant enters an LTC facility and/or hospital (L/H) in the same calendar month. A waiver month does not become an L/H month; Example: A member is approved for the waiver and becomes a waiver participant in June. That same month, the member enters an LTC facility and/or hospital. June would still be considered a waiver month and not an L/H month because the member was approved for the waiver for at least one day of the calendar month. See Bridges Glossary for the definitions of Waiver Month and L/H Month. NOTE: MHL HCBS Waiver months start on the first day of the month and end on the last day of the month. There is no mid-month start date or end date other than upon admission or discharge to/from a Nursing Facility.

NONFINANCIAL ELIGIBILTY FACTORS

The eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Non-Citizen Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Use special MA policies in the MA eligibility determination:

- A waiver participant is a group of one even when he/she lives with a spouse; see BEM 211.
- The Special MA Asset Rules in BEM 402 apply when completing the *Initial Asset Assessment*; see special initial asset assessment rules for waiver applicants in this item for rules on determining the first period of continuous care.
- The extended-care category is available to waiver participants; see BEM 164.
- Gross income must be at or below 300 percent of the SSI Federal Benefit Rate. An individual cannot spenddown income to waiver eligibility; see BEM 500.

A waiver participant may no longer qualify for waiver services; however, they may still qualify for MA.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

Initial Asset Assessment for 1915 (C) Waiver Applicants

An Initial Asset Assessment (IAA) may be needed for potential Waiver participants with a spouse. The IAA is used to protect a certain amount of the couple's combined resources for the community spouse. It does not determine the start of Medicaid eligibility. Use policy in BEM 402 to determine if an IAA is appropriate.

An IAA uses a first day of continuous care; see BEM 402 for definition. The first period of continuous care is a period of at least

30 consecutive days where the institutionalized spouse/applicant has been or is expected to be:

- In a hospital and/or LTC facility; and/or
- Approved for the Waiver.

Note: The period is no longer continuous when none of the above is true for 30 or more consecutive days; see BEM 402 for examples. The first period or continuous care may have occurred in the past; however, the applicant must be currently receiving services to complete an IAA. If there is no past period of continuous care, then the IAA date must start on the first day that meets the definition of continuous care in BEM 402.

Notices

MI Coordinated Care waiver activities are performed by HDEs who meet the federal definition of administering the MA program. Therefore, you can share the following information with the HDE without a signed release from the participant:

- A copy of the DHS-3503, Verification Checklist.
- A copy of the DHS-4588, Initial Asset Assessment Notice.

The original DHS-3503, and DHS-4588 must be sent to the participant or the guardian, court or agency that is legally responsible for the participant.

Do not enter HDEs in Bridges as a third-party type. Only the participant's legal guardian, court or agency legally responsible for the participant can be entered as a third-party type.

HOSPICE SERVICES

In MI Coordinated Health, HCBS Waiver participants may receive hospice services and waiver services simultaneously. However, individuals with elected hospice services prior to enrolling in MI Coordinated Health are ineligible for the program. If an existing MICH participant elects hospice services, the participant may remain enrolled in the program and obtain the hospice service through the Medicare FFS benefit.

MICH COVERED SERVICES

The MI Health Link program offers an array of services to dually eligible individuals enrolled in the program. Covered services include all health care services covered by Medicare and Medicaid:

- Dental and vision services.
- Diagnostic testing and lab services.
- Emergency and urgent care.
- Equipment and medical supplies.
- Home health services.
- Hospitalizations and surgeries.
- Medications (without co-payments).
- Nursing home services.
- Hospice (if elected while enrolled).
- Primary care and specialty services.
- Transportation for medical emergencies and medical appointments.
- Care Coordination.

Services for long-term support and services include:

- Adult day program.
- Chore services.
- Community transition services.
- Equipment to help with activities of daily living.
- Fiscal intermediary services.
- Home delivered meals.
- Home modifications.
- Non-medical transportation.
- Nursing home care.
- Personal care.
- Personal Emergency Response System (PERS).
- Preventive nursing services.

- Private duty nursing.
- Respite.

Home and Community Based services available through the MICH1915(c) Waiver include:

- Adaptive Medical Equipment and Supplies.
- Adult Day Program.
- Assistive Technology.
- Care Coordination.
- Chore Services.
- Environmental Modifications.
- Expanded Community Living Supports.
- Fiscal Intermediary.
- Home Delivered Meals.
- Non-Medical Transportation.
- Personal Emergency Response Systems (PERS).
- Preventative Nursing Services.
- Private Duty Nursing.
- Respite.

MICH MDHHS LOCAL OFFICE RESPONSIBILITIES

Caseworkers must check for Medicare enrollment or eligibility at time of MA application and redetermination/renewal to avoid placement in the Healthy Michigan Plan (HMP) when the individual could be eligible for MICH through a HDE. At the time of MA application and redetermination/renewal, the caseworker should review the State Online Query (SOLQ) and Consolidated Inquiry to ensure the individual is not enrolled in Medicare. If the individual is enrolled in Medicare, they are not eligible for HMP, but may qualify for MI Coordinated Health/HDE; see BAM 801, SSA Data Exchanges.

DEEMING PERIOD FOR MI COORDINATED HEALTH

The deeming period is a temporary grace period that allows individuals enrolled in MI Coordinated Health (MICH) to continue receiving Medicaid-covered services while their Medicaid eligibility is being re-evaluated through the redetermination process.

Purpose of Deeming

Deeming ensures continuity of care for beneficiaries who may experience delays in completing or processing their Medicaid redetermination paperwork. During this period, members retain access to:

- Medicare services through their MICH plan.
- Most Medicaid services, including long-term supports and behavioral health care.

Eligibility for Deeming

A member may enter the deeming period if:

- They are currently enrolled in MICH.
- Their Medicaid redetermination paperwork is not submitted or processed by the due date.

Duration of Deeming

- The deeming period lasts for three, four, five or six months, depending on deeming period elected by the plan, following the missed redetermination deadline.
- During this time, the members remain enrolled in MICH and continues to receive services.

Member Notification

- Members will receive a written notice from their MICH health plan indicating they are in the deeming period.
- The notice will include instructions for submitting or correcting redetermination paperwork.

End of Deeming

- If full Medicaid eligibility is reconfirmed during the deeming period, the member continues uninterrupted enrollment in MICH.
- If eligibility is not re-established, the member will be disenrolled from MICH and will:

- Receive Medicare services through traditional Medicare or a Medicare Advantage plan.
- Lose access to Medicaid-covered services.

VERIFICATION REQUIREMENTS

Home and Community based services listed in this item are used to determine the first day of continuous care for the IAA must be verified.

VERIFICATION SOURCES

Review SMA screen in Bridges for enrollment dates.

EXHIBIT I MICH INTEGRATED CARE ORGANIZATIONS

HDE Name	COUNTIES SERVED
Aetna Better Health of Michigan, Inc. 855-676-5772 www.aetna.com/medicare-dsnp/michigan	Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Region 10: Macomb Region 12: Wayne
AmeriHealth Caritas VIP Care 844-964-4433 www.amerihealthcaritasvipcare.com/mi	Region 10: Macomb Region 12: Wayne
HAP CareSource To enroll: 855-524-6993 Current members: 833-230-2057 www.caresource.com/mi/plans/mich/	Region 10: Macomb Region 12: Wayne
Humana Dual Integrated 855-281-6070 www.provider.humana.com/medicaid/michigandsnp	Region 10: Macomb Region 12: Wayne
Meridian Complete 888-437-0606 www.mmp.mimeridian.com	Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Region 10: Macomb Region 12: Wayne
Molina Healthcare, Inc. 855-735-5604 www.MolinaHealthcare.com/Medicare	Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Van Buren excluding St. Joseph Region 10: Macomb Region 12: Wayne
Priority Health Choice, Inc. 844-836-4123 www.priorityhealth.com/medicare/dsnp	Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Region 10: Macomb Region 12: Wayne
United Healthcare Community Plan, Inc. 855-645-2501 www.uhc.com/communityplan/call?cid=sp:dsnp-bng-uhc-bp-dsnp	Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Region 10: Macomb Region 12: Wayne
Upper Peninsula Health Plan 877-349-9324 www.uphp.com/medicare	Region 1: All counties in the Upper Peninsula Except Chippewa, Menominee and Gogebic

LEGAL

MA

Social Security Act, Section 1915
42 CFR Part 435.217, 441.350,.400, 438, 422.