Midwest Health Plan

Provider Newsletter
December 2018

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Contact Information

For	Contact
• Claims questions	(888) 654-2200 and follow the prompts

• Adding a provider to your office
• Changes in:
  • Office addresses
  • Remittance payment addresses
  • Demographic changes
	• Robin Owczarzak
	Phone: (313) 664-8793 Fax: (313) 664-5859
	Email: rowczarzak@hap.org
	• Leslie Linares
	Phone: (313) 664-8529 Fax: (313) 664-5860
	Email: llinares@hap.org

• Other operational issues	Provider Services • Suzanne Kayner: (313) 664-8763 • Peggy O'Neil: (810) 230-2071

HAP Midwest Rebranding

The plans we offer through HAP Midwest Health Plan, Inc. will become HAP Empowered plans effective January 1, 2019.

Only our plan name is changing. Members are still with HAP Midwest Health Plan, Inc. and their coverage has not changed. The new plan name better reflects both our goals as a company to be "oneHAP" and the benefits of having HAP Midwest Health Plan coverage.

The chart below shows how this change is being implemented.

Current name	New name (effective Jan. 1)
HAP Midwest Medicaid	HAP Empowered Medicaid
HAP Midwest Healthy Michigan Plan	HAP Empowered Healthy Michigan Plan
HAP Midwest MI Child program	HAP Empowered MI Child program
HAP Midwest Children's Special Health Care Services program	HAP Empowered Children's Special Health Care Services program
HAP Midwest MI Health Link	HAP Empowered MI Health Link

What you should know about this change

- Provider contracts and payments are not affected by this change. You will continue to be contracted and paid through HAP Midwest, HAP or Alliance Health and Life Insurance Company® as appropriate to your contract.
- You will continue to utilize the same systems you use today to verify eligibility, submit claims and more.
- All HAP Midwest members will receive a HAP Empowered identification card to start using on January 1, 2019.
- HAP Midwest email addresses will change from **midwesthealthplan.com** to **hap.org** on January 1, 2019. For example, stucker@midwesthealthplan.com will change to stucker@hap.org.

Provider Enrollment in CHAMPS Requirement

Per the Michigan Department of Health and Human Services, all providers serving Medicaid beneficiaries must be enrolled in CHAMPS. This is the state's online Medicaid enrollment and billing system. It ensures all providers who participate in Medicaid comply with federal screening and enrollment requirements.

The MDHHS has issued final deadlines for CHAMPS enrollment:

- **For dates of service on or after Jan. 1, 2019,** MDHHS will prohibit contracted Medicaid Health Plans and Dental Health Plans from making payments to typical providers not actively enrolled in CHAMPS. Examples of typical providers include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.
- **For dates of service on or after July 1, 2019,** MDHHS Fee-for-Service and Medicaid Health Plans will prohibit payment for prescription drug claims written by a prescriber who is not enrolled.

For more information on CHAMPS and to enroll, visit **michigan.gov/MedicaidProviders**.

Billing Members

Providers who accept a patient as a Medicaid beneficiary with HAP Midwest Medicaid can't bill the beneficiary for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if HAP Midwest Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain prior authorization, or the claim is over one year old and has never been billed to HAP Midwest.

Qualified Medicare Beneficiary Program

Members in the Qualified Medicare Beneficiary Program (QMB) program are enrolled in both Medicaid and Medicare and receive help paying for:

- Part A or Part B premiums
- Deductibles
- Coinsurance
- Copayments

All providers, suppliers, pharmacies and out-of-state providers who render services to dual eligible members are prohibited from billing Medicare cost sharing to members enrolled in the QMB program. For more information, please visit: **cms.gov** and search on SE1128, then select the PDF: *Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program.*

Note: cost-sharing does not apply to dual eligible members enrolled in MI Health Link (ICO) program.

Online Provider Directory Requirements

To remain compliant with the regulatory directory requirements, we need to display the information below in HAP Midwest provider directories.

- Non-English languages, including American Sign Language, spoken by the provider or offered onsite by skilled medical interpreters.
- If the provider completed cultural competence training.
- Specific accommodations at the provider's location for individuals with physical disabilities (e.g., wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, other accessible equipment).
- As applicable, any areas the provider has training in and experience treating, including physical disabilities, chronic illness, HIV/AIDS, serious mental illness, homelessness, deafness or hard-of-hearing, blindness or visual impairment, co-occurring disorders, or other areas of specialty.
  For behavioral health providers, this includes training in and experience treating trauma, child welfare, or substance abuse

Submitting information

The above information can be self-reported to HAP Midwest. Please follow these steps:

- Log in at **midwesthealthplan.com**
- Select *Providers* tab
- Select *Update Training/Languages Info*
- Select the applicable options and submit

Please take a minute and update your information now.

We appreciate your cooperation in helping us keep our provider directories compliant with regulatory guidelines.

Physician Incentive Disclosure

HAP Midwest does not pay financial incentives to practitioners or providers to withhold any health care or health care related services. HAP Midwest does not make decisions about hiring, promoting, or terminating practitioners, providers or other staff based on the likelihood that the individual supports, or tends to support, the denial of benefits or services. HAP Midwest does not reward practitioners, providers or other individuals for issuing denials of coverage. HAP Midwest makes decisions on evidence-based criteria and benefits coverage.

Michigan Care Improvement Registry

Per your contract with HAP Midwest Health Plan and Public Act 91 of 2006, all immunization providers are required to report childhood immunizations to MCIR. This affects immunizations administered to persons born Jan. 1, 1994 to present. If you need information on reporting or access call (888) 217-3903 or visit **mcir.org.** They can also assist you in improving your immunization rates by using MCIR to run batch reports and monthly immunization recall letters.

Reporting Communicable Diseases

State law requires providers to report all communicable diseases to the local health department. The AIM Provider Tool Kit includes a helpful brochure, *Table of Reportable Diseases in Michigan*. Copies of the brochure and other information can be found at **aimtoolkit.org.**

Vaccines for Children (VFC)

As a Medicaid provider, you are required to get your vaccines through the VFC program. The Alliance for Immunization in Michigan tool kits include information on VFC and MICR as well as "catch up schedules", storage information, vaccine information sheets and more! Contact your local health department if you have questions about the VFC program. The AIM tool kit can be found at **aimtoolkit.org.**

Healthy Michigan Plan Health Risk Assessment Completion Instructions

HAP Midwest Health Plan offers a $25 incentive for primary care physicians who complete and return the HRA. This incentive payment is part of the Pay for Performance (P4P) bonus program. To be eligible, PCPs must:

- Complete and sign the HRA.
- Give the member a copy.
- Fax the completed HRA to (844) 225-4602.
- Bill with CPT code 96160. It will be processed at a $0.00 fee. The transaction will appear on the remittance advice and submitted to the Michigan Department of Health and Human Services as an encounter.

If you have any questions, please contact (844) 214-0870.

Dental Care

It's important to remind your patients that routine dental checks (even while pregnant) can catch hidden tooth problems early and lower their risk for tooth decay. Waiting to see a dentist until they feel pain might be too late to treat decay. Despite improvements in oral health care, the U.S. spends more than $113 billion each year on costs related to dental care. HAP Midwest members can learn more about their dental benefits by calling Delta Dental at (800) 838-8957.

Smoking Cessation Program

HAP Midwest has a smoking cessation program for members. The Michigan Tobacco Quitline is a free, phone-based program to help members quit using tobacco. Members will work one-on-one with a health coach to develop a quit plan. Members can enroll in the program by:

- Self-referral
- PCP referral
- Health plan referral

To refer a member to the program, call **1- 800 QUIT NOW (784-8669)**.

For more information, please call **(888) 654-2200**.

Medicare Outpatient Observation Notice

Per the Federal Notice of Observation Treatment and Implication for Care Eligibility Act, passed on August 6, 2015, all hospitals and critical access hospitals are required to provide written and oral notification to individuals receiving observation services as outpatients for more than 24 hours.

The MOON is intended to inform members who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status. It must be delivered no later than 36 hours after observation services begin.

For MOON instructions, frequently asked questions and the final rule, visit **cms.gov**. Click *Medicare*, then, under Medicare – *General Information*, click on *Beneficiary Notices Initiative (BNI)*, then *Medicare Outpatient Observation Notice (MOON)*.

Pharmacy Updates

All the changes outlined below are effective January 1, 2019.

Prior Authorization Changes

There is new contact information for prior authorization requests for HAP Empowered Medicaid and HAP Empowered MI Health Link.

For	Contact
Faxed requests for prior authorization or exceptions	**Fax: (313) 664-5460**
Prior Authorization Line	**Phone: (313) 664-8940, option 3**

Transition to HAP Medicare Part D drug formulary

We are transitioning to the HAP Medicare Part D drug formulary for HAP Empowered MI Health Link. Here are the changes:

- Humalog and Humulin will no longer be covered. Novolog and Novolin products will be covered. If this change affects any of your patients, you'll receive a letter along with a list of your patients. You can find detailed information about formularies below.
- HAP Empowered MI Health Link members can receive a 90-day supply of chronic medications, instead of the current limit of 30 days. Please write a 90-day supply when your patient is stabilized on a chronic medication (e.g., diabetes medications, hypertension medications, cholesterol medications). This is a positive change that can improve medication adherence rates and reduce the number of trips to the pharmacy.

Changes to our opioid dispensing rules for HAP Empowered MI Health Link members

Our opioid dispensing rules are changing based on the Center for Medicare and Medicaid Services expectations. Please see details below.

New point of sale pharmacy edits

1. Care coordination edit
   Any opioid claim will reject at the pharmacy if:
   - It exceeds a morphine milligram equivalent (MME) dose of 90 mg and
   - There is more than one opioid prescriber in the previous six months

   This rejection ensures care is being coordinated between providers when there are multiple opioid prescribers. Pharmacies can consult with providers and override this rejection at the point of sale.

2. Seven-day supply limit for acute pain
   - Opioid claims will be limited to a seven-day supply when used for acute pain. Acute pain will be determined at the point of sale based on the history of opioid fills. If a member has not filled opioids in the previous 108 days, HAP will assume that an opioid is being prescribed for acute pain. The pharmacy **can't** override this edit.

3. Multiple long-acting opioid medications
    - If a member is filling two long-acting opioid medications simultaneously, the subsequent drugs will reject. Pharmacies will be able to override this rejection at the point of sale if they confirm that therapy is appropriate.

4. Concomitant use of benzodiazepines
    - If a member has overlapping claims for benzodiazepine and opioid medications, the subsequent drug will reject. Pharmacies will be able to override this rejection at the point of sale if they confirm that concomitant use is appropriate.

For more information on opioid rules for 2019, visit **cms.gov** and select:

- Outreach & Education
- Medicare Learning Network® (MLN) Homepage
- MLN Matters Articles
- Select 2018
- Enter SE 18016 in the Filter On box

Drug Management Program (DMP)

Our Drug Management Program helps ensure our members use their prescription opioid medications safely. A member may be enrolled in the DMP if **all** the criteria below is met.

1. Prescription exceeds 90 mg MME opioid dose in the previous six months
2. Member has four or more prescribers contributing to opioid use in previous six months
3. Member has four or more pharmacies dispensing opioids in the previous six months

Once a member is enrolled in the program, we consult with providers to determine if the opioid use is appropriate and medically necessary. If we decide that a member is at risk for mis-using or abusing opioid medications, we may limit access to opioids and/or benzodiazepines by:

- Requiring the member to get all prescriptions for opioid medications from one pharmacy
- Requiring the member to get all prescriptions for opioid medications from one doctor
- Limiting the amount of opioid medication we will cover

We will communicate with members and providers in advance of putting any limitations in place. Members and providers will have the chance to appeal our decision.

The DMP may not apply if the member has certain medical conditions, such as cancer, or is receiving hospice care or living in a long-term care facility.

Formulary Information

You can find the following drug formulary information our website.

- Restrictions and preferences
- Explanation of limits
- How to use the formulary
- How to submit an exception request
- Generic drugs
- Step therapy
- Prior authorization

You can also view or print the complete formulary document, along with prior authorization criteria and other information.

A printed copy of the drug formulary and related documents are also available upon request. Please contact Pharmacy Care Management at (313) 664-8940, option 3.

HAP Empowered MI Health Link Formulary

The 2019 HAP Empowered MI Health Link formulary can be found at **hap.org/mihealthlink.** You can search for drugs alphabetically or by type of drug. The drug formulary may change annually on January 1 and throughout the year.

HAP Empowered Medicaid Formulary

HAP administers the Michigan Medicaid Health Plan Common Formulary. General information about the common formulary and a history of formulary changes can be found at **hap.org/medicaid**.

HAP posts the drug formularies on the website annually and posts updates about formulary changes throughout the year. If there are changes that result in drug restrictions or replacements, HAP will notify affected members and their prescriber.

HAP Midwest Health Plan Access and Availability Standards

Topic	Standard	Measurement Tool
Medicaid Government Program		
Availability of Practitioners: HAP Midwest Health Plan will assure the availability of primary and key specialty practitioners to its members		
Number of Primary Care Practitioners (PCPs) • General and Internal Medicine • Family Practice • Pediatricians	Ratio of PCPs to members: 1:500	On an annual basis HAP Midwest will compute the ratio of the combination of PCPs to membership, using the provider and member data from the MC400 and Cactus systems. Membership is defined as the total enrolled population.
Number of Key Specialty Practitioners (High-Volume) • OB/GYN • Top 2 Specialties based on high-volume claims data	Ratio of Practitioners to members: 1:4,000	On an annual basis HAP Midwest will compute the ratios of SCPs to membership, using provider and member data from the MC400 and Cactus systems. Membership is defined as the total enrolled population, or relevant population for Obstetrics/Gynecology (female members).
Number of High-Impact Practitioners • Oncology	1:4,000	On an annual basis HAP Midwest will compute the ratio of high-impact specialists to membership, using provider and member data from MC400 and Cactus systems.
Geographic access: Distance to PCPs, Specialists and Hospital Services. Specialists include: • OB/GYN • Top 2 Specialties based on high-volume claims data	A PCP, Pediatricians, and Specialist Services will be 30 minutes/30 miles for non-rural and 40 minutes/40 miles for Rural from a member's home. Hospital Services will be 30 minutes/30 miles for non-rural and 60 minutes/60 miles for Rural from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the MC400 and Cactus systems.
Geographic access: Distance to High Impact Specialists • Oncology	Non-rural: A high-impact practitioner will be 40 minutes/40 miles from a member's home Rural: A high-impact practitioner will 60 minutes/60 miles from a member's home	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the MC400 and Cactus systems
Outpatient Behavioral Health*	**Outpatient Behavioral Health*** Services will be 30 minutes/30 miles for non-rural and 75 minutes/75 miles for Rural from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the MC400 and Cactus systems

Topic	Standard	Measurement Tool
Medicaid Government Program		
Accessibility of Services: Service will be provided "in the appropriate time frame"		
Appointment lead time: Primary Care		Performance will be monitored in the annual Primary Care Access Survey (PCAS) and the After-Hours Telephone Access Survey.
• **Preventive (regular) or Routine Care** – care provided in asymptomatic situations to prevent the occurrence or progression of conditions	Within 30 days of request	Performance will be monitored in the annual Primary Care Access Survey (PCAS).
• **Non-urgent Symptomatic care** – care provided in symptomatic non-urgent conditions	Within 7 days of request	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Urgent care** – care for serious, but nonemergency injury or illness	Same or next day (Within 48 hours)	Performance will be monitored in the annual Primary Care Access Survey (PCAS) and the After-Hours Telephone Access Survey.
• **After hours care**	Physicians or their designee shall be available by telephone twenty-four (24) hours per day, seven (7) days per week.	Performance will be monitored in the annual After-Hours Telephone Access survey.
• **Emergency Services**	Immediately 24 hours/day 7 days a week	Performance will be monitored in the annual After-Hours Telephone Access Survey.
• **Wait time in the office**--How long before the member is seen by the provider after checking in with the receptionist?	Less than 30 minutes	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
Accessibility of Services: Service will be provided "in the appropriate time frame"		
Appointment lead time: High-Volume Specialist and High-Impact Specialist		
• **Acute Specialty Care (Non-Urgent with symptoms)**	Within 5 days of request	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
• **Specialty Care (Routine without symptoms)**	Within 6 weeks of request	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
• **Urgent care** – care for serious, but nonemergency injury or illness	Same or next day (< 48 hours)	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.

Topic	Standard	Measurement Tool
Medicaid Government Program		
Accessibility of Services: Service will be provided "in the appropriate time frame"		
Appointment lead time: Behavioral Health*		
• **Routine Care**	Within 10 days of request	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
• **Non-life threating emergency**	Within 6 hours of request	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
• **Urgent care** – care for serious, but nonemergency injury or illness	Same or next day (< 48 hours)	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
Accessibility of Services: Service will be provided "in the appropriate time frame"		
Appointment lead time: Dental		
• **Emergency Dental Services**	Immediately 24 hours/day 7 days per week	Performance will be monitored in the annual After-Hours Telephone Access Survey.
• **Routine Care**	Within 21 days of request	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Preventive Services**	Within six weeks of request	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Urgent care** – care for serious, but nonemergency injury or illness	Within 48 hours	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Initial Appointment**	Within eight weeks of request	Performance will be monitored in the annual Primary Care Access Survey (PCAS)

*Behavioral Health is limited to Covered Services

All days are Business Days

Topic	Standard	Measurement Tool
MMP Government Program		
Availability of Practitioners: HAP Midwest Health Plan will assure the availability of primary and key specialty practitioners to its members		
Number of Primary Care Practitioners (PCPs) • General and Internal Medicine • Family Practice • Pediatricians	Ratio of PCPs to members **Minimum 40 providers**	On an annual basis HAP Midwest will compute the ratio of the combination of PCPs to membership, using the provider and member data from the MC400 and Cactus systems. Membership is defined as the total enrolled population. Guidance from the CMS MMP HSD Criteria Reference Table
Number of Key Specialty Practitioners • OBGYN • Cardiology • Ophthalmology	Ratio of Practitioners to members **OBGYN minimum 1 provider** **Cardiology minimum 7 providers** **Ophthalmology minimum 6 providers**	On an annual basis HAP Midwest will compute the ratios of SCPs to membership, using provider and member data from the MC400 and Cactus systems. Membership is defined as the total enrolled population, or relevant population for Obstetrics/Gynecology (female members). Guidance from the CMS MMP HSD Criteria Reference Table
Number of High-Impact Practitioners • Oncology	Ratio of Practitioners to members **Oncology minimum 5 providers**	On an annual basis HAP Midwest will compute the ratio of high-impact specialists to membership, using provider and member data from MC400 and Cactus systems. Guidance from the CMS MMP HSD Criteria Reference Table
Geographic access: Distance to PCPs, Specialists and Hospital Services. Specialists include: • OB/GYN • Top 2 Specialties based on high-volume claims data	A PCP and Pediatricians will be 10 minutes/5 miles from a member's home. OBGYN will be 30 minutes/15 miles from a member's home Hospital Services will be 20 minutes/10 miles from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the MC400 and Cactus systems. Guidance from the CMS MMP HSD Criteria Reference Table
Geographic access: Distance to High Impact Specialists • Oncology	Oncology will be 20 minutes/10 miles from a member's home	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the MC400 and Cactus systems. Guidance from the CMS MMP HSD Criteria Reference Table

Topic	Standard	Measurement Tool
MMP Government Program		
Accessibility of Services: Service will be provided "in the appropriate time frame"		
Appointment lead time: Primary Care		Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Preventive (regular) and Routine care** – care provided in asymptomatic situations to prevent the occurrence or progression of conditions	Within 30 days of request	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Non-urgent Symptomatic care** – care provided in symptomatic non-urgent conditions	Within 24 hours	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **Urgent care** – care for serious, but nonemergency injury or illness	Within 24 hours	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
• **After-hours care**	Physicians or their designee shall be available by telephone twenty-four (24) hours per day, seven (7) days per week.	Performance will be monitored in the annual After-Hours Telephone Access survey.
• **Emergency Services**	Immediately 24 hours/day 7 days a week	Performance will be monitored in the annual After-Hours Telephone Access survey.
• **Wait time in the office**--How long before the member is seen by the provider after checking in with the receptionist?	Less than 30 minutes	Performance will be monitored in the annual Primary Care Access Survey (PCAS)
Accessibility of Services: Service will be provided "in the appropriate time frame"		
Appointment lead time: High Volume Specialist and High Impact Specialist		
• **Acute Specialty Care (Non-Urgent with symptoms)**	Within 24 hours	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
• **Specialty Care (Routine without symptoms)**	Within 6 weeks of request	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.
• **Urgent care** – care for serious, but nonemergency injury or illness	Within 24 hours	Performance will be monitored in the annual Specialist Appointment Access Survey or available data reported by provider organizations.

Questions about HAP Midwest Health Plan?

You can always call us at (888) 654-2200 for more information. We also have the following information posted online at **hap.org/midwest**. If you prefer a hard copy, call the number listed above and we will mail it to you.

- Affirmative statement about UM incentives
- Complex case management
- Coordination of Care between Behavioral Health and Primary Care Providers
- Covered and non-covered benefits
- Credentialing information
- Fraud, Waste and Abuse Information
- Evaluation of medical technology
- HAP Midwest's policy for making an appropriate practitioner reviewer available to discuss any utilization management denial decision and how to contact a reviewer
- Member rights and responsibilities
- Pharmacy procedures and formularies
- Privacy and HIPAA information
- Utilization management criteria