Provider Manual
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Section 1: Overview

HAP Empowered offers the following products:

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<th>Program</th>
<th>Service area (counties)</th>
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<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
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<tr>
<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
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</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

In 2019, the plans we offered through HAP Midwest Health Plan, Inc. became HAP Empowered plans. Provider contracts and payment were not affected. On January 1, 2020, the HAP Midwest Health Plan entity name changed to HAP Empowered Health Plan, Inc. Provider contracts, checks and remittance advices all reflect the HAP Empowered name today.

General overview

HAP Empowered Health Plan, Inc., a Michigan Medicaid Health Plan, is a wholly owned subsidiary of Health Alliance Plan of Michigan (HAP). It is a Michigan nonprofit, taxable corporation. It’s accredited by the National Committee on Quality Assurance and has a contract with the Michigan Department of Health and Human Services to provide health care services to Michigan Medicaid (including Children’s Special Health Care Services), and Healthy Michigan Plan members in the following counties:

- Genesee
- Huron
- Lapeer
- Macomb
- Oakland
- Sanilac
- Shiawassee
- St. Clair
- Tuscola
- Wayne

We're contracted with the federal government to administer Medicare benefits to anyone who has both medical assistance from the State, Medicare (Parts A and B) and lives in Wayne or Macomb County.

HAP Empowered follows guidelines from the Michigan Department of Health and Human Services which can be found in the MDHHS Medicaid Provider Manual. The manual contains coverage, billing, and reimbursement policies for Medicaid, Healthy Michigan Plan, Children’s Special Health Care Services, Maternity Outpatient Medical Services (MOMS), and other healthcare programs administered by the MDHHS.

HAP Empowered MI Health Link

HAP Empowered MI Health Link provides high quality, seamless and cost-effective care through coordinated, person-centered services meeting the unique needs of all members who are dual eligible for both Medicare and Medicaid. We work collaboratively with Pre-Paid Inpatient Health Plans, long term support services and primary care physicians and specialists to improve the quality of care while limiting duplication of services and ensuring cost-effective plans of care. All services provided are consistent with the Medicare and Medicaid manuals, guidance, memoranda and other related documents.

HAP Empowered contracts with primary care physicians and specialty care physicians who are licensed in the state of Michigan as either a medical doctor or a doctor of osteopathic medicine.

All HAP Empowered physicians must meet the credentialing standards and uphold the managed care philosophy of the plan.

Mission statement

HAP Empowered Health Plan is committed to providing excellence in our managed care product lines for our members, through fiscally responsible programs that assure access to and the delivery of cost-effective and quality medical services.
Section 2: Network Development and Contracting Process

HAP Empowered offers the following products:

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| HAP Empowered MI Health Link | Integrated Care for Medicare and Medicaid Dual Eligible | Macomb and Wayne |

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Joining HAP Empowered

To join HAP Empowered, email providernetwork@hap.org. We’ll send the appropriate documents to the provider to complete and return. The Credentialing department will process the completed forms.

Changes in provider information

If any of the information below changes, please email the updated information to providernetwork@hap.org.

- Address
- Billing and remittance addresses
- Providers listed under existing tax ID
- Tax IDs, NPI numbers, etc.
- Providers who have voluntarily or otherwise terminated their contract

Changes in Provider Network

HAP Empowered will make a good faith effort to give written notice of termination of a network provider within 15 days after receipt or issuance of the termination notice to each member who received primary care from, or was seen on a regular basis by, the terminated provider.

Provider terminations by HAP Empowered

HAP Empowered may immediately terminate a provider contract, pursuant to the termination provisions set forth in the provider agreement. Grounds for immediate termination include:

- Conviction of Medicaid or Medicare fraud or any other fraudulent activity
- Failure to meet or comply with HAP Empowered credentialing requirements
- Suspension or exclusion from the state Medicaid program, federal Medicare program or any other governmental public-sector program
- The possibility of the member’s safety or care being adversely affected by the contract’s continuation

Termination process

Here is the process, if the HAP Chief Medical Officer or Medical Director agrees to terminate the provider:

1. The Lead Contract Administrator submits a draft letter and supporting documentation to HAP’s legal counsel.
2. Upon approval from HAP’s legal counsel, the Director of Provider Contracting notifies the provider by fax and certified mail.
3. The Enrollment Services department notifies members of reassignment to another network PCP as appropriate.
4. Internal departments are notified to ensure activities such as claims payment and prior authorization are stopped.
Network adequacy
HAP Empowered monitors its provider network to ensure reasonable availability and accessibility of medical care and services for members. We annually review:
- Mapping of providers and members
- Telephone accessibility and appointment availability of each PCP

To ensure network adequacy, the Provider Contracting department:
- Follows the standard ratio for travel time to and from network providers
- Reviews the provider network to strategically locate additional primary care and specialist providers within the service area where needed
- Ensures adequate primary care physician to enrollee ratios

Reporting
The Provider Contracting department ensures required reports are provided to regulatory agencies and accrediting bodies in a timely and accurate manner.

Physician incentive disclosure
HAP Empowered does not pay financial incentives to practitioners or providers to withhold any health care or health care related services. HAP Empowered 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 Empowered does not reward practitioners, providers or other individuals for issuing denials of coverage. HAP Empowered makes decisions on evidence-based criteria and benefits coverage.
Section 3: Credentialing

HAP Empowered offers the following products:

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</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

HAP and HAP Empowered ensure all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and recredentialing decisions are non-discriminatory and not based on an applicant's race, ethnic or national identity, gender, age or sexual orientation.

Providers have the right to be informed of their application status throughout the credentialing process.

Primary Care Physicians
A PCP is an MD or DO listed as a general practice, family medicine, pediatrician or internal medicine practitioner. OB-Gyn practitioners and other specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, seven days per week. PCPs must be available to see patients a minimum of 20 hours per practice location per week.

Who is credentialed and recredentialed?
We credential and recredential the following practitioners:

- Allopaths
- Board certified behavior analysts
- Certified nurse midwives
- Certified registered nurse anesthetists
- Chiropractors
- Dentists (only oral and maxillofacial surgeons providing care under medical benefits)
- Fully-licensed psychologists (PhD or PsyD)
- Licensed professional counselors
- Master level psychologists
- Master level social workers
- Nurse practitioners
- Optometrists
- Osteopaths
- Podiatrists
- Physician assistants
- Psychiatric clinical nurse specialists

Who is not credentialed?
We do not credential:

- Practitioners who practice exclusively within the inpatient setting and provide care for members being directed to the hospital or another inpatient setting (i.e., hospitalists, pathologists, radiologists, anesthesiologists, neonatologists and emergency room physicians)
- Practitioners who practice exclusively within freestanding facilities
- Practitioners who provide care for members being directed to the facility
- Locum tenens providers
- General dentistry providers
Verification
All potential candidates must complete a Council for Affordable Quality HealthCare application. HAP verifies:

- Board certification
- DEA or CDS certificates
- Education and training
- Hospital affiliations
- Licensure
- Malpractice history
- Work history
- Sanction information

Credentialing policy and process

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Credentialing Policy</th>
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<tbody>
<tr>
<td>Policy Number:</td>
<td>D.CREDENTIALING.001</td>
</tr>
<tr>
<td>Policy Owner:</td>
<td>Sheri L. Chatterson MSM, CHFP, MBA</td>
</tr>
<tr>
<td></td>
<td>Vice-President Provider Network Management</td>
</tr>
<tr>
<td>Department(s):</td>
<td>Credentialing Department</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>April 5, 1995</td>
</tr>
<tr>
<td>Last Revision Date:</td>
<td>July 23, 2019</td>
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1. POLICY STATEMENT
HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Midwest Health Plan, Inc.) ensure that all practitioners applying for affiliation meet rigorous credentialing standards prior to approval for participation. All credentialing and recredentialing decisions are non-discriminatory and not based upon an applicant’s race, ethnic/national identity, gender, or age sexual orientation.

2. STANDARDS
HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Midwest Health Plan, Inc.) have a well-defined Credentialing and recredentialing process for evaluating and selecting licensed Independent practitioners to provide care to its members.

3. REGULATORY REQUIREMENTS AND REFERENCES
- National Committee for Quality Assurance (NCQA) standards
- Centers for Medicare & Medicaid Services (CMS) guidelines
- Michigan Department of Community Health (MDHHS) guidelines
- Michigan Department of Insurance and Financial Services (DIFS)

4. DEFINITIONS
- CMS: Centers for Medicare & Medicaid Services guidelines
- DIFS: Michigan Department of Insurance and Financial Services
- MDHHS: Michigan Department of Health and Human Services
- NCQA: National Committee for Quality Assurance standards

5. PROCEDURES

<table>
<thead>
<tr>
<th>Relevant Standard</th>
<th>Procedure</th>
<th>Procedure Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Assessment and Review of Practitioners who provide care to HAP members.</td>
<td>Manager, Credentialing Department</td>
</tr>
</tbody>
</table>
Practice/Procedure/Requirements for Compliance

1. Types of practitioners to credential and recredential:

    This policy applies to practitioners who have an independent relationship including Allopaths (MD), Osteopaths (DO), Dentists (DDS) (only oral and maxillofacial surgeons providing care under medical benefits), Podiatrists (DPM), Chiropractors (DC), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Optometrists (OD), Board Certified Behavior Analysts (BCBA), fully licensed Psychologists (PhD/PsyD), Master Level Psychologists (LLP), and Master Level Social Workers (LMSW). Licensed Professional Counselors (LPC) are credentialed as an exception based on the health plan’s need.

    PCP availability: A PCP is described as a MD or DO who is listed as a General Practice, Family Medicine, Pediatrician or Internal Medicine Practitioner. OB/Gyn practitioners and other specialists may be designated as a PCP if they agree to provide care for all medical conditions. PCPs must provide or arrange for coverage of services 24 hours per day, 7 days per week. PCPs must be available to see patients a minimum of 20 hours per practice location per week.

    Practitioners who do not need to be credentialed are those who practice exclusively within the inpatient setting and provide care for organization members only as a result of members being directed to the hospital or another inpatient setting (i.e., Hospitalists, Pathologists, Radiologists, Anesthesiologists, Certified Registered Nurse Anesthetists, Neonatologists and Emergency room physicians), practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and locum tenens, general dentistry.

2. Verification sources used for credentialing and recredentialing:

    Primary source verification is documented using a checklist which includes the name of the primary source used, the date of verification, the signature or initials of the person who verified the information and the report date, if applicable.

    Application:

    The CAQH application must include a signed current attestation confirming to be accurate and completeness of the application within the required time frame of 180 days prior to the Credentialing Committee’s decision. If the signature attestation exceeds 180 calendar days before the credentialing decision, the practitioner must re-attest that the information on the application is current and complete.

    The application must also include the following:
    - Reasons for inability to perform the essential functions of the position.
    - Lack of present illegal drug use.
    - History of loss of license and felony convictions.
    - History of loss or limitation of privileges or disciplinary actions.
    - Current malpractice insurance coverage.
**Licensure:**
HAP verifies a current, valid license to practice and a controlled-substance license as applicable in states where the practitioner provides care to its members is present, is within the prescribed time limit of 180 calendar days and is active at the time of the Credentialing Committee’s Decision.

- Obtains internet verification, oral or written verification directly from the State of Michigan Department of Licensing and Regulatory Affairs (LARA) or certification agency.
- Obtains either oral, written, or Internet verification for all other state licenses utilizing the appropriate state-licensing agency.
- Review of information of sanctions, licensures, or scope of practice covers the most recent five-year period available through the data source.
- Information on state sanctioning activity from the State of Michigan Department of Consumer and Industry Services Bureau of Health Services at the time of license verification.

**DEA or CDS Certificates:**
HAP verifies a current and valid DEA or CDS certificate with no restrictions or limitations (if applicable) in each state where the practitioner provides care to members through one of the following. Verification is obtained prior to the credentialing decision. Recent graduates, or fellows applying for initial credentialing or practitioners that move from another state, may have a HAP covering practitioner for up to six months until they obtain their DEA.

- Confirmation with the state pharmaceutical licensing agency, where applicable
- A copy of DEA or CDS certificate
- Documented visual inspection of the original certificate
- Confirmation with the DEA or CDS agency
- Confirmation with the National Technical Information Services (NTIS) database
- Confirmation with the American Medical Association (AMA) Physician Master File
- The DEA and CDS certificate is not applicable to chiropractors.

**Education and Training:**
Practitioners must have completed at least three years of post-graduate medical education in an approved internship and/or residency program (MD or DO) or DO’s with only one-year post-graduate training before 1989 in an approved program and board certification. Verification of board certification meets the requirement for verification of education and training since medical specialty boards verify both.

HAP verifies the highest of the three levels of education and training obtained by the practitioner prior to the credentialing decision. Graduation from medical or professional school, residency, if appropriate, and board certification, if appropriate.

The agencies/authorities recognized at the time of this policy are the following:

- The Accreditation Council for Graduate Medical Education (ACGME)
- American Medical Association (AMA) Physician Master Profile
- The American Osteopathic Association (AOA)
- Royal College of Physicians and Surgeons of Canada
- The American Podiatric Medical Association (AMPA) Council on Podiatric Medical Education
- Graduation from a Commission on Dental Accreditation (CODA) accredited training program – Oral Surgeons
- Completion of an accredited psychologist program with an approved internship/clinical practice requirement
• Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists with an approved internship/clinical practice requirement
• Chiropractic College
• Graduate from an optometry program that is accredited by the Accreditation council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program.
• Completion of a master's degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiner of Social Work.
• Master's Degree from a program approved by the State of Board of Counseling
• Master's or doctoral degree in Psychology (LLP’s)
• Doctoral degree in Psychology (Psychology)
• Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine or a field related to behavior analysis and approved by the BACB and must obtain BCBA Certification.
• Confirmation from state licensing agency, at least annually HAP obtains written confirmation from the state licensing agency that it obtains primary source verification directly from the training program.

**Board Certification:**
HAP verifies board certification and documents the expiration date within the 180-calendar day time limit including lifetime certification status. If the medical board does not provide the expiration date for a practitioner's board certification, verification of the board certification status and date of verification is documented within the practitioners file.

Board Certification is verified by one or more of the following HAP recognized agencies/authorities are:

- American Board of Medical Specialties (ABMS Certifacts)
- American Osteopathic Association (AOA) Physician Profile Report
- Royal College of Physicians and Surgeons of Canada
- American Board of Addiction Medicine
- American Board of Sleep Medicine
- American Board of Oral and Maxillofacial Surgery
- American Podiatric Medical Association (APMA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Lower Extremity Surgery (ABLES)
- American Board of Multiple Specialties in Podiatry (ABMSP)
- American Board of Podiatric Medicine (ABPM)
- American Midwifery Certification Board (AMCB)
- National Commission on Certification of Physician Assistants
- Nurse Practitioners meet the advanced practice certification standards of one of the following certification organizations:
  a. American Nurses Credentialing Center (ANCC)
  b. American Academy of Nurse Practitioners
  c. National Certification Board of Pediatric Nurse Practitioners and Nurses, Inc.
  d. National Certification Corporation (NCC) for obstetric, gynecologic, and neonatal nursing specialties
  e. Oncology Nursing certification corporation
  f. Pediatric Nursing Certification Board
  g. American Association of Critical-Care Nurses
**Work History:**
HAP obtains a minimum of the most recent five years of relevant work history through the practitioner's application or CV within 180 calendar day time limit. Relevant experience includes work as a health professional. If the practitioner has practiced fewer than five years from the date of verification of work history, the time frame starts at the date of initial licensure. The application or CV must include the beginning and ending month and year for each position the practitioner's employment experience. If the practitioner has had continuous employment for five years or more with no gaps in work history providing the year is acceptable.

- Clarify either verbally or in writing each gap in employment that exceeds six months.
- If the gap in work history exceeds one year, the practitioner clarifies the gap in writing.
- Document its review of work history, including any gaps, within the credentialing file.
- Work history can be documented on the application, CV or checklist. Documentation will include the signature or initials of staff who reviewed work history and the date of review.

**Malpractice History:**
HAP obtains confirmation of the past five years of history of malpractice settlements from the malpractice carrier or the National Practitioner Databank (NPDB) within 180 calendar day time limit.

The five-year period may include residency or fellowship years. HAP does not need to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.

**Hospital Affiliation:**
HAP verifies all current hospital affiliations as attested to on the application. In the event of a "red flag", previous hospitals affiliations are also verified.

**Sanction Information:**
HAP reviews and evaluates State sanctions, restrictions on licensure, limitations on scope of practice, and Medicare and Medicaid Sanctions prior to making a credentialing/recredentialing decision. The practitioner's file will contain sufficient documentation to demonstrate that the credentialing information is present at the time of the credentialing decision within the 180-calendar day time limit from the following agencies/sources:

- NPDB
- State Medicaid agency or intermediary and the Medicare intermediary
- List of Excluded Individuals and Entities (maintained by OIG), available over the Internet
- Medicare Exclusion Database
- MDHHS Sanction Provider List, available over the Internet
- SAMS web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits
- AMA Physician Master File entry
- FSMB
- CMS Preclusion Provider List
3. Criteria for credentialing and recredentialing:

HAP assures that all practitioners applying for affiliation meet rigorous credentialing standards prior to providing care to members. The provider must submit information and documentation of his/her education, qualification and certification which qualifies them to be identified as a specialist in a particular field of medicine. It is anticipated that the services to HAP members, performed by that credentialed specialist, would be consistent with the medical specialty for which the provider applied for and was evaluated and credentialed by HAP. Credentialed specialists are accordingly expected to provide covered services to HAP members that are within the scope of the specialty that was credentialed by HAP after review of the providers application.

Practitioners will go through the recredentialing process within 36 months of the previous credentialing decision. The recredentialing process will include the consideration of practitioner performance indicators obtained through various forms of data, which may include but not limited to results of quality of care reviews, quality of service events, the monitoring of practitioners Appeals and Grievances, U/M information, and member satisfaction surveys. The recredentialing cycle begins with the date of the initial credentialing decision. HAP counts the 36-month cycle to the month, not to the day.

If HAP cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave or a sabbatical, but the contract between HAP and the practitioner remains in place, HAP will recredential the practitioner upon his or her return. HAP will document the reason for the delay in the practitioner’s file. It is acceptable to recredential practitioners on leave. HAP will verify that a practitioner who returns from military assignment, maternity leave or a sabbatical has a valid license to practice before he or she resumes seeing patients. Within 60 days of when the practitioner resumes practice, HAP will complete the recredentialing cycle.

If a practitioner is given administrative termination for reason beyond HAP’s control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, HAP may recredential the practitioner as long as it’s documented that the practitioner was terminated for reasons beyond HAP’s control and was recredentialed and reinstated within 30 calendar days of termination. HAP will initially credential practitioners if reinstatement is more than 30 calendar days after termination.

- Completion of a CAQH application.
- Completion of at least three years of post-graduate training in an approved internship and/or residency program (MD or DO) or DOs with only one-year post-graduate training before 1989 in an approved program and board certification.
- Completion of an accredited physician assistant program with an approved internship/clinical practice requirements and hold a current active certification by the National Commission on Certification of Physician Assistants.
- Completion of an accredited nurse midwife program, nurse practitioner, clinical nurse specialists or CRNA program with an approved internship/clinical practice requirements.
- Nurse Practitioners and Physicians Assistants must submit evidence of collaborative or practice agreement between applicant and a designated HAP credentialed physician.
- Graduate from an optometry program that is accredited by the Accreditation council on Optometric Education (ACOE) of the American Optometric Association (AOA). Optometrists must complete a four-year post-baccalaureate Doctor of Optometry Degree program.
• Completion of a master’s degree in social work (MSW) with a major focus of study in the treatment of Behavioral Medicine or equivalent field, as defined by the Michigan Board of Examiner of Social Work.

• **Licensed Professional Counselor**: Current Michigan license to practice as a Licensed Professional Counselor Master's degree from a program approved by the state Board of Counseling.

• **Fully Licensed Psychologist**: Current Michigan license to practice as a Licensed Psychologist. Doctoral degree in psychology from an institution approved by the State of Michigan Board of Psychology.

• **Limited License Psychologist/LLP**: Current Michigan license to practice as a Limited License Psychologist. Master's or doctoral degree in psychology from an institution approved by the Michigan Board of Psychology.

• **Board Certified Behavior Analyst (BCBA)**: Possession of a minimum of a bachelor's and a master's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine or a field related to behavior analysis and approved by the BACB and must obtain BCBA Certification.

• Board certification in the requested area of practice is recommended. Board certification does not apply to chiropractors or psychologists.

• Recent graduates of residency programs who are not board certified at the time of application are encouraged to attain board certification within four years of completing the training program.

• Specialties such as OB/GYN and all surgery related specialties are encouraged to attain board certification within six years of completing the training program.

• Non-boarded practitioners see Section 4; Process for making credentialing and recredentialing decisions.

• **Unrestricted Licensure in the State of Michigan.**

• **Unrestricted DEA in the State of Michigan or arrangements with a HAP contracted/credentialed provider with a valid DEA for required prescriptions will be considered for approval or denial at the discretion of the Credentialing Committee.** For initial practitioners or practitioners that move from another state, they may have a covering practitioner for up to six months until they obtain their DEA.

• **Affiliation with a hospital, as applicable.** Select specialists including Physical Medicine & Rehab, Dermatology, Ophthalmology and Psychology are not required to have an affiliation with a hospital. All others must have hospital affiliations. For PCPs, hospital affiliation is not required if they are able to identify a credentialed contracted practitioner to oversee the care of their members.

• **Current Malpractice insurance, with at least $100,000/$300,000 coverage.** Verify malpractice coverages and amounts from the CAQH application or obtain a copy of face sheet from practitioner.

• **Federal Torte Coverage - In lieu of malpractice insurance for practitioners delivering care at federal facilities, the file must include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage.**

• **For practitioners requesting assignment of a dual PCP and specialist, each designation must be assigned to a separate network.**

• **Eligible to participate in Medicare and Medicaid and must not be excluded from participation in any governmental healthcare program.**

• **Willingness to participate in Medicare and does not appear on the Medicare Opt-Out List.**

• **Lack of current sanction and/or suspension from Medicare or Medicaid, or Federal Employees Health Benefits (FEHB).** Exclusion or sanctions from a federal health care program shall cause an automatic termination as an affiliated practitioner.
• Willingness to cooperate with Quality Management and Utilization Management programs, including willingness to permit a credentialing site visit and medical record-keeping practices review if requested.
• Willingness to accept the HAP fee schedule as payment in full.
• Willingness to accept new patients for all contracted product lines.
• Favorable professional liability history including malpractice claims history with no more than $200,000 per claim or no more than 5 claims within the past five years.
• Not excluded from SAMS.
• Lack of present illegal drug use.
• Attest to any felony convictions.
• No unexplained gaps in work history.
• Obtain disclosure of Ownership and control of network provider
• Lack of fraud, waste and abuse documentation from Audit Department or FWA Response Team.

4. Process for making credentialing and recredentialing decisions:
   Decision-making is governed by a majority vote of the Credentialing Committee for practitioners who do not meet minimum HAP standards and is nondiscriminatory. Each decision is based upon information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies Committee decisions will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance. All credentialing activities are in compliance with NCQA, State of Michigan Department of Consumer and Industry Services Bureau of Health Services, and all other applicable laws and regulatory bodies.

The Credentialing Committee considers all applicants, including those who have been granted waivers in the context of all available information. In the case of waivers, the Committee must weigh the lack of adherence to standards with factors such as:
   • Perceived value to HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Midwest Health Plan, Inc.) and/or the membership, which merits approval despite failure to meet the standard, and/or
   • Perceived professional qualities, which may not be appropriately reflected in the HAP standard requiring board certification and residency training, including:
     a. Demonstrated motivation to participate in HAP and follow managed care procedures
     b. Special need for practitioners in the geographic area/network
     c. Reputation in the community
     d. Prominence in the network’s managed care organization
     e. Professional experience/Continuing Medical Education experience
     f. Partnership with current HAP practitioners of perceived exceptional quality
   • Board certification waivers are reviewed for initial applicants only. To be considered for a board certification waiver, the practitioner must submit a letter of recommendation including network need from their (hospital) department chair or three letters of recommendation from HAP contracted and credentialed practitioners. Board certification waivers will be considered for approval or denial at the discretion of Credentialing Committee.
   • Board certification extensions are granted to recredentialing applicants who provide proof from board stating they are scheduled to sit for the exam. Credentialing Committee reserve the right for approval or denial of Board certification extensions.
• Physician’s certificates that expired and who fail to become recertified, or those physicians whose board eligible period expired or lapsed and have no plans of certifying or recertifying must provide a written explanation to Credentialing Committee to continue their affiliation. Credentialing Committee reserves the right for approval or denial.

• The Credentialing Committee may determine that some applicants who meet minimum HAP standards should not be approved for participation, for example:
  – Lack of demonstrated motivation to participate cooperatively as a practitioner and follow the managed care/quality management procedures
  – Lack of perceived need for practitioners in the geographic area/network
  – Unfavorable reputation in the community
  – Lack of good standing at affiliated hospital
  – Perceived lack of quality of medical school/residency experience
  – Failure to comply with the ethics of the profession

5. Process for managing credentialing files that meet the organization’s established criteria:
• All credentialing files that do not meet minimum credentialing standards must be reviewed by the Credentialing Committee.
• Credentialing files that meet minimum credentialing standards, “clean files”, are reviewed and approved by the medical director or an equally qualified practitioner.
• Medical Director’s Review of Clean Files.
  a. The Medical Director reviews and approves all practitioners that meet minimum requirements.
  b. The Medical Director’s approval is obtained through a handwritten signature.
  c. The list of clean files is documented in the meeting minutes and the total number of clean files is presented to the Credentialing Committee.

6. Process for delegating credentialing or recredentialing:
• The credentialing process for affiliation with HAP may be delegated to another credentialing body if the potential delegate passes the pre-delegated evaluation, along with the approval from the Credentialing Oversight Committee and a signed executed mutually agreed upon delegated agreement.
• In all cases, HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Midwest Health Plan, Inc.) retains ultimate authority over the process and engage in oversight activities to ensure that minimum standards are applied (Refer to CR 8 Delegated Credentialing).

7. Process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner:
• The Credentialing Committee does not discriminate on the basis of the applicant’s race, nationality/country of origin, gender, age, sexual orientation, or types of procedures or patients cared for by the practitioner.
• All members and guests of the Credentialing Committee sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis.
• On an annual basis the Credentialing Committee reviews credentialing files (in-process, denied and approved files) to ensure that there is no pattern of discrimination or evidence of individual discrimination.

8. Process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization:
• If the information received varies substantially from the information provided on the application, the credentialing staff requests clarification from the practitioner and
provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to provider by certified mail or secured e-mail.

9. **Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision:**
Practitioners are notified within 60 calendar days of the committee’s decision.
- Approval notices are forwarded from Credentialing to Provider Contracting for processing and distribution to the practitioners.
- Denial notices are sent from Credentialing to the practitioner via certified mail.

10. **Medical director or other designated physician’s direct responsibility and participation in the credentialing program:**
- The Medical Director is responsible for the Credentialing and Oversight Committees.
- The Medical Director ensures that HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Midwest Health Plan, Inc.) carries out its credentialing activities in the most efficient, effective way possible and that all credentialing activities are in compliance with the Credentialing Policies, NCQA standards, State of Michigan Department of Consumer and Industry Service Bureau of Health Services, and all other applicable laws and regulations. The Medical Director may approve initial and recredentialing files that meet all credentialing criteria or may determine that additional review is necessary by the Credentialing Committee.

11. **Process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law:**
- All members and guests of the Credentialing and Oversight Committees sign a statement of confidentiality and nondiscriminatory decision-making on an annual basis.
- Members and guests of the Credentialing and Oversight Committees will not discuss or share information that was obtained at this meeting, or in preparation or follow-up to the meeting. Information is to be utilized only as it is originally intended.
- Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Oversight Committee in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.
- Committee members and guests will not discuss, share or use any peer review information for any purpose other than peer review.
- Access to credentials documents will be restricted to authorized staff, Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Oversight.
- Minutes, reports and files of Credentialing Oversight Committee meetings will be maintained in a confidential manner in locked cabinets or in the physicians file imaging system. The physician file once it has been imaged is transferred offsite in a secure and restricted environment for the duration of seven (7) years. At the end of seven (7) years, the file is shredded/destruction in compliance with Offsite Records Storage, Retrieval, Destruction (Office Services Corporate Policy).
- Copies of the minutes will not be allowed to be removed from the site of the Credentialing Committee. All minutes and documentation will be shredded immediately following the meeting.
- The identity of a person whose condition or treatment has been studied in the Committee is confidential and the Committee shall remove the person’s name and address from the record before the Committee releases or publishes a record of its proceedings, or its report, findings, and conclusions. Except as otherwise provided, the record of proceedings and the reports, findings, and conclusions and data collected by
or for this Committee are confidential, are not public records, and are not discoverable and shall not be used as evidence in a civil action or administrative proceeding.

- Disclosure of credentialing information is limited to information needed (i.e., name, address, network, specialty, education and training, board certification status, hospital affiliation) for provider directory, provider assignment or on-line directory.
- All Credentialing staff is required to change their passwords every 180 days. For maintaining confidentiality, staff will not write down their password; but remember it. If a user leaves the organization, a system administrator will make sure to delete that person's user account within 30 days.

12. Process for ensuring those listings in practitioner directories and other materials for members are consistent with credentialing data.
   - The practitioner directory excludes all practitioners that are not independently contracted and credentialed who practice in an inpatient setting. The directory may differ based on member's benefit level.
   - Practitioner-specific information, including education and training, board certification status, specialty, hospital affiliation, gender and language information, that is made available to HAP and its subsidiaries (all products lines) and the general public is derived directly from the Credentialing department's database.
   - All practitioner-specific information (education and training, board certification status, specialty, hospital affiliation, gender and language information) is verified through the credentialing process and entered into CACTUS. After the Credentialing Committee's approval, this information is entered into the claims database, where practitioner directories and all practitioner-specific information are derived.
   - The Credentialing staff is responsible for entering practitioner specific information into CACTUS. Any discrepancies are validated and corrected within 30 days.
   - Practitioner-specific information is also validated during the recredentialing process which takes place every three years.

Practitioners Rights

1. HAP notifies practitioner about their rights to:
   - It is the practitioner's right to review information obtained to evaluate the practitioners credentialing application, attestation or CV.
   - Each practitioner has the right to review certain information obtained during the verification process. Practitioners do not have the right to review information such as recommendations or other information that is considered to be peer-review protected.
   - The practitioner may review credentialing policies and procedures upon written request.

2. Correction of erroneous information:
   - If the information received varies substantially from the information provided on the application, HAP requests clarification from the practitioner and provides the practitioner an opportunity to amend the erroneous information. Notification of erroneous information is sent to provider by certified mail or secured e-mail.
   - The practitioner is asked to respond in writing within 14 days of receipt of the certified letter.
   - The practitioner mails the response to the Manager of Credentialing by certified mail.
   - If the practitioner chooses to exercise his or her right to correct the erroneous information:
     - HEALTH ALLIANCE PLAN and its subsidiaries (Alliance Health Life Insurance Company, HAP Preferred Inc. and HAP Midwest Health Plan, Inc.) further investigate the primary source information.
− This information, along with the practitioner's response, is presented to the Credentialing Committee for review and resolution.
− The practitioner is notified via certified mail within 14 days of the Credentialing Committee's decision.
− If the practitioner chooses not to exercise his or her right to correct the erroneous information, or does not respond within 14 days:
  − The information is presented to the Credentialing Committee for review and resolution, without input from the practitioner.
  − The practitioner is notified of the committee decision via standard procedure.

3. **Receive the status of their credentialing or recredentialing application, upon request:**
   - If the practitioner requests the status of his/her application, HAP provides practitioner with approximate date when the application will be presented to the Credentialing Committee and any outstanding primary source verification letters either by telephone or written correspondence. Practitioners do not have the right to review information such as recommendations or other information that is considered to be peer-review protected.

4. **Notification of Practitioner Rights:**
   - Practitioners are notified of these rights upon their initial request for a contract and on an ongoing basis. CR1 is sent along with the initial request for a contract. Credentialing policies and procedures are made available to all HAP contracted practitioners on an ongoing basis on the provider portal of the website and practitioners are notified annually and offered hard copies of the policies and procedures if web access is unavailable.
**Ongoing Monitoring**

We conduct ongoing monitoring of practitioner sanctions, complaints and quality and safety issues within 30 days of its release between formal credentialing and takes appropriate actions against practitioners when it identifies an occurrence of poor quality.

**Collecting and reviewing Medicare and Medicaid sanctions and reviews information within 30 calendar days of its release by the reporting entity.**

Verifies practitioners’ Medicaid and Medicare status from a query of one of the following:
- AMA Physician Master File Entry
- FEHB Program Department Record, published by the Office of Personnel Management, Office of the Inspector General
- NPDB-HIPDB
- List of Excluded Individuals and Entities (maintained by OIG), available over the internet
- Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracted organizations
- State Medicaid agency or intermediary and the Medicare intermediary
- SAMS web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits

**Collecting and reviewing sanctions or limitation on license and reviews information within 30 calendar days of its release by the reporting entity.**

Reviews physician sanctions or limitation on licensure status from a query of one of the following:
- Disciplinary Action Report, published by the Michigan Department of Consumer & Industry Services
- NPDB-HIPDB

Reviews non-physician healthcare practitioner sanctions or limitation on licensure status from a query of one of the following:
- Appropriate state agencies
- NPDB-HIPDB
- State licensure or certification board

**Reviewing provider/practitioners self-reporting and individual/employee screening:**
- Providers are required to self-report claim/payment errors immediately to HAP Empowered.
- Providers are required to conduct screening on individuals/employees to be compliant MDHHS-OIG guidelines.
Section 4: Provider Services

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
<td>Genesee, Huron, Lapeer,</td>
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<tr>
<td></td>
<td>• HAP Empowered MIChild</td>
<td>Macomb, Oakland, Sanilac,</td>
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<tr>
<td></td>
<td>• HAP Empowered Children's Special Health Care Services</td>
<td>Shiawassee, St. Clair,</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Healthy Michigan Plan</td>
<td>Tuscola and Wayne</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

Communicating with providers

HAP Empowered communicates with its provider network via its website at hap.org/empoweredproviders. It contains the most up to date information including:

- Pertinent policies and procedures
- Weekly member eligibility
- Financial information, including pay for performance information and remittance advices
- Clinical guidelines
- Provider Manual


Member advocacy

HAP Empowered does not prohibit any participating practitioner or allied health professional from discussing treatment options with members, regardless of benefit coverage, or from advocating on behalf of a member in any grievance, utilization review process or individual authorization process to obtain health care services. Practitioners may freely communicate with patients about their treatment, including medication treatment options, regardless of benefit coverage limitations. Since the member’s participation is an integral part of making decisions about their treatment and care, HAP Empowered encourages providers to develop care plans with their patients or their patients’ guardians or representatives.

Primary care physician—coordinator of care

The PCP is responsible for supervising, coordinating and providing primary care to HAP Empowered members. A PCP is an MD or DO who is listed as a practitioner in family practice, general practice, internal medicine or pediatrics. The PCP develops a plan of care collaboratively with the member, specialists, social workers, hospitals, rehabilitation clinics, other clinicians, and family members.

Ob-Gyn practitioners, physician assistants, nurse practitioners and other specialists may be designated as PCPs if they agree to act as the PCP for certain chronic conditions or circumstances.

Female members are provided access to a women’s health specialist within the provider network to provide for women’s necessary preventive and routine health care services. This is in addition to the member’s designated PCP if that provider is not a women’s health specialist.
PCP reporting requirements
Participating PCPs must submit all encounters with assigned members to HAP Empowered. We are required to submit this information to the MDHHS.

Payment Structure
Fee-for-service
The PCP fee-for-service contract will process claims for all primary care and referral services at amounts equal to the current Medicaid fee-for-service rates.

Primary care physician pay-for-performance bonus program
HAP Empowered has a pay-for-performance program, also called P4P, for PCPs. Payment is based on quality outcomes for specific measures. Annually, we review our P4P and may revise it based on quality outcomes from the measurement year and goals set for the upcoming year.

Note: HAP Empowered reserves the right to use practitioner performance data for activities designed to improve quality of care and services and overall member experience.

PCP accessibility and availability
PCPs are required to:

- Provide covered services seven days a week, 24 hours per day.
- Be available to see patients a minimum of 20 hours per location per week.
- Give written prior notice to HAP Empowered of alternative coverage arrangements during times of non-availability. PCPs should encourage their members to contact them whenever possible, prior to seeking health care services outside of their office.
- Offer office hours to HAP Empowered Medicaid members that are no less than those offered to commercial members or for HAP Empowered Medicaid fee-for-service members.
- Be actively enrolled in The Community Health Automated Medicaid Processing System or CHAMPS on date of service. 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.
## Access to care standards

Per the HAP Empowered Health Plan contract, all providers must follow the access and availability standards outlined below.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Standard</th>
<th>Measurement Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Government Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Availability of Practitioners</strong>: HAP Empowered Health Plan will assure the availability of primary and key specialty practitioners to its members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Primary Care Practitioners (PCPs)</td>
<td>Ratio of PCPs to members: 1:500</td>
<td>On an annual basis HAP Empowered reviews and updates the ratios of PCP's to membership, per the MDHHS Medicaid Contract</td>
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<tr>
<td>- General and Internal Medicine</td>
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<tr>
<td>- Family Practice</td>
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<tr>
<td>- Pediatricians</td>
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<td></td>
</tr>
<tr>
<td>Number of Key Specialty Practitioners (High-Volume)</td>
<td>Ratio of Practitioners to members: 1:4,000</td>
<td>On an annual basis HAP Empowered will compute the ratios of SCPs to membership, using provider and member data from the claims systems. Membership is defined as the total enrolled population, or relevant population for Obstetrics/ Gynecology (female members).</td>
</tr>
<tr>
<td>- OB/GYN</td>
<td></td>
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</tr>
<tr>
<td>- Top 2 Specialties based on high-volume claims data</td>
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</tr>
<tr>
<td>Number of High-Impact Practitioners</td>
<td>1:4,000</td>
<td>On an annual basis HAP Empowered will compute the ratio of high-impact specialists to membership, using provider and member data from claim systems.</td>
</tr>
<tr>
<td>- Oncology</td>
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<tr>
<td>Geographic access: Distance to PCPs, Specialists and Hospital Services. Specialists include:</td>
<td>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.</td>
<td>HAP Empowered will conduct an annual analysis using GeoNetworks software, provider data from the claims systems per the MDHHS Medicaid Contract</td>
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<tr>
<td>- OB/GYN</td>
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<tr>
<td>- Top 2 Specialties based on high-volume claims data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic access: Distance to High Impact Specialists</td>
<td>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</td>
<td>HAP Empowered will conduct an annual analysis using GeoNetworks software, provider data from the claims systems per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>- Oncology</td>
<td></td>
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<tr>
<td>Outpatient Behavioral Health*</td>
<td>Onoutpatient Behavioral Health* Services will be 30 minutes/30 miles for non-rural and 75 minutes/75 miles for Rural from a member's home.</td>
<td>HAP Empowered will conduct an annual analysis using GeoNetworks software, provider data from the claims systems per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>Accessibility of Services: Service will be provided “in the appropriate time frame”</td>
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</tr>
<tr>
<td>Topic</td>
<td>Standard</td>
<td>Measurement Tool</td>
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<td>----------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medicaid Government Program</td>
<td></td>
<td>Appointment lead time: Primary Care</td>
</tr>
<tr>
<td>• Preventive (regular) or Routine Care – care provided in asymptomatic situations to prevent the occurrence or progression of conditions</td>
<td>Within 30 business days of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Primary Care Physicians (PCP) and Specialty practices, the CAHPS Survey and the After-Hours Telephone Access Survey per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Non-urgent Symptomatic care – care provided in symptomatic non-urgent conditions</td>
<td>Within 7 business days of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Primary Care Physicians (PCP) and Specialty practices and CAHPS Survey per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Urgent care – care for serious, but nonemergency injury or illness</td>
<td>Within 48 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Primary Care Physicians (PCP) and Specialty practices and CAHPS Survey per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• After hours care</td>
<td>Physicians or their designee shall be available by telephone twenty-four (24) hours per day, seven (7) days per week.</td>
<td>Performance will be monitored in the annual After-Hours Telephone Access survey per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Emergency Services</td>
<td>Immediately 24 hours/day; 7 days a week</td>
<td>Performance will be monitored in the annual After-Hours Telephone Access Survey per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Wait time in the office--How long before the member is seen by the provider after checking in with the receptionist?</td>
<td>Less than 30 minutes</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Primary Care Physicians (PCP) and Specialty practices</td>
</tr>
<tr>
<td>Accessibility of Services: Service will be provided “in the appropriate time frame”</td>
<td></td>
<td>Appointment lead time: High-Volume Specialist and High-Impact Specialist</td>
</tr>
<tr>
<td>• Acute Specialty Care (Non-Urgent with symptoms)</td>
<td>Within 5 business days of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Specialty Care (Routine without symptoms)</td>
<td>Within 6 weeks of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Urgent care – care for serious, but nonemergency injury or illness</td>
<td>Within 48 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>Accessibility of Services: Service will be provided “in the appropriate time frame”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Standard</td>
<td>Measurement Tool</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td>Medicaid Government Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment lead time: Behavioral Health*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine Care</td>
<td>Within 10 business days of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Non-life threatening emergency</td>
<td>Within 6 hours of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Urgent care – care for serious, but nonemergency injury or illness</td>
<td>Within 48 hours of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>Accessibility of Services: Service will be provided “in the appropriate time frame”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment lead time: Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Dental Services</td>
<td>Immediately 24 hours/day 7 days per week</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Routine Care</td>
<td>Within 21 business days of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Preventive Services</td>
<td>Within 6 weeks of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Urgent care – care for serious, but nonemergency injury or illness</td>
<td>Within 48 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
<tr>
<td>• Initial Appointment</td>
<td>Within 8 weeks of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract</td>
</tr>
</tbody>
</table>

*Behavioral health is limited to covered services
<table>
<thead>
<tr>
<th>Topic</th>
<th>Standard</th>
<th>Measurement Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
<td><strong>Standard</strong></td>
<td><strong>Measurement Tool</strong></td>
</tr>
<tr>
<td><strong>MMP Government Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Availability of Practitioners:</strong> HAP Empowered Health Plan will assure the availability of primary and key specialty practitioners to its members</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Primary Care Practitioners (PCPs)</strong></td>
<td>Ratio of PCPs to members</td>
<td>On an annual basis HAP Empowered will use the ratio of the combination of PCPs to membership, per the MMP 3-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table. Membership is defined as the total enrolled population.</td>
</tr>
<tr>
<td>• General and Internal Medicine</td>
<td>Minimum 33 providers</td>
<td></td>
</tr>
<tr>
<td>• Family Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pediatrists</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of Key Specialty Practitioners</strong></td>
<td>Ratio of Practitioners to members</td>
<td>On an annual basis HAP Empowered will use the ratio of the combination of high-volume specialists to membership, per the MMP 3-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table. Membership is defined as the total enrolled population, or relevant population for Obstetrics/Gynecology (female members).</td>
</tr>
<tr>
<td>• OBGYN</td>
<td>OBGYN minimum 2 provider</td>
<td></td>
</tr>
<tr>
<td>• Top 2 Specialties based on high-volume claims data</td>
<td>Top 2 Specialties minimum number of providers per CMS MMP HSD criteria</td>
<td></td>
</tr>
<tr>
<td><strong>Number of High-Impact Practitioners</strong></td>
<td>Ratio of Practitioners to members</td>
<td>On an annual basis HAP Empowered will use the ratio of high-impact specialists to membership, Per the MMP 3-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table</td>
</tr>
<tr>
<td>• Oncology</td>
<td>Oncology minimum 4 providers</td>
<td></td>
</tr>
<tr>
<td><strong>Geographic access: Distance to PCPs, Specialists and Hospital Services. Specialists include:</strong></td>
<td>A PCP and Pediatricians will be</td>
<td>HAP Empowered will conduct an annual analysis using GeoNetworks software and provider data from the claims systems. Per the MMP 3-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table</td>
</tr>
<tr>
<td>• OB/GYN</td>
<td>10 minutes/5 miles from a member's home.</td>
<td></td>
</tr>
<tr>
<td>• Top 2 Specialties based on high-volume claims data</td>
<td>OBGYN will be 30 minutes/15 miles from a member's home</td>
<td></td>
</tr>
<tr>
<td><strong>Geographic access: Distance to High Impact Specialists</strong></td>
<td>Oncology will be 20 minutes/10 miles from a member's home</td>
<td>HAP Empowered will conduct an annual analysis using GeoNetworks software and provider data from the claims systems. Per the MMP 3-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table</td>
</tr>
<tr>
<td>• Oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accessibility of Services:</strong> Service will be provided “in the appropriate time frame”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment lead time: Primary Care</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among PCP and Specialist practices, the CAHPS Survey and After-hours Telephone Access Survey.</td>
<td></td>
</tr>
<tr>
<td>• Preventive (regular) and Routine care – care provided in asymptomatic situations to prevent the occurrence or progression of conditions</td>
<td>Within 30 days of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among PCP and Specialist practices and CAHPS Survey</td>
</tr>
<tr>
<td>• Non-urgent Symptomatic care – care provided in</td>
<td>Within 24 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among PCP and Specialist practices and CAHPS Survey</td>
</tr>
<tr>
<td>Topic</td>
<td>Standard</td>
<td>Measurement Tool</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>MMP Government Program</strong></td>
<td>symptomatic non-urgent conditions</td>
<td>practices and CAHPS Survey per the MMP 3-Way Contract</td>
</tr>
<tr>
<td><strong>Urgent care</strong> – care for serious, but nonemergency injury or illness</td>
<td>Within 24 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among PCP and Specialist practices and CAHPS Survey per the MMP 3-Way contract</td>
</tr>
<tr>
<td><strong>After-hours care</strong></td>
<td>Physicians or their designee shall be available by telephone twenty-four (24) hours per day, seven (7) days per week.</td>
<td>Performance will be monitored in the annual After-Hours Telephone Access survey per the MMP 3-Way Contract</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Immediately 24 hours/day 7 days a week</td>
<td>Performance will be monitored in the annual After-Hours Telephone Access survey per the MMP 3-Way Contract</td>
</tr>
<tr>
<td><strong>Wait time in the office</strong> – How long before the member is seen by the provider after checking in with the receptionist?</td>
<td>Less than 30 minutes</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among PCP and Specialist practices</td>
</tr>
</tbody>
</table>

**Accessibility of Services:** Service will be provided “in the appropriate time frame”

**Appointment lead time:** High Volume Specialist and High Impact Specialist

<table>
<thead>
<tr>
<th>Topic</th>
<th>Standard</th>
<th>Measurement Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Specialty Care (Non-Urgent with symptoms)</strong></td>
<td>Within 24 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MMP 3-way Contract</td>
</tr>
<tr>
<td><strong>Specialty Care (Routine without symptoms)</strong></td>
<td>Within 6 weeks of request</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations</td>
</tr>
<tr>
<td><strong>Urgent care</strong> – care for serious, but nonemergency injury or illness</td>
<td>Within 24 hours</td>
<td>Performance will be monitored in the annual Access to Care Survey conducted among Specialist practices or available data reported by provider organizations per the MMP 3-Way Contract</td>
</tr>
</tbody>
</table>

**Pharmacy access requirements**
Pharmacy services are available within 30 minutes travel time and during evenings and weekends.
PCP request for member transfer

Sometimes, a HAP Empowered member may make it medically impossible to safely or prudently render care. Examples include:

- Forging or altering prescriptions
- Fraud or misrepresentation
- Medical non-compliance
- Patient and physician incompatibility
- Violent or life-threatening behavior

As a result, the PCP may request the member to transfer to another HAP Empowered provider or be removed from the plan. The transfer process is outlined below.

PCP process

1. Submit a written request to the HAP Empowered Medical Director to transfer or disenroll the member. The letter must:
   - Clearly indicate the reason for the request and the specific incidents that led to the request.
   - Include supporting documentation including medical records, police or security reports, incident reports.
2. The PCP should wait for HAP Empowered to notify the member.

HAP Empowered process

1. The Medical Director or designee reviews the documentation and requests clarification or additional information from the PCP as appropriate. Note: failure to respond to such requests will result in denial of the transfer or disenrollment.
2. If the request for transfer or disenrollment is approved, HAP Empowered will send the appropriate notice to the member, PCP and the State of Michigan. The member must receive 30-days advance notice to allow adequate time to select another provider or make other arrangements for health care services.

For more information, please contact HAP Empowered Customer Service at (888) 654-2200.
Section 5: Customer Service

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
</table>
| HAP Empowered Medicaid        | • Traditional Medicaid  
                               | • HAP Empowered MIChild  
                               | • HAP Empowered Children's Special Health Care Services  
                               | • HAP Empowered Healthy Michigan Plan | Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne |
| HAP Empowered MI Health Link  | Integrated Care for Medicare and Medicaid Dual Eligible | Macomb and Wayne                 |

The material in this section applies to all plans unless otherwise noted.

The Customer Service department is the first point of contact. Customer Service representatives are trained to respond to all member and provider questions and concerns.

<table>
<thead>
<tr>
<th>Member/Plan</th>
<th>HAP Empowered Customer Service</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>(888) 654-2200 (TTY: 711)</td>
<td>7:30 a.m. to 5:30 p.m.</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>(888) 654-0706 (TTY: 711)</td>
<td>7:30 a.m. to 8:00 p.m.</td>
</tr>
</tbody>
</table>

Language interpretation is with an interpreter and a HAP Empowered representative on the phone.

PCP assignment

New members enrolled in a HAP Empowered plan via Michigan ENROLLS can select a HAP Empowered PCP at the time of plan selection or HAP Empowered will assign one to them no later than 30 days after the effective date of enrollment. PCP assignments are based on the member's zip code in relation to the PCP's office zip code.

Member accessibility to PCP services

HAP Empowered is committed to ensuring accessible and timely medical care and services for all members as outlined below.

- Members have a PCP for routine medical care and specialty referrals.
- HAP Empowered provides reasonable availability and accessibility to primary care by ensuring that the size of the contracted provider network is adequate and contains providers who are available to members within 30 minutes travel time and/or 30 miles of the member's residence.
- All HAP Empowered PCPs must be available, make the appropriate coverage available in their absence, for their assigned HAP Empowered members on a 24-hour per day, seven days per week basis, for urgent care and emergency care referrals.

Member request for PCP transfers

Members in a HAP Empowered plan have the right to request a transfer to another HAP Empowered PCP by calling the appropriate Customer Service number below.

<table>
<thead>
<tr>
<th>Member/Plan</th>
<th>HAP Empowered Customer Service</th>
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<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
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<td>(888) 654-0706 (TTY: 711)</td>
<td>7:30 a.m. to 8:00 p.m.</td>
</tr>
</tbody>
</table>

Language interpretation is with an interpreter and a HAP Empowered representative on the phone.

HAP Empowered reserves the right to immediately transfer any member to another PCP, specialist, ancillary provider or hospital, if the member’s health or safety is in jeopardy.
Member complaints and grievance resolution

HAP Empowered has a centralized process to address, resolve and track all member complaints and grievances. All members receive written information outlining this process in their welcome packet.

The Customer Service department receives, investigates, tracks and responds to all member complaints and grievances. A HAP Empowered representative may contact PCP offices during the investigation. A prompt response from the PCP is important and appreciated.

All formal complaints and grievances are tracked monthly and quarterly and reported to the Peer Review Committee, Quality Improvement Committee and the Board of Directors. A semi-annual report is submitted to the MDHHS per contractual requirements.

Dental care

Dental care is an important part of your patient’s overall health. Dental benefits for your HAP Empowered patients are outlined below.

<table>
<thead>
<tr>
<th>Dental care for</th>
<th>Benefit details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>Dental services are a covered benefit for pregnant women. Pregnant members will receive a Delta Dental benefit card. They can receive dental services during pregnancy through the last day of the third calendar month after pregnancy due date.</td>
</tr>
<tr>
<td>Children</td>
<td>The state of Michigan’s Medicaid program covers dental care for children. The state contracts with Delta Dental and Blue Cross Blue Shield of Michigan. Together, they provide a network of dentists for children ages 0-20. Children are enrolled automatically and get an ID card from the dental plan.</td>
</tr>
</tbody>
</table>

If your HAP Empowered patients have questions about their dental benefits, they can call HAP Empowered Customer Service at (888) 654-2200 (TTY: 711).

Transportation

If a member in a HAP Empowered plan can’t obtain transportation for medical services, we will coordinate it for them. Members must declare there are no resources available to them. Members can request transportation services by calling the appropriate Customer Service number below, at least three business days prior to their scheduled appointments.

<table>
<thead>
<tr>
<th>Member/Plan</th>
<th>HAP Empowered Customer Service</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>(888) 654-2200 (TTY: 711)</td>
<td>7:30 a.m. to 5:30 p.m.</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>(888) 654-0706 (TTY: 711)</td>
<td>7:30 a.m. to 8:00 p.m.</td>
</tr>
</tbody>
</table>

Language interpretation is with an interpreter and a HAP Empowered representative on the phone.

Wheelchair lift vans and child car seats are available upon request. All requests for same-day and next-day transportation depend on transportation company availability.

Mileage reimbursement is available to the member and anyone who drives them to and from their medical appointment.
Language interpretation and services for hearing and speech impaired

HAP Empowered is committed to maintaining open lines of communication with all members and providers. We've contracted with vendors to provide language interpretation services and services for communicating with hearing- and speech-impaired members. This is a free service for our members.

For more information on using these services, please call Customer Service.

<table>
<thead>
<tr>
<th>Member/Plan</th>
<th>HAP Empowered Customer Service</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>(888) 654-2200 (TTY: 711)</td>
<td>7:30 a.m. to 5:30 p.m.</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>(888) 654-0706 (TTY: 711)</td>
<td>7:30 a.m. to 8:00 p.m.</td>
</tr>
</tbody>
</table>

Language interpretation is with an interpreter and a HAP Empowered representative on the phone.

Member's rights and responsibilities – HAP Empowered Medicaid members

Below are the member's rights and responsibilities. They can also be found in the member's handbook.

Members have a right to:

- Be treated with respect and their right to privacy and confidentiality.
- Get care that meets their health needs.
- Get information about HAP Empowered Health Plan’s services and providers, practitioners and rights and responsibilities.
- Work with doctors in decision making about their health care.
- Choose or change their PCP.
- A candid talk of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Decide what type of care they would want if critically ill. This is called Advance Directive.
- Get medical care through a Federally Qualified Health Center.
- Take part in decisions about their health care including refusing treatment or asking about treatment options.
- Ask for advice from another doctor when they are not sure about the care their doctor suggests.
- Ask for a copy of their medical records and ask for amendments or corrections.
- Get timely service from Customer Service.
- Voice complaints or appeals about HAP Empowered Health Plan or the care HAP Empowered Health Plan provides.
- Call or visit the Customer Service department to file an oral or a written grievance or appeal.
- Ask for an administrative fair hearing with the Department of Health and Human Services.
- Ask for their grievance to be reviewed by the Department of Financial and Insurance Services if they are unhappy with the decision made by HAP Empowered Health Plan.
- Get information about HAP Empowered Health Plan operations and structure or make suggestions regarding HAP Empowered Health Plan’s services and providers. Make suggestions about HAP Empowered Health Plan member rights and responsibilities.
- Be free of any form of restraint or seclusion used as a way to coerce, discipline, convenience or retaliate.
- Receive a second medical opinion from an in-network provider.
- Receive a second medical opinion from an out-of-network provider, if an in-network provider is not available. If an in-network provider is not available, the plan will arrange for an out-of-network provider. Plan approval is required.
Members have a responsibility to:

- Keep good health habits.
- Learn how HAP Empowered Health Plan works.
- Follow HAP Empowered Health Plan policies for getting health care services.
- Choose a PCP.
- Show their HAP Empowered Health Plan and MI Health cards when they need care.
- Make sure no one else uses their HAP Empowered Health Plan and MI Health cards.
- Treat other members, HAP Empowered Health Plan staff and providers with respect.
- Give information, to the extent possible, that HAP Empowered Health Plan and their doctors need to give them the care they need.
- Understand their health problems and work with their doctor to develop care that you both agree on.
- Follow plans and advice for care that they have agreed to with their doctor.
- Keep scheduled appointments. Arrive on time. If they cannot keep their appointment, call their doctor as soon as they can.
- Report any suspected fraud and abuse.
- Know what to do when their PCP’s office is closed.
- Call us to give us the new address and phone number if they move or change their phone number. For HAP Empowered Medicaid, call (888) 654-2200. For HAP Empowered MI Health Link, call (888) 654-0706. They must call their caseworker at their local Department of Human Services office.
- Call their DHS worker and let them know about the changes, if they have a baby, or if their family size changes for any reason. Call HAP Empowered Health Plan and let us know too.

**Member rights and responsibilities - HAP Empowered MI Health Link members**

Members of HAP Empowered MI Health Link are guaranteed the rights on the following list. Specifically, they are guaranteed:

- The right to be treated with dignity and respect
- The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law
- The right to be provided a copy of their medical records, upon request, and to request corrections or amendments to these records, as allowed
- The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information or source of payment
- The right to have all plan options, rules and benefits fully explained, including through use of a qualified interpreter if needed
- Access to an adequate network of primary and specialty providers who are capable of meeting their physical access, communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting
- The right to choose a plan and provider at any time, and have that choice become effective the first calendar day of the following month. This includes choosing a plan other than ours
- The right to have a voice in the governance and operation of the integrated system, provider or health plan
- The right to participate in all aspects of care, including the right to refuse treatment and to exercise all rights of appeal
• They have a responsibility to be fully involved in maintaining their health and making
decisions about their health care, including the right to refuse treatment if desired, and they
must be appropriately informed and supported to this end. Specifically, they must:
  – Receive a Health Risk Assessment upon enrolling in our plan and participate in the
development and implementation of their Individual Integrated Care and Supports Plan.
The assessment will include considerations of social, functional, medical, behavioral,
wellness and prevention domains, an evaluation of their goals, preferences, strengths
and weaknesses and a plan for managing and coordinating Their care. They, or their
authorized representative, also have the right to request a reassessment by the
Integrated Care Team and be fully involved in any such reassessment.
  – Receive complete and accurate information on their health and functional status by the
Integrated Care Team.
  – Be provided information on all program services and health care options, including
available treatment options and alternatives, presented in a culturally appropriate
manner, taking into consideration their condition and ability to understand. If they are
unable to participate fully in treatment decisions, they have the right to designate a
representative. This includes the right to have translation services available to make
information appropriately accessible at the time their needs necessitate the disclosure
and delivery of such information in order to allow them to make an informed choice.
  – Be encouraged to involve caregivers or family members in treatment discussions and
decisions.
  – Have advance directives explained and to establish them if they so desire.
  – Receive reasonable advance notice, in writing, of any transfer to another treatment
setting and the justification for the transfer.
  – Be afforded the opportunity file an appeal if services are denied that they think are
medically indicated, and to be able to ultimately take that appeal to an independent
external system of review.
  – Receive medical and non-medical care from a team that meets their needs, in a manner
that is sensitive to their language and culture, and in an appropriate care setting,
including their home and community.
  – Be free from any form of restraint or seclusion used as a means of coercion, discipline,
convenience or retaliation.
  – Be free to exercise their rights and that the exercise of those rights does not adversely
affect the way our plan, our providers or the State Agency treats you.
  – Receive timely information about plan changes. This includes the right to request and
obtain the information listed in the orientation materials at least once per year, and the
right to receive notice of any significant change in the information provided in the
orientation materials at least 30 calendar days prior to the intended effective date of the
change.
  – Be protected from liability for payment of any fees that are the obligation of the ICO.
  – Not to be charged any cost sharing for any services they receive as part of this plan.
  – Be given information on how to contact their Care Coordinator.
Section 6: Member Eligibility and Enrollment

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
</table>
| HAP Empowered Medicaid   | • Traditional Medicaid  
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                          • HAP Empowered Children’s Special Health Care Services  
                          • HAP Empowered Healthy Michigan Plan                   | Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne |
| HAP Empowered MI Health Link | Integrated Care for Medicare and Medicaid Dual Eligible                | Macomb and Wayne                                            |

The material in this section applies to all plans unless otherwise noted.

The Michigan Department of Health and Human Services determines the beneficiary's eligibility for public assistance.

Michigan ENROLLS, the enrollment broker for Michigan Medicaid programs, provides educational material about the Medicaid health plans available in the member’s county. Michigan ENROLLS assists Medicaid members in choosing the health plan of their choice. If the member doesn’t choose a health plan, Michigan ENROLLS will auto assign one to them.

Plans are notified monthly via a data file exchange of the Medicaid members enrolled in their plan.
<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Eligibility criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children's Special Health Care Services</strong>&lt;br&gt;Persons with Special Health Care Needs</td>
<td>A health care program for children and some adults with special health care needs</td>
<td>• Qualifying medical condition.&lt;br&gt;• Age:&lt;br&gt;  - Children must be under the age of 21&lt;br&gt;  - Persons 21 and older with cystic fibrosis or certain hereditary blood coagulations disorders commonly known as hemophilia may also qualify.&lt;br&gt;• Citizenship:&lt;br&gt;  - A US citizen.&lt;br&gt;  - A documented non-citizen who has been admitted for permanent residence.&lt;br&gt;  - A non-citizen legally admitted migrant farm worker (i.e., seasonal agricultural worker).&lt;br&gt;• Must be a Michigan resident.</td>
</tr>
<tr>
<td>Dual eligible</td>
<td>Secondary coverage for cost sharing portion of the fee-for-service Medicare primary coverage</td>
<td>• Persons with both Medicare and full Medicaid eligibility.&lt;br&gt;• Have full Medicaid coverage in addition to FFS Medicare.</td>
</tr>
<tr>
<td><strong>Healthy Michigan Plan</strong></td>
<td>A health insurance program for Michigan residents at a low cost so that more people can have health care coverage</td>
<td>• Age 19 - 64 years.&lt;br&gt;• Have income at or below 133% of the federal poverty level.&lt;br&gt;• Doesn’t qualify for or not enrolled in Medicare.&lt;br&gt;• Doesn’t qualify for or not enrolled in other Medicaid programs.&lt;br&gt;• Not pregnant at the time of application.&lt;br&gt;• Michigan residents.</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>Comprehensive health care coverage provided by the state for people of all ages with low income</td>
<td>Determined by the state. Criteria include:&lt;br&gt;• Age.&lt;br&gt;• Income.&lt;br&gt;• Financial resources.&lt;br&gt;• Other information.</td>
</tr>
<tr>
<td><strong>MiChild</strong></td>
<td>A health insurance program for the uninsured for children of Michigan’s working families</td>
<td>• Must be a US citizen (some legal immigrants qualify).&lt;br&gt;• Must live in Michigan.&lt;br&gt;• Must be under age 19.&lt;br&gt;• Family must meet income requirements.&lt;br&gt;• Children must not have other insurance coverage.</td>
</tr>
<tr>
<td><strong>MI Health Link</strong></td>
<td>Complete health care coverage for people in specific Michigan counties who are age 21 and over and currently enrolled in both Medicare and Medicaid</td>
<td>• Age 21 and older.&lt;br&gt;• Enrolled in both Medicare and Medicaid.&lt;br&gt;• Not enrolled in hospice.&lt;br&gt;• Live in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren or Wayne counties or any county in the Upper Peninsula.</td>
</tr>
</tbody>
</table>
New members
We mail a welcome packet with plan and benefit information to new members within 10 calendar days from receipt of enrollment data from MDHHS or CMS. The ID card is sent separately by first class mail. The welcome packet is sent by standard mail.

The contents of each welcome packet are outlined below:

- **HAP Empowered Medicaid Packets**
  - Welcome letter
  - Medicaid Member Handbook

- **HAP Empowered Healthy Michigan Packets**
  - Cover letter
  - Medicaid Member Handbook
  - Health Risk Assessment cover letter
  - Health Risk Assessment
  - Peace of Mind Patient Advocate Designation Form
  - Frequently asked Questions about a Patient Advocate Designation
  - Envelope pre-addressed to Peace of Mind Registry

- **HAP Empowered MI Health Link Packets**
  - ID card
  - Welcome letter
  - Summary of Benefits
  - Member Handbook
  - Non-discrimination Notice
  - Diabetes letter
  - Find your doctors, pharmacies insert

Verifying eligibility
Providers must verify member eligibility prior to rendering services as it can change monthly. Services provided when a member is not enrolled in HAP Empowered will not be covered. Providers can verify eligibility by one of the methods below.

<table>
<thead>
<tr>
<th>HAP provider portal</th>
<th>• Log in at hap.org and select Member Eligibility (for dates of service July 1, 2019 forward. • PCPs can obtain a list of assigned members by logging in at hap.org and selecting Member Eligibility, then Click Here to View Member Roster. The list is updated monthly.</th>
</tr>
</thead>
</table>
| HAP Empowered Customer Service | HAP Empowered Medicaid: (888) 654-2200  
HAP Empowered MI HealthLink: (888) 654-0706 |
| CHAMPS web portal | milogintp.michigan.gov |
| CHAMPS Provider Support | (800) 292-2550, option 5, then 2 |
ID Cards

HAP Empowered Medicaid members carry two ID cards:

- **Michigan Medicaid ID Card**
  This card should indicate if the member is enrolled in Michigan Medicaid.

![Michigan Medicaid ID Card](image)

- **HAP Empowered Medicaid ID Card**
  This card if for members enrolled in HAP Empowered Medicaid, HAP Empowered Children’s Special Health Care Services, HAP Empowered Healthy Michigan Plan.

![HAP Empowered Medicaid ID Card](image)

HAP Empowered MI Health Link members have one ID card.

![HAP Empowered MI Health Link ID Card](image)

**Note:**
- Possession of a HAP Empowered ID card does not guarantee member eligibility or coverage.
- Providers must verify eligibility prior to services being rendered to guarantee payment.
- Any member who abuses the enrollment card by allowing others to use it to fraudulently obtain services will be reported to the MDHHS or the CMS for immediate termination from the plan.
- If you suspect a non-eligible person using a member's ID card, please report the occurrence to the HAP Empowered Compliance Hotline at *(877) 746-2501 (TTY: 711)*. The number is available 24/7.
Disenrollment from a plan

HAP Empowered Medicaid

The MDHHS allows for disenrollment from Medicaid health plans as outlined below:

- **Enrollment errors by MDHHS**
  If a non-eligible individual or Medicaid member who resides outside the plan's service area is enrolled in a Medicaid plan and the MDHHS is notified within 15 days of enrollment effective date, the MDHHS will retroactively disenroll the individual. If the MDHHS is notified 15 days after the enrollment effective date, the MDHHS will disenroll the enrollee prospectively the first day of the next month.

- **Special disenrollment**
  HAP Empowered may initiate special disenrollment requests to the MDHHS if the member exhibits any of the following:
  - Violent or threatening behavior involving physical acts of violence
  - Making physical or verbal threats of violence against contracted providers, staff or the public at HAP Empowered locations
  - Stalking

**HAP Empowered MI Health Link**

HAP Empowered may never, verbally, in writing or by any other action or inaction, request or encourage a HAP Empowered MI Health Link member to disenroll except when the member:

- Has a change in residence* (includes incarceration)
- Loses entitlement to either Medicare Part A or Part B
- Loses Medicaid eligibility
- Dies
- Materially misrepresents information regarding reimbursement for third-party coverage

*When members permanently move out of the HAP Empowered MI Health Link service area or leave HAP Empowered’s service area for over six consecutive months, they must disenroll from HAP Empowered MI Health Link.
Section 7: Referrals and Authorizations

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
<td>Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered MIChild</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Children’s Special Health Care Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Healthy Michigan Plan</td>
<td></td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

HAP Empowered does not require referrals to see an in-network specialist. The specialist may require a referral from the member’s PCP. Some services and procedures require prior authorization. Referrals and prior authorizations must be obtained prior to services being rendered.

Urgent requests should be marked urgent. Urgent requests will be accepted when the member or their physician believes waiting for a decision under the standard time frame could place the member’s life, health or ability to regain maximum function in serious jeopardy.

Referrals and prior authorization for services should be made to in-network providers whenever possible. Contracted providers can be found in our online provider directory at hap.org. To refer a member to an out-of-network provider, call our Referral Management department at (313) 664-8950.

Non-contracted providers should contact our Referral Management department at (313) 664-8950 for authorizations.

Submitting a referral or prior authorization

The member’s PCP or the servicing provider (e.g. DME provider, specialist) obtains the referral and prior authorization online by:

- Logging in at hap.org and selecting Authorizations.

Supporting clinical documentation must be included with all requests.

Requests must be timely, complete and legible. Otherwise the results may be:

- Delays in processing the request
- Claims denials
- Unnecessary delays or cancellations of procedures

Requests for the services below should not be submitted online. Instead, fax the request to (313) 664-5820. You can also call (313) 664-8800. You can inquire about a request currently being processed for placement or ask questions about the precertification process.

- Inpatient rehabilitation at hospitals
- Long-term care at hospitals
- Skilled nursing facilities
- Subacute rehabilitation
Criteria used in decision making
We use objective and evidenced-based criteria when determining the medical appropriateness of requested health care services. This includes criteria from:

- Interqual
- The Centers for Medicare & Medicaid Services
- The state of Michigan
- Internally developed and adopted criteria based on industry standards with input and review from participating physicians

Decisions are based on the accepted local practice of medicine and health delivery system characteristics and the patient’s:

- Age
- Co-morbidities
- Home environment, when applicable
- Individual needs
- Medical complications
- Current treatment progress
- Psychosocial situation

Authorization decisions are mailed to the PCP and servicing provider. The PCP should give a copy to the member and retain a copy in their medical record.

Prior authorization decision timeframes

<table>
<thead>
<tr>
<th>Request type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent pre-service</td>
<td>A decision will be provided as quickly as the clinical condition warrants, not to exceed 15 calendar days, or 14 calendar days for Medicare Advantage and HAP Empowered MI Health Link members.</td>
</tr>
<tr>
<td>Urgent pre-service</td>
<td>A decision will be provided within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Post-service decisions</td>
<td>A decision will be provided within 30 calendar days of the request; 14 calendar days for Medicare Advantage and HAP Empowered MI Health Link members.</td>
</tr>
</tbody>
</table>

Prior authorization requests

Only certain procedures, care or equipment require an approved authorization. For example:

- Anesthesia for oral surgery
- Bariatric procedures
- Breast reconstruction
- Breast reduction
- Chemotherapy
- Chiropractic services
- Cosmetic surgery (e.g. blepharoplasty, scar revision)
- Durable medical equipment
- Home health care
- Hospice care
- Human organ transplant
- In-office infusion therapy (specific medications)
- Nursing home care (non-custodial)
- Prosthetics and orthotics
- Occupational therapy
- Oxygen and related supplies
- Physical therapy
- Services with a non-contracted provider
- Some elective ambulatory surgeries and invasive procedures
- Speech therapy
- Transplant services

For a complete list of services that require authorization, log in at hap.org and select Procedure Reference Lists under Quick Links.

The following in-network services do not require plan notification:

- Allergy testing
- Obstetrics and gynecology
- Outpatient specialty physician consults and services
- Outpatient diagnostics
- Outpatient mental health visits
- Routine radiology services
Per the terms of our contract with the MDHHS, members may access any of the following services directly, without prior authorization or referral from their PCP or HAP Empowered:

- Emergency room services - facility and professional components
- Emergency transportation
- Family planning services or OB services at any provider
- Services provided by Federally Qualified Health Centers
- Services provided by Public Health Departments
- STD services at any provider
- Well-child exams with a contracted pediatrician
- Well-women exams with a contracted provider

**Skilled nursing**

HAP Empowered members have a skilled nursing benefit as follows:

<table>
<thead>
<tr>
<th>Membership</th>
<th>Number of days allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>45 days</td>
</tr>
<tr>
<td></td>
<td>Note: If additional time is needed, the member would be disenrolled to straight Medicaid. The HAP Empowered Health Services department will assist with this process.</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>100 days</td>
</tr>
</tbody>
</table>

**Important**

- This benefit covers inpatient admissions to physical rehabilitative facilities, not substance abuse rehabilitation facilities.
- The medical director or designee reviews the admission request for appropriateness of admission, length of stay, etc.
- Custodial care is not a covered benefit except for HAP Empowered MI Health Link members.

**Second opinions**

HAP Empowered covers second opinions. If an in-network provider isn't available for a second opinion, the member can visit an out-of-network provider. An approved prior authorization is required. There is no cost to the member.

**Vision services**

Vision services include eye examination (refraction), lenses and frames. Members in HAP Empowered plans can access vision services directly by contacting Heritage Optical at (800) 252-2053. Contracted vision providers can be found in our online provider directory at hap.org.

**Behavioral health care**

HAP Empowered members requiring mental health services may obtain these services by:

- Obtaining a referral from their PCP to a plan approved psychiatrist or contracted behavioral health provider
- Self-referring to a contracted psychiatrist or contracted behavioral health care provider

For emergencies, members can go to the closest hospital that provides psychiatric services.

HAP Empowered Medicaid does not cover substance abuse services. Members should be referred to the Community Mental Health board in the county where they live.
**Case management**

The HAP Empowered case management programs assist members in following the plan of care prescribed by their physician. It helps them regain or maintain optimum health or functional capability in the right setting in a cost-effective manner. Participation in case management is voluntary and members can terminate at any time.

A comprehensive evaluation of the social well-being, mental health and physical health is done to determine the barriers to adhering to the plan of care.

Goals are set in conjunction with all parties involved in the member's care. The program is dependent upon the cooperative participation of HAP Empowered, contracted ancillary providers, physicians, hospitals and the member, to ensure timely, effective and medically realistic goals.

The program is structured to ensure qualified individuals make medical decisions using nationally recognized criteria and without undue influence of HAP Empowered's fiscal operation.

To initiate an evaluation for case management services, contact the Health Services department at (888) 654-2200. Select option 3, then option 1.

**Elective hospital admissions**

Authorization is not required prior to the member's admission to the hospital. **However, the procedure or surgery may require prior authorization.** The hospital is responsible for obtaining the authorization within 24 hours or the next business day after the admission. Requests can be submitted online. Log in at hap.org and select Authorizations. Include appropriate clinical information. Physicians and hospitals are subject to non-payment if procedures are deemed unnecessary. We review all hospital admissions using:

- CMS surgical list
- Established HAP criteria
- InterQual criteria
- InterQual surgical list

**Emergent hospital admissions**

- Prior authorization is not required for emergency admissions.
- Providers are not required to call HAP prior to – or at the time of – an emergent inpatient admission.
- Authorization requests should be submitted online after admission to allow collection of the appropriate clinical data. You can log in at hap.org and select Authorizations.
- Requests will not be denied for late notification if they are received within 24 hours or the next business day of the admission.
- All hospital admission requests are reviewed using:
  - CMS surgical list
  - Established HAP criteria
  - InterQual criteria
  - InterQual surgical list

Providers can find approval status online by logging in at hap.org and selecting Authorizations.

**Laboratory services**

We provide coverage for laboratory services. Prior authorization is required for genetic testing.
Section 8: Long-Term Services and Supports for HAP Empowered MI Health Link Members

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Service area (counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered MIChild</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Children’s Special Health Care Services</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Healthy Michigan Plan</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

Qualified HAP Empowered MI Health Link members have access to a variety of long-term services and supports and home and community-based services to help them meet daily needs for assistance independently and improve their quality of life.

LTSS and HCBS benefits are provided over an extended period, mainly in member homes and communities. They are also available in facility-based settings (e.g., nursing facilities), or as outlined in a member's individual integrated care and supports plan.

Overall, the HAP Empowered model of care promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care. HAP Empowered care managers work closely with community partners and HCBS providers to expedite evaluation and access to services.

The HAP Empowered MI Health Link program provides seamless coordination between medical care, LTSS, HCBS and mental health and substance use benefits covered by Medicare and Medicaid.

Home and Community Based Services (HCBS) Waiver that our plan pays for include:

- Adult day program
- Assistive technology
- Chore services
- Environmental modifications
- Expanded Community Living Supports*
- Fiscal Intermediary Services*
- Home delivered meals
- Non-medical transportation
- Preventive nursing services
- Private duty nursing
- Respite care services

The above services require prior authorization.
Section 9: Billing & Reimbursement

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
</tr>
</thead>
</table>
| HAP Empowered Medicaid | • Traditional Medicaid  
                       | • HAP Empowered MIChild  
                       | • HAP Empowered Children’s Special Health Care Services  
                       | • HAP Empowered Healthy Michigan Plan                                |
|                       | Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne |
| HAP Empowered MI Health Link | Integrated Care for Medicare and Medicaid Dual Eligible |
|                       | Macomb and Wayne |

The material in this section applies to all plans unless otherwise noted.

Our department makes every effort to ensure prompt and accurate claims processing, adjudication and payment.

We contract with the Centers for Medicare & Medicaid Services and the Michigan Department of Health and Human Services. We follow billing guidelines for claims processing under each contract unless otherwise indicated in this section.

Claims contact information

<table>
<thead>
<tr>
<th>Member/Plan</th>
<th>HAP Empowered Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>(888) 654-2200, select prompt 2, then 2</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>(888) 654-0706, select prompt 2, then 2</td>
</tr>
</tbody>
</table>

CHAMPS

Per the MDHHS, 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.

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](http://michigan.gov/medicaidproviders).
Ensure claims for your HAP Empowered patients get paid

Effective December 21, 2019, please follow the guidelines below when submitting claims for your HAP Empowered patients.

- Do not use payer ID MHP77.
- Do not submit claims via the HAP Empowered website.
- Submit claims with any date of service to HAP Empowered as follows:
  - For electronic claims submission:
    - Use direct connection with HAP or Change Healthcare clearinghouse
    - Use HAP Payer ID 38224
  - For paper claims submission, send to:
    HAP Empowered Claims
    P.O. Box 2578
    Detroit, MI 48202

Reminder for checking status on claims already submitted

Please follow the guidelines below when checking claims status.

<table>
<thead>
<tr>
<th>For Claims with dates of service prior to July 1, 2019</th>
<th>Log in at hap.org with your vendor login and password and select:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <strong>Claims</strong> and then the appropriate link:</td>
</tr>
<tr>
<td></td>
<td><strong>HAP Empowered Historical Information</strong></td>
</tr>
<tr>
<td></td>
<td>• <strong>Remittance Advice</strong>; then this link:</td>
</tr>
<tr>
<td></td>
<td>Click here to view the documents for dates of service prior to July 1, 2019 for your HAP Empowered patients. (Remittance Advice, EDI Claims Errors, EDI 835, Pickup EDI 999 Files, Pickup EDI 277CA Files, Vendor Financial Statements)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For Claims with dates of service July 1, 2019, forward</th>
<th>Log in at hap.org with your vendor login and password and select:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Claims or Remittance Advice.</strong></td>
</tr>
</tbody>
</table>

If you have any questions, please contact (888) 654-2200 and follow the prompts.

Ensure claim adjustments for your HAP Empowered patients get paid

Effective December 21, 2019, claim adjustments (e.g., corrected claims, replacement claims and voided claims) must be submitted for your HAP Empowered patients as outlined below.

<table>
<thead>
<tr>
<th>For Dates of Service</th>
<th>Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to July 1, 2019</td>
<td>Via paper to:</td>
</tr>
<tr>
<td></td>
<td>HAP Empowered Claims</td>
</tr>
<tr>
<td></td>
<td>PO Box 2578</td>
</tr>
<tr>
<td></td>
<td>Detroit, MI 48202</td>
</tr>
<tr>
<td></td>
<td>Note: Claim adjustments submitted electronically for these dates of service will reject.</td>
</tr>
<tr>
<td>July 1, 2019 and forward</td>
<td><strong>Electronically via:</strong></td>
</tr>
<tr>
<td></td>
<td>Change Healthcare clearinghouse and use Payer ID: 38224</td>
</tr>
<tr>
<td></td>
<td><strong>Paper to:</strong></td>
</tr>
<tr>
<td></td>
<td>HAP Empowered Claims</td>
</tr>
<tr>
<td></td>
<td>PO Box 2578</td>
</tr>
<tr>
<td></td>
<td>Detroit, MI 48202</td>
</tr>
</tbody>
</table>
Out-of-network providers
Out-of-network providers must follow the HAP Empowered referral requirement and claims submission processes.

<table>
<thead>
<tr>
<th>Member plan</th>
<th>HAP Empowered Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>(888) 654-2200, Select prompt 2, then 1.</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>(888) 654-0706, Select prompt 2, then 1.</td>
</tr>
<tr>
<td>All language interpretation is done with an interpreter and the HAP Empowered representative on the phone.</td>
<td></td>
</tr>
</tbody>
</table>

EFT registration
- If you're currently are set up for EFT with HAP, there is nothing you need to do.
- If you aren't set up for EFT with HAP, please complete an EFT form. Log in at hap.org; select Resources, Working with HAP; Billing Information; Sign Up for Electronic Billing.

Verifying member eligibility
Providers must verify member eligibility and effective dates of health plan enrollment before rendering covered services. You can verify member eligibility by one of the methods below.

| HAP provider portal | • Log in at hap.org and select Member Eligibility (for dates of service July 1, 2019 forward).  

- PCPs can obtain a list of assigned members by logging in at hap.org and selecting Member Eligibility, then Click Here to View Member Roster. The list is updated monthly.  |
|---------------------|----------------------------------------------------------------------------------------------------------------------|
| HAP Empowered Customer Service | HAP Empowered Medicaid: (888) 654-2200  

HAP Empowered MI HealthLink: (888) 654-0706 |
| CHAMPS web portal | milogintp.michigan.gov  |
| CHAMPS Provider Support | (800) 292-2550, option 5, then 2 |

Members in HAP Empowered plans are entitled to all covered services provided by traditional Medicare and Medicaid Managed Care.

Filing limitations

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>Filing timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters for capitated services</td>
<td>Submit within 30 days from the date of service</td>
</tr>
<tr>
<td>Initial claim for non-capitated services</td>
<td>Submit within 180 days from the date of service</td>
</tr>
<tr>
<td>COB claims where other carrier is primary when primary carrier was billed within their filing limits, and the carrier's EOP identifies payment or denial of the claim</td>
<td>Submit within 60 days from the notification date of the other carrier EOP. Be sure to attach other carrier's EOP to your claims when submitting to HAP Empowered.</td>
</tr>
<tr>
<td>Rejected claims</td>
<td>Resolved within one year from the date of service</td>
</tr>
<tr>
<td>Claims appeals</td>
<td>Must be filed within 60 days from the original denial date</td>
</tr>
<tr>
<td>Claim complaints or disputes</td>
<td>Must be filed within 60 days from the date of the original remittance advice</td>
</tr>
</tbody>
</table>
**General billing guidelines**

- Submit claims for complete episode of care.
- Do not bill future dates of service.
- Do not submit single claim with date span across calendar years except in the case of inpatient facility MS-DRG and APR-DRG billing.
- Submit supporting documentation for unlisted CPT/HCPCS codes.
- Interim billing is not accepted.
- Indicate the appropriate HAP Empowered product name in the upper right corner on CMS-1500 claim form and in field 61 on the CMS-1450 (UB-04) form.
- Claims and encounters must be computer generated or typed and signed by the servicing provider and submitted via:
  - Paper
    - A CMS-1500 Claim form
    - A CMS-1450 (UB-04) Claim form
    - Electronically through the clearing house Change HealthCare
- Handwritten entries are not acceptable anywhere on the claim form except for the signatures.
- Electronic signatures are acceptable.
- Mandatory items on claim forms must be completed or the claim cannot be processed. Refer to claim form submission guidelines within this section.
- Conditional items, if applicable, on claim forms are required or the claim may not be processed. Refer to claim form submission guidelines within this section.
- Blank items may be left empty and will not affect claims processing. Refer to claim form submission guidelines within this section.
- All claims must contain an NPI number submitted as follows:
  - Field 24 J of the CMS-1500 form
  - FL 56 of the UB-04 form
- Submit the member ID number as follows:

<table>
<thead>
<tr>
<th>Product</th>
<th>Billing ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>Use the 11-digit HAP member ID number from the HAP Empowered MI Health Link ID card.</td>
</tr>
<tr>
<td>HAP Empowered Medicaid</td>
<td>Use the 11-digit HAP ID number from the HAP Empowered Medicaid ID card.</td>
</tr>
</tbody>
</table>

For more information and instructions on completing claim forms, visit cms.hhs.gov and click on *Regulation and Guidance*, then under Guidance, click on *Manuals*.

**Clean claims**

- HAP Empowered pays clean claims within 30 days.
- If any mandatory or conditional information is missing, the claim is considered unclean. Examples of unclean claims: invalid member ID, provider data discrepancy, NPI and tax ID do not match.
- Unclean claims will be returned or rejected within 60 days for HAP Empowered MI Health Link and 30 days for HAP Empowered Medicaid.

**Returned claims**

- Paper claims are returned when they can't be entered due to invalid information such as the billing provider not being in system or the member not being enrolled in a HAP Empowered plan.
- It’s important to resubmit these claims within filing time limits.
Rejected claims

- Claims are rejected when pertinent information is available to enter the claim in the system, but information needed to complete the reimbursement adjudication process is missing.
- Be sure to review rejections from your remittance advice and resubmit corrections within filing limits.

Claim form submission guidelines

CMS-1500 version (02-12)

Legend

- Mandatory - Must be completed. If blank, the claim can’t be processed.
- Conditional - If applicable, it is required. If left blank, the claim can’t be processed.
- Blank - May be left empty and will not affect the processing of your claim.

<table>
<thead>
<tr>
<th>Field locator</th>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blank</td>
<td>Patient/Insured Information</td>
</tr>
<tr>
<td>1a</td>
<td>Mandatory</td>
<td>Insured's ID Number as shown on insured’s ID card</td>
</tr>
<tr>
<td>2</td>
<td>Mandatory</td>
<td>Enter the patient’s last name, first name, and middle initial (if any) in that order.</td>
</tr>
<tr>
<td>3</td>
<td>Mandatory</td>
<td>Enter the patient’s eight-digit birthdate (MMDDYY) and sex.</td>
</tr>
<tr>
<td>4</td>
<td>Conditional</td>
<td>Mandatory if the patient has other insurance primary to Medicaid</td>
</tr>
<tr>
<td>5</td>
<td>Blank</td>
<td>Enter patient’s current address.</td>
</tr>
<tr>
<td>6</td>
<td>Conditional</td>
<td>If item 4 is complete, check the appropriate box, Patient relationship to Insured.</td>
</tr>
<tr>
<td>7</td>
<td>Conditional</td>
<td>Complete if item 4 and 11 are completed.</td>
</tr>
<tr>
<td>8</td>
<td>Blank</td>
<td>Reserved for National Uniform Claim Committee use.</td>
</tr>
<tr>
<td>9</td>
<td>Conditional</td>
<td>Mandatory if item 11d is YES.</td>
</tr>
<tr>
<td>9a</td>
<td>Conditional</td>
<td>Enter second insurance policy or group number for policyholder in item 9.</td>
</tr>
<tr>
<td>9b</td>
<td>Blank</td>
<td>Reserved for NUCC Use.</td>
</tr>
<tr>
<td>9c</td>
<td>Blank</td>
<td>Reserved for NUCC Use.</td>
</tr>
<tr>
<td>9d</td>
<td>Conditional</td>
<td>Enter insurance plan name or program name for policyholder in item 9.</td>
</tr>
<tr>
<td>10a</td>
<td>Mandatory</td>
<td>Check YES or NO if condition is employment-related.</td>
</tr>
<tr>
<td>10b</td>
<td>Mandatory</td>
<td>Check YES or NO if condition is related to an auto accident. If YES, indicate state postal code.</td>
</tr>
<tr>
<td>10c</td>
<td>Mandatory</td>
<td>Check YES or NO if condition is related to accident other than auto.</td>
</tr>
<tr>
<td>10d</td>
<td>Blank</td>
<td>Claim codes (Designated by NUCC)</td>
</tr>
<tr>
<td>11</td>
<td>Conditional</td>
<td>Mandatory if patient has insurance primary to Medicaid. Enter primary insurance policy group number.</td>
</tr>
<tr>
<td>11a</td>
<td>Conditional</td>
<td>Enter date of birth (MMDDYY) and sex for policyholder in item 4.</td>
</tr>
<tr>
<td>11b</td>
<td>Conditional</td>
<td>Enter the employer’s name or school for policyholder in item 4.</td>
</tr>
<tr>
<td>11c</td>
<td>Conditional</td>
<td>Enter insurance plan name or program name for policyholder in item 4.</td>
</tr>
<tr>
<td>11d</td>
<td>Conditional</td>
<td>Check YES, if appropriate and complete item 9 – 9d.</td>
</tr>
<tr>
<td>12</td>
<td>Blank</td>
<td>Patient or authorized person’s signature</td>
</tr>
<tr>
<td>13</td>
<td>Blank</td>
<td>Insured’s or authorized person’s signature</td>
</tr>
<tr>
<td>14</td>
<td>Conditional</td>
<td>If item 10b or 10c is YES, date of accident must be reported.</td>
</tr>
<tr>
<td>15</td>
<td>Blank</td>
<td>Other date</td>
</tr>
<tr>
<td>16</td>
<td>Blank</td>
<td>Dates patient unable to work in current occupation</td>
</tr>
<tr>
<td>Field locator</td>
<td>Status</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17</td>
<td>Mandatory</td>
<td>Enter the referring/ordering physician’s name.</td>
</tr>
<tr>
<td>17 a, b</td>
<td>Mandatory</td>
<td>17a: Enter other ID# of the provider in item 17, if available. 17b: Enter NPI# of referring, ordering or supervising provider.</td>
</tr>
<tr>
<td>18</td>
<td>Conditional</td>
<td>Report the admit and discharge dates for services during an inpatient hospital stay.</td>
</tr>
<tr>
<td>19</td>
<td>Conditional</td>
<td>May leave blank at this point or enter documentation or remarks as required</td>
</tr>
<tr>
<td>20</td>
<td>Blank</td>
<td>Outside lab charges</td>
</tr>
<tr>
<td>21</td>
<td>Mandatory</td>
<td>Enter the ICD_10 CM (e.g. using 4th or 5th digits) or ICD-10 diagnosis codes, using up to 7 characters, to the highest level of specificity that describes the patient's condition. Enter the applicable ICD indicator to identify which version of the ICD is being reported. Maximum of 12 diagnosis can be entered.</td>
</tr>
<tr>
<td>22</td>
<td>Conditional</td>
<td>Resubmission code 7 and original form #</td>
</tr>
<tr>
<td>23</td>
<td>Conditional</td>
<td>Enter the Empowered prior authorization number for services requiring an authorization or the 10-digit CLIA number as appropriate. For authorization requirements, log in at <a href="http://hap.org">hap.org</a>; select Procedure Reference Lists under Quick Links.</td>
</tr>
<tr>
<td>24A</td>
<td>Mandatory</td>
<td>Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. Enter the month, day and year for each procedure, using the format &quot;MMDDYY.&quot; Date spans on a single claim should not cross years.</td>
</tr>
<tr>
<td>24 B,C</td>
<td>Mandatory</td>
<td>Enter the appropriate 2-digit place of service. Emergency indicator Y=yes, N=no</td>
</tr>
<tr>
<td>24D</td>
<td>Mandatory</td>
<td>Procedures, services or supplies (CPT or HCPCS) modifier</td>
</tr>
<tr>
<td>24E</td>
<td>Mandatory</td>
<td>Diagnosis pointer</td>
</tr>
<tr>
<td>24F</td>
<td>Mandatory</td>
<td>Enter your charge without decimals, commas or dollar signs.</td>
</tr>
<tr>
<td>24G</td>
<td>Mandatory</td>
<td>Enter the number of units.</td>
</tr>
<tr>
<td>24H</td>
<td>Blank</td>
<td>EPSDT/Family Plan</td>
</tr>
<tr>
<td>24I</td>
<td>Mandatory</td>
<td>Qualifying ID if other than NPI</td>
</tr>
<tr>
<td>24J</td>
<td>Mandatory</td>
<td>Rendering Provider ID# shaded area for non-NPI #'s; non-shaded area, NPI required</td>
</tr>
<tr>
<td>25</td>
<td>Mandatory</td>
<td>Enter the provider’s Federal Tax ID or Social Security Number.</td>
</tr>
<tr>
<td>26</td>
<td>Mandatory</td>
<td>Enter the patient account number assigned by the provider or supplier.</td>
</tr>
<tr>
<td>27</td>
<td>Blank</td>
<td>Accept Assignment.</td>
</tr>
<tr>
<td>28</td>
<td>Mandatory</td>
<td>Enter sum of charges in 24F.</td>
</tr>
<tr>
<td>29</td>
<td>Conditional</td>
<td>Report amount of other insurance payment.</td>
</tr>
<tr>
<td>30</td>
<td>Blank</td>
<td>Reserved for NCUU Use.</td>
</tr>
<tr>
<td>31</td>
<td>Mandatory</td>
<td>Signature of provider or supplier and date</td>
</tr>
<tr>
<td>32</td>
<td>Mandatory</td>
<td>Enter name and address of facility where services were rendered.</td>
</tr>
<tr>
<td>33 a,b</td>
<td>Mandatory</td>
<td>Billing provider’s or supplier’s name, address, zip code and phone number (a) Billing provider’s NPI  (b) other ID number</td>
</tr>
</tbody>
</table>

**Note:** The provider ID number entered in box 33 must correspond with the EIN or SSN entered in box 25 and the provider in box 31. If they don’t match, the W-9 information on file will be returned for invalid provider information.
Taxonomy Codes Required on Professional Claims

Effective January 1, 2020, taxonomy codes are required when submitting professional claims for all HAP and HAP Empowered lines of business. This is consistent with National Uniform Billing Guidelines and is critical for accurate and timely claims processing.

Taxonomy codes should be submitted as follows:

- **On a CMS-1500 claim form:**
  - **Rendering**
    - Box 24i should contain the qualifier ZZ
    - Box 24j should contain the taxonomy code
  - **Billing**
    - Box 33b should contain the qualifier along with the taxonomy code
  - **Referring**
    - If a referring provider is indicated in box 17 on the claim, then Box 17a should contain the qualifier of ZZ along with the taxonomy code in the next column.

- **Electronic submission**
  Follow the 5010 Implementation Guide for submitting a PRV segment at the billing or rendering level. Please see details below.
  - **Billing**
    PRV01 = BI
    PRV02 = PXC
    PRV03 = <taxonomy code>
  - **Rendering**
    PRV01 = PE
    PRV02 = PXC
    PRV03 = <taxonomy code>

Claims may deny if the taxonomy is missing or incorrect.
NPIs on CMS 1500 Claim Submission

There are two types of NPIs—individual or organization. When submitting claims electronically, the NPIs must match the entity type being submitted within any of the loops that have individual or organizational NPIs. For example:

- Entity type = 1: Must be used when submitting an individual NPI.
- Entity type = 2: Must be used when submitting an organizational NPI.

Claims submitted with the incorrect entity type and NPI combination in any loop will be rejected with the following message:

- NPI and entity type qualifier combination does not align in NPPES or is not active in NPPES.

Below are instructions for the information to submit in Form Locator 32 and 33.

<table>
<thead>
<tr>
<th>Form Locator 32</th>
<th>Billing instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If the “Service Facility Location” is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and “Service Facility Location” is not used.</td>
<td></td>
</tr>
<tr>
<td>• When reporting an NPI in the “Service Facility Location,” the entity must be an external organization to the Billing Provider.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form Locator 33</th>
<th>Billing instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use the “billing” NPI that you would expect to receive payment under. For example:</td>
<td></td>
</tr>
<tr>
<td>• If you’re an individual provider and want to be paid under the individual NPI, then report the individual NPI in box 33a of the CMS-1500 claim form.</td>
<td></td>
</tr>
<tr>
<td>• If you’re a physician group and want to be paid under the group NPI, then report the group NPI in box 33a of the CMS-1500 claim form.</td>
<td></td>
</tr>
</tbody>
</table>

For more information, refer to the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual at nucc.org.

Providers submitting claims electronically can refer to the 837 Implementation Guide for instructions.

Michigan Department of Health and Human Services
Newborn Recoveries

To avoid upfront EDI rejections from HAP Empowered for timely filing limit, newborn recovery claims with a date of service greater than one year must be:

- Billed within 60 days of MDHHS remittance advice date
- Submitted via paper with supporting remittance advice to HAP Empowered at: P.O. Box 2578 Detroit, MI 48202
UB-04 CMS-1450 claims form

For efficient claims processing, please follow the guidelines below.

- Refer to the National Uniform Billing Committee Manual for details on field locator data to be submitted. Visit nubc.org for more information.
- Electronic submission is strongly encouraged.
- For paper submissions, use the red UB-04 form.
- Handwritten claims are not acceptable and will be returned.
- Print must be dark enough to read easily.

<table>
<thead>
<tr>
<th>UB-04 field locator</th>
<th>Field status</th>
<th>Description of field</th>
<th>Information to be included</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mandatory</td>
<td>The name and service location of the provider submitting the bill</td>
<td>Billing provider name, street address and telephone number</td>
</tr>
<tr>
<td>2</td>
<td>Mandatory</td>
<td>Pay to name and address</td>
<td>Address where payments are to be sent if different than FL 1</td>
</tr>
<tr>
<td>3a</td>
<td>Mandatory</td>
<td>Patient control number</td>
<td>Patient’s unique alphanumeric number assigned to facilitate records and posting of payments.</td>
</tr>
<tr>
<td>3b</td>
<td>Conditional</td>
<td>Medical or health record number</td>
<td>The number assigned to the patient’s medical or health record by the provider</td>
</tr>
<tr>
<td>4</td>
<td>Mandatory</td>
<td>Type of bill</td>
<td>A code indicating the specific type of bill. The first digit is a leading zero. Do not include the leading zero on electronic claims.</td>
</tr>
<tr>
<td>5</td>
<td>Mandatory</td>
<td>Federal tax number</td>
<td>Number assigned to the provider by the federal government for tax reporting</td>
</tr>
<tr>
<td>6</td>
<td>Mandatory</td>
<td>Statement covers period</td>
<td>The beginning and ending service dates of the period included on this bill. The from date should not be confused with the admission date in FL 12. Report all services provided to the same patient using only one claim form to ensure correct benefit coverage. Enter both from and through dates using the MMDDYYYY format. Outpatient claims date spans on a single claim should not cross years.</td>
</tr>
<tr>
<td>7</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Mandatory</td>
<td>Patient name and identifier</td>
<td>Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer</td>
</tr>
<tr>
<td>9</td>
<td>Mandatory</td>
<td>Patient address</td>
<td>The complete mailing address of the patient</td>
</tr>
<tr>
<td>10</td>
<td>Mandatory</td>
<td>Patient birth date</td>
<td>In MMDDYYYY</td>
</tr>
<tr>
<td>11</td>
<td>Mandatory</td>
<td>Patient sex</td>
<td>M, F or U=unknown</td>
</tr>
<tr>
<td>12</td>
<td>Mandatory</td>
<td>Admission or start of care date</td>
<td>Start date for episode of care. For inpatient this is the date of the admission.</td>
</tr>
<tr>
<td>13</td>
<td>Conditional</td>
<td>Admission hour</td>
<td>The code referring to the hour during which the patient was admitted to the facility</td>
</tr>
<tr>
<td>14</td>
<td>Mandatory</td>
<td>Priority or type of visit</td>
<td>A code indicating the priority of the admission or type visit</td>
</tr>
<tr>
<td>15</td>
<td>Mandatory</td>
<td>Source of referral of admission or visit</td>
<td>A code indicating the source of the referral of the admission or visit</td>
</tr>
<tr>
<td>UB-04 field locator</td>
<td>Field status</td>
<td>Description of field</td>
<td>Information to be included</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>16</td>
<td>Mandatory</td>
<td>Discharge hour</td>
<td>Code indicating the discharge hour of the patient from inpatient care</td>
</tr>
<tr>
<td>17</td>
<td>Mandatory</td>
<td>Patient discharge status</td>
<td>A code indicating the disposition of discharge status of the patient at the end service</td>
</tr>
<tr>
<td>18-28</td>
<td>Conditional</td>
<td>Condition codes</td>
<td>A code used to identify conditions or events relating to this bill that may affect processing (alphanumeric sequence)</td>
</tr>
<tr>
<td>29</td>
<td>Blank</td>
<td>Reserved</td>
<td>The accident state field contains the two-digit state abbreviation where the accident occurred.</td>
</tr>
<tr>
<td>30</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>31-34, 35-36</td>
<td>Conditional</td>
<td>Occurrence codes and dates</td>
<td>The code and associated date defining a significant event relating to the bill that may affect payer processing. Refer to NUBC Manual for list of codes.</td>
</tr>
<tr>
<td>37</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Conditional</td>
<td>Responsible party name and address</td>
<td>The name and address of the party to whom the bill is being submitted</td>
</tr>
<tr>
<td>39-41</td>
<td>Conditional</td>
<td>Value codes and amounts</td>
<td>A code structure to define amounts or values that identify data elements necessary to process the claim as qualified by the payer organization</td>
</tr>
<tr>
<td>42</td>
<td>Mandatory</td>
<td>Revenue code</td>
<td>Code that identifies specific accommodation, ancillary services or unique billing arrangements</td>
</tr>
<tr>
<td>43</td>
<td>Blank</td>
<td>Revenue description</td>
<td>The standard abbreviated description of the related revenue code included on the bill</td>
</tr>
<tr>
<td>44</td>
<td>Conditional</td>
<td>HCPCS, accommodation rates and HIPPS rate codes</td>
<td>The HCPCS applicable to ancillary service and outpatient bills, accommodation rate for inpatient bills, HIPPS rate codes</td>
</tr>
<tr>
<td>45</td>
<td>Mandatory</td>
<td>Service date</td>
<td>The date in MMDDYYYY format the outpatient service was provided</td>
</tr>
<tr>
<td>46</td>
<td>Mandatory</td>
<td>Service units</td>
<td>A quantitative measure of services rendered by revenue category to or for the patient</td>
</tr>
<tr>
<td>47</td>
<td>Mandatory</td>
<td>Total charges</td>
<td>Total charges for the primary payer for both non-covered and covered charges</td>
</tr>
<tr>
<td>48</td>
<td>Conditional</td>
<td>Non-covered charges</td>
<td>Noncovered charges for destination payer as it pertains to the related revenue code</td>
</tr>
<tr>
<td>49</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Conditional</td>
<td>Payer identification</td>
<td>The number used by the health plan to identify itself</td>
</tr>
<tr>
<td>51</td>
<td>Conditional</td>
<td>Health plan identification number</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Conditional</td>
<td>Release of information certification indicator</td>
<td>Code indicates whether the provider has a signed statement from the patient on file permitting the provider to release data to another organization</td>
</tr>
<tr>
<td>53</td>
<td>Mandatory</td>
<td>Assignment of benefits</td>
<td>Code indicates provider has a signed form authorizing the third-party payer to remit payment directly to the provider</td>
</tr>
<tr>
<td>UB-04 field locator</td>
<td>Field status</td>
<td>Description of field</td>
<td>Information to be included</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>54</td>
<td>Conditional</td>
<td>Prior payments</td>
<td>The amount the provider has received to date by the health plan toward payment of this bill</td>
</tr>
<tr>
<td>55</td>
<td>Conditional</td>
<td>Estimated amount due</td>
<td>The amount estimated by the provider to be due from the indicated payer</td>
</tr>
<tr>
<td>56</td>
<td>Mandatory</td>
<td>National provider identifier</td>
<td>The unique identification number assigned to the provider submitting the bill</td>
</tr>
<tr>
<td>57</td>
<td>Blank</td>
<td>Other billing provider identifier</td>
<td>A unique identification number assigned to the provider submitting the bill by the health plan</td>
</tr>
<tr>
<td>58</td>
<td>Mandatory</td>
<td>Insured's name</td>
<td>The name of the individual under whose name the insurance benefit is carried.</td>
</tr>
<tr>
<td>59</td>
<td>Mandatory</td>
<td>Patient's relationship to insured</td>
<td>Code indicating the relationship of the patient to the identified insured</td>
</tr>
<tr>
<td>60</td>
<td>Mandatory</td>
<td>Insured's unique identifier</td>
<td>The unique number assigned by the health plan to the insured</td>
</tr>
<tr>
<td>61</td>
<td>Conditional</td>
<td>Insured's group name</td>
<td>The group or plan name through which the insurance is provided to the insured</td>
</tr>
<tr>
<td>62</td>
<td>Conditional</td>
<td>Insured's group number</td>
<td>The identification number, control number or code assigned by the carrier to identify the group under which the individual is covered</td>
</tr>
<tr>
<td>63</td>
<td>Conditional</td>
<td>Treatment authorization code</td>
<td>A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payer</td>
</tr>
<tr>
<td>64</td>
<td>Conditional</td>
<td>Document control number</td>
<td>The control number assigned to the original bill by the health plan as a part of internal control</td>
</tr>
<tr>
<td>65</td>
<td>Conditional</td>
<td>Name of insured's employer</td>
<td>The name of the employer that provides health care coverage for the insured individual in FL</td>
</tr>
<tr>
<td>66</td>
<td>Mandatory</td>
<td>Diagnosis and procedure code qualifier (ICD-9 and ICD-10 version indicator)</td>
<td>The qualifier that denotes the version of International Classification of Diseases</td>
</tr>
<tr>
<td>67</td>
<td>Mandatory</td>
<td>Principal diagnosis code and present on admission indicator</td>
<td>The ICD-9CM codes or ICD-10 describing the principal diagnosis. POA reporting y=yes, n=no, u=unknown</td>
</tr>
<tr>
<td>67a-q</td>
<td>Mandatory</td>
<td>Other diagnosis code</td>
<td>The ICD-9CM or ICD-10 diagnosis codes that coexist at the time of admission</td>
</tr>
<tr>
<td>68</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Mandatory</td>
<td>Admitting diagnosis code</td>
<td>The ICD-9CM or ICD-10 diagnosis code describing the patient's diagnosis at the time of inpatient admission</td>
</tr>
<tr>
<td>70a-c</td>
<td>Mandatory</td>
<td>Patient's reason for visit</td>
<td>The ICD-9CM or ICD-10 diagnosis codes describing the patient's reason for visit at the time of outpatient registration</td>
</tr>
<tr>
<td>71</td>
<td>Conditional</td>
<td>Prospective payment system</td>
<td>The PPS code assigned to the claim to identify the DRG based on the grouper</td>
</tr>
<tr>
<td>72a-c</td>
<td>Conditional</td>
<td>External cause of injury code</td>
<td>The ICD diagnosis codes pertaining to external cause of injuries, poisoning or adverse effect</td>
</tr>
<tr>
<td>73</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Conditional</td>
<td>Principal procedure code and date</td>
<td>The ICD code that identifies the principal procedure performed. Enter the date of that procedure.</td>
</tr>
<tr>
<td>UB-04 field locator</td>
<td>Field status</td>
<td>Description of field</td>
<td>Information to be included</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>74a-e</td>
<td>Conditional</td>
<td>Other procedure codes and dates</td>
<td>The ICD codes identifying all significant procedures other than the principal procedure</td>
</tr>
<tr>
<td>75</td>
<td>Blank</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Conditional</td>
<td>Attending provider name and identifiers</td>
<td>The attending provider is the individual who has overall responsibility for the patient’s medical care and treatment reported in this claim.</td>
</tr>
<tr>
<td>77</td>
<td>Conditional</td>
<td>Operating physician name and identifiers</td>
<td>The name and identification number of the individual with the primary responsibility for performing the surgical procedures</td>
</tr>
<tr>
<td>78-79</td>
<td>Conditional</td>
<td>Other individual provider names and identifiers</td>
<td>The name and ID number of the individual corresponding to the provider type category indicated in this section of the claim</td>
</tr>
<tr>
<td>80</td>
<td>Conditional</td>
<td>Remarks field</td>
<td>Area to capture additional information necessary to adjudicate the claim</td>
</tr>
<tr>
<td>81</td>
<td>Blank</td>
<td>Code-code field</td>
<td>To report additional codes related to a form locator or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set</td>
</tr>
</tbody>
</table>
Specific claim coding requirements

Coordination of benefits
- Medicaid is the payer of last resort.
- Providers must report all other insurance or liability coverage using all other payment resources before submitting a claim to HAP Empowered.
- An explanation of payment or explanation of benefits from the primary carrier must accompany the claim to coordinate benefits.
- Professional, facility and ancillary services not covered by the primary insurance carrier and billed to HAP Empowered must comply with our authorization requirements to be reimbursed. See Referrals and Authorizations section in this manual.
- It’s highly recommended to submit COB claims electronically and indicate the primary insurance detail payments lines in loop 2400. COB claims may be submitted on paper with other insurance explanation of payment attached.

Durable medical equipment, prosthetics and orthotics
- When billing for equipment and supplies that have a descriptor reflecting a daily rate or per diem where the total number of days is used as units, the claim must reflect span dates in the From and To date columns. Example: S5502 (home infusion therapy catheter care/maintenance implanted access device) per diem:
  - Dates on the claim should be reported using the From and To dates.
  - Always include the appropriate modifier on all DMEPOS claims.

E & M billing guidelines
We follow CMS payment guidelines. For more information, visit [cms.gov](http://cms.gov). Click on Regulations & Guidance, then, under Guidance, click on Manuals. Under Manuals click on Internet-Only Manuals (IOMs), and then on Medicare Claims Processing Manual. Select Chapter 12 - Physicians/Non-physician Practitioners and go to Section 30.6.7, 6.9 Payments for Office, Other Outpatient and Inpatient Hospital Visits.

Two E & M services on same date of service
We will pay two E & M office visits billed by a physician, or physician of the same specialty from the same group practice, for the same beneficiary on the same day when it is documented that the visits were for unrelated problems in the office, off-campus outpatient hospital or on-campus outpatient when the E & M procedures are billed for unrelated problems and could not have been provided during the same encounter.

In a hospital inpatient setting, only one E & M is allowed per day, per physician or covering physicians in the same group or specialty. If physicians with different specialties are responsible for different aspects of the patient’s care, both visits may be billed with different diagnoses. We follow CMS payment guidelines.

For more information, visit [cms.gov](http://cms.gov). Click on Regulations & Guidance, then, under Guidance, click on Manuals. Under Manuals click on Internet-Only Manuals (IOMs), and then on Medicare Claims Processing Manual. Select Chapter 12 - Physicians/Non-physician Practitioners and go to Section 30.6.7, 6.9 Payments for Office, Other Outpatient and Inpatient Hospital Visits.
Emergency services
- Medical emergency is defined as services necessary to treat an emergency medical condition.
- Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child
  - Serious impairment to bodily functions or serious dysfunction of any bodily organ or part
- Pursuant to our agreement with the MDHHS, HAP Empowered provides coverage for emergency services and medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (42 USCS 1395 dd (a)).
- HAP Empowered members may receive emergency screening and stabilization services without prior authorization.

Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers
- For services performed on or after Aug. 1, 2017, FQHC, RHC and TCH can submit claims by one of the methods below.
  - Electronic: Use the ASC X12N 837 5010 institutional format.
  - Paper: Use the National Uniform Billing Code claim form.
- Claims submitted after the date above using the professional claim formats CMS-1500 or 837P will be denied. For more information refer to the Medicaid Policy Bulletin: MSA 17-10. You can find these bulletins when you visit Michigan.gov/mdhhs and select: Doing business with MDHHS; Information for Medicaid Providers; Providers; Policy, Letters & Forms.

Long-term support services
- Long-term supports and services include:
  - Nursing facility services
  - State plan personal care services
  - Supplemental services for individuals who live in the community and do not meet nursing facility level of care determination
  - HAP Empowered MI Health Link home and community-based services and waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD.
- These services require authorization.
- Claims can be submitted via:
  - Electronically: Use ASCX12N 5010 837 I (institution)
    Use ASCX12N 5010 837 P (professional)
  - Paper: CMS-1500 claim form or UB-04 claim form based on the service type

Urgent care services
- Bill appropriate level E & M codes for urgent care services. Also include the appropriate codes for all other services provided on the same day.
- Providers will be reimbursed at the Medicaid fee schedule. You can find fee schedules when you visit Michigan.gov/mdhhs. Click on Assistance Programs, then Medicaid, then Providers, then Billing and Reimbursement, then Provider Specific Information.
- For authorization requirements, log in at hap.org and select Procedure Reference Lists under Quick Links.
Modifier GA-Pre-service notice of non-coverage was provided by the plan for HAP Empowered MI Health Link only

- Use modifier GA when:
  - The plan made an organization determination and gave the member a Notice of Denial of Medicare Coverage (CMS-10003) before the enrollee received the non-covered services.
  - The member refused your offer of obtaining a pre-service determination and wanted to proceed with the service.
  - The member wanted to proceed with the service and doesn’t want to appeal a denial of coverage notice from HAP Empowered.
- If you bill for a noncovered service using modifier GA and a plan provider has not referred the enrollee, the claim will go to patient liability and you may bill the member.
- If you bill for a noncovered service without using the GA modifier, HAP Empowered Medicare will deny your claim. It will go to provider liability.

Nine-digit zip code reminder

In 2012, health care providers covered by the Health Insurance Portability and Accountability Act who submit transactions electronically were required to use version 5010 standards for claims and other specific electronic transactions.

In addition, 5010 requires providers to report a nine-digit zip code as part of their practice’s street address and when they report a service facility address.

Claims submitted without a nine-digit zip code will reject during preprocessing.

Payment procedure

- All paper claims and encounters are date stamped on the day received.
- Claims and encounters are processed within 30 days of receipt.
- Payment for all noncapitated, authorized, medically necessary services are paid at current Medicare or Medicaid fee schedules. Note: Contracted rates supersede this statement.
- Providers may not balance bill HAP Empowered Medicaid members or dual eligible members with HAP Empowered MI Health Link for unauthorized services if the enrollee had no prior knowledge of liability for the service.

Remittance advice

<table>
<thead>
<tr>
<th>For</th>
<th>Process</th>
</tr>
</thead>
</table>
| Obtaining a remittance advice for dates of service July 1, 2019, and forward | • Log in at hap.org with your vendor ID and password and select Remittance Advice.  
  **Important!**  
  • Your vendor ID number is a HAP assigned number associated with a tax ID number.  
  • Vendor ID numbers can be found:  
    - On a check stub  
    - Vendor site label in the body of your EFT deposit email |
| Obtaining a remittance advice for dates of service prior to July 1, 2019 | 1. Log in at hap.org with your vendor ID and password.  
  2. Select Remittance Advice.  
  3. Select the link To view HAP Midwest Remittance Advices. |
| 835 file | If you don’t get an 835 from HAP today, contact HAP’s EDI Business Coordinator at eCommerce@hap.org to inquire about electronic claims submission. |
| MI Health Link Remittance Advice | There will be one line item displaying a combined payment for the Medicare and Medicaid components of the MI Health Link plan. |
Explanation codes

Be sure to review the explanation codes on your remittance advice.
- They indicate the reason a service line was rejected.
- They give information about service lines and may point out potential problems.

For a description of the explanation codes, log in at hap.org.

Billing members

Providers who accept a patient as a Medicaid beneficiary with HAP Empowered Medicaid, the beneficiary cannot be billed for:
- Medicaid-covered services, providers must inform the beneficiary before the service is provided if HAP Empowered 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 Empowered.

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.

Balance billing

- Providers may not balance bill HAP Empowered Medicaid members or dual eligible members with HAP Empowered MI Health Link for unauthorized services if the enrollee had no prior knowledge of liability for the service.
- Cost-sharing does not apply to dual eligible members in HAP Empowered MI Health Link or HAP Empowered Medicaid dual eligible. For more information, visit cms.gov. Select Outreach & Education, then, under Find your provider type, select Health & drug plans, then Medical Learning Network® provider compliance.
Balance billing by provider type – HAP Empowered MI Health Link only

The table below is from the Medicare Managed Care Manual-Chapter 4- Benefits and Beneficiary Protections, Section 170.2 (Medicaid).

<table>
<thead>
<tr>
<th>Type of provider</th>
<th>Balance billing rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan contracted and noncontracted providers that are original Medicare participating providers</td>
<td>Balance billing not allowed.</td>
</tr>
<tr>
<td>Noncontracted, non-Medicare participating providers</td>
<td>Bill HAP Empowered the difference between the enrollee’s copayment or coinsurance and the original Medicare limiting charge, which is the maximum amount original Medicare requires a Medicare Advantage Organization to reimburse a provider.</td>
</tr>
<tr>
<td>Noncontracted, non-Medicare participating DME suppliers</td>
<td>Bill HAP Empowered the difference between the enrollee's cost-sharing (copayment or coinsurance) and your charges.</td>
</tr>
</tbody>
</table>

Claim correction and resubmission

Resubmitting a rejected claim – when there is no payment of any service line
- If all service lines of a claim are rejected and the information can be corrected, resubmit all services on a new claim with correct information.
- Facility and professional bills may be submitted as new claims.

Replacement or adjustment claims – for partial payment on previously billed claim
- Claims adjustments should be submitted when:
  - All or a portion of the claim was underpaid or overpaid.
  - Services are added to or deleted from the original submission.
  - A third-party payment was received after HAP Empowered made payment.
- On the replacement claim, be sure to include all service lines from the original claim, not just adjusted lines or the late charge adjustment.
- HAP Empowered will reverse the original claim and reenter the newly billed claims to ensure total adjudication and correct payment.
- Do not submit a claim as an adjustment claim when:
  - There has been no payment issued on the original claim.
  - HAP Empowered had not previously processed the claim.
Checking claims status

Contracted and noncontracted providers can check claims status by one of these methods:

- Logging in at hap.org with username and password and selecting Claims.
  (Note: There’s a link to view HAP Empowered historical information).
- Logging in at hap.org with vendor login and password and selecting Remittance Advice.
  (Note: There is a link to view HAP Empowered claims historical information).
- Calling Customer Service:

<table>
<thead>
<tr>
<th>For</th>
<th>HAP Empowered Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid members</td>
<td>(888) 654-2200, select prompt 2, then 2</td>
</tr>
<tr>
<td>HAP Empowered MI Health Link members</td>
<td>(888) 654-0706, select prompt 2, then 2</td>
</tr>
</tbody>
</table>

Post-payment review

HAP Empowered reserves the right to review claims and encounters to determine:

- Appropriate billing code
- Benefit level for service
- Completeness of claim
- Duplication of service
- Eligibility of member
- Prior authorization as indicated

When the services rendered appear to exceed the customary level of care, HAP Empowered may require medical records, reports, treatment records, or discharge summaries as appropriate.

National Correct Coding Initiative

The HAP Empowered claims edit system incorporates National Correct Coding Initiative methodologies for all products. More information can be found at cms.gov. Select Medicare, then, under Coding, National Correct Coding Initiative Edits.

Reimbursement methodologies include:

- NCCI procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for multiple reasons.
- Medically Unlikely Edits (MUE’s) and units-of-service edits that define for each HCPCS/CPT code:
  - The number of units of service beyond the reported number of units allowed
  - The surgical procedure billed that should be considered as a component of the global surgical fee

Providers may not:

- Bill HAP Empowered members for a denied service based on NCCI code pair edits or MUEs.
- Use an Advance Beneficiary Notice of non-coverage to seek payment from members.
Negative Balance on the Remittance Advice

Following 835 standards, we only report claims that contributed to the negative balance one time.

Identifying a Negative Balance on the Remittance Advice

You can access your remittance advice by:
- Logging in at hap.org with your vendor ID and password
- Selecting Remittance Advice

Negative balances can be easily identified on the Remittance Advice Summary page by:
- A Payment Number starting with “NB” (see below)

Note: Negative balances are specific to a line of business as designated in the Company Name column (e.g., Alliance Health and Life Insurance Company, HAP Empowered). In the example below, the RA for payment date 12/20/2017 is for Alliance Health and Life Insurance Company (Alliance). The next RA for Alliance is the RA dated 12/27/2017.

<table>
<thead>
<tr>
<th>Search Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor ID :</td>
</tr>
<tr>
<td>Payment Number :</td>
</tr>
<tr>
<td>Member ID :</td>
</tr>
<tr>
<td>Patient Account No :</td>
</tr>
<tr>
<td>Payment Date From :</td>
</tr>
<tr>
<td>Payment Date To :</td>
</tr>
<tr>
<td>Service Date From :</td>
</tr>
<tr>
<td>Service Date To :</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Search Results</th>
<th>3 Results Found</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name</td>
<td></td>
</tr>
<tr>
<td>ALLIANCE HEALTH AND LIFE INSURANCE COMPANY</td>
<td>5677</td>
</tr>
<tr>
<td>ALLIANCE HEALTH AND LIFE INSURANCE COMPANY</td>
<td>NB0000000000001</td>
</tr>
<tr>
<td>ALLIANCE HEALTH AND LIFE INSURANCE COMPANY</td>
<td>0</td>
</tr>
</tbody>
</table>
For illustration purposes, the examples below follow the Alliance Health and Life Insurance Company.

- Select the PDF or Excel file with the first negative balance from the RA Search Results page. In our example, we'll open the RA dated 12/20/2017 with the amount ($20.00) and payment number 0.

**Week 1**

![Search Results](image)

- Claims 1 and 2 are causing the negative balance of $20 in week 1.

![Invoice](image)
**Week 2**

- Claims 3 and 4 are causing further negative balance of $20 in week 2.
- Please note the following fields in the RA header:
  
  - **Remittance Amount**: This field shows the total NET_AMT of the claims in current Remittance Advice (RA).
  
  - **Previous Balance**: This field shows the forward balance from previous week (week 1 in this case) for the vendor.
  
  - **Payment Amount**: Shows the difference between the Remittance Amount and the Previous Balance.

**Week 3**

- Claim 7 is offsetting the previous negative.
Negative Balance Credits

Any payments submitted to HAP that are applied to current negative balances will be displayed in the lower section of the RA. See screen shot below (PHI removed).

The balance will be reduced according to the payment applied. The claim number in this section should be the originating claim(s) that generated the negative balance.

![Remittance Advice](image)

**Legend**

<table>
<thead>
<tr>
<th>RA Column</th>
<th>Explanation of values in column</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Check applied to Negative Balance</td>
<td>Provider check number submitted to HAP</td>
</tr>
<tr>
<td>Claim Number</td>
<td>Claim that initiated the negative balance</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member for the claim that initiated the negative balance</td>
</tr>
<tr>
<td>Patient ID</td>
<td>Patient ID for the claim that initiated the negative balance</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of Service for the claim that initiated the negative balance</td>
</tr>
<tr>
<td>NET AMT</td>
<td>Amount from provider check applied to the existing negative balance</td>
</tr>
</tbody>
</table>

You can send payments for negative balances to the appropriate HAP line of business, attention NB Refund Request, 2850 West Grand Blvd., Detroit, MI 48202.
Section 10: Claims Appeals

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
<td>Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered MIChild</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Children’s Special Health Care Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Healthy Michigan Plan</td>
<td></td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

Claims appeals process

Contracted and noncontracted providers have the right to appeal claims denials made by HAP Empowered.

Providers can appeal claims by following the processes outlined below. There are two levels of appeals. All appeals must be submitted in writing to:

HAP Empowered Medicaid
Healthcare Management
Attention: Denials and Appeals
P.O. Box 2578
Detroit, MI 48202

All appeals must include:
- A cover letter documenting reason for appeal
- Member details
- Date of service
- Claim number
- Copy of prior authorization, if applicable
- Additional documentation supporting the appeal
- Reference to the previously processed claim

HAP Empowered responds to appeal requests within 60 days of receipt.

Process

<table>
<thead>
<tr>
<th>Appeal</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Submit appeal within 60 days of original claim denial.* HAP Empowered reviews the appeal and approves or upholds denial. If denial is upheld, HAP Empowered will send a letter to the provider advising of rights to level 2 appeal.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Submit appeal within 60 calendar days from date on level 1 denial letter.* HAP Empowered reviews the appeal and approves or upholds the denial. If denial is upheld, HAP Empowered will send a letter to the provider advising of their right to request a review by our internal Account Receivable Reconciliation Group.</td>
</tr>
<tr>
<td>Account Receivable Reconciliation Group (ARRG)</td>
<td>Submit appeal within 60 days of level 2 denial.* HAP Empowered stakeholders, identified as the ARR, meet no less than every 90 days to reconcile outstanding bills and payments. All appeal decisions will be finalized at the AARG.</td>
</tr>
</tbody>
</table>

*Appeals received after 60 days will be returned with a letter indicating untimely filing and no action will be taken.
Claims appeals for HAP Empowered MI Health Link noncontracted providers

Noncontracted providers have 60 days from the date of the initial organization determination to request a claims payment appeal. HAP Empowered has 30 days to review and respond to the request. Here is the process:

- Submit a written request along with any supporting documentation.
- Include a completed, signed Waiver of Liability form. To find this form, visit hap.org/empoweredproviders, select Forms, then Provider – Waiver of Liability (PDF)
- Mail request, documentation and Waiver of Liability to:
  
  HAP Empowered Health Plan
  Appeal & Grievance
  P.O. Box 2578
  Detroit, MI 48202

Note: If the Waiver of Liability is incomplete or unsigned or the request for appeal is sent more than 60 days after the date of the initial organization determination, the request for payment appeal will be sent to the Independent Review Entity for dismissal at the end of the appeal timeframe.
Claims appeals process for noncontracted hospitals

Rapid dispute resolution process for noncontracted hospitals - Medicaid only
Noncontracted hospitals can follow the MDHHS Rapid Dispute Resolution Process for claims denials. The RDRP applies to disputes with noncontracted hospital providers that have signed the Hospital Access Agreement. This agreement is between the hospital and MDHHS. The RDRP is outlined below.

Hospital Access Agreement Rapid Dispute Resolution Process

1. Hospitals and health plans agree to exhaust their efforts to achieve reconciliation solutions for outstanding accounts via internal means on a regular ongoing basis, including the use of an Accounts Receivable Reconciliation Group (ARRG), before pursuing the Rapid Dispute Resolution Process (RDRP).

2. Where a disputed claim, or group of similar claims, remains, either the Hospital or the Health Plan may submit a request to the Department for RDRP. Upon receipt of a request by either the Hospital or the Health Plan, the Department will advise the other party that the disputed claim or group of similar claims will be resolved in this manner.

3. The Department will contact a mediator, selecting one at random from the list of available mediators that it has prepared, within fifteen (15) calendar days of election/agreement by both parties to proceed. The mediator will schedule the mediation session within fifteen (15) calendar days of contact by the Department. The mediator will issue his/her decision within fifteen (15) calendar days of the mediation session. The mediators will be disinterested parties without conflict of interest with either the Health Plan or the Hospital.

4. Hospitals and Health Plans agree that, should a Hospital or a Health Plan elect this process, the outcome, including any monetary award, will be binding. Both parties agree to assume the burden of cost for presentation of their positions before the mediator. The cost of the mediator will be borne proportionally.

5. If the Hospital’s position is granted, the Health Plan agrees to make payment for the disputed claim(s) within thirty (30) days. If the Health Plan fails to make payment within the required timeframe, the Department will enforce the decision through a withhold of the disputed amount from the Health Plan’s capitation payment and direct payment to the Hospital.

6. If the Health Plan’s position is granted and results in the Hospital obligated to reimburse the Health Plan, the Hospital agrees to make payment within thirty (30) days. If the Hospital fails to make payment within the required timeframe, the Department will enforce the decision through an adjustment of future Hospital payments and direct the disputed amount to the Health Plan.

You can review the RDRP here at michigan.gov/mdhhs and search Hospital Access Initiative.
Section 11: Clinical Appeals

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
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</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
<td>Genesee, Huron, Lapeer, Macomb,</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered MIChild</td>
<td>Oakland, Sanilac, Shiawassee, St.</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Children’s Special Health Care Services</td>
<td>Clair, Tuscola and Wayne</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Healthy Michigan Plan</td>
<td></td>
</tr>
<tr>
<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

Providers can appeal a utilization management decision made by HAP Empowered. The appeal must be submitted in writing to the address or fax number listed below based on the appeal type:

<table>
<thead>
<tr>
<th>Appeal Type</th>
<th>Address</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service or Pre-Service Expedited</td>
<td>HAP Empowered Health Plan</td>
<td>(313) 664-5866</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2578</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detroit, MI 48202</td>
<td></td>
</tr>
<tr>
<td>Post-Service</td>
<td>HAP Empowered Health Plan</td>
<td>(313) 664-5904</td>
</tr>
<tr>
<td></td>
<td>Healthcare Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attention: Denials and Appeals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2578</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detroit, MI 48202</td>
<td></td>
</tr>
</tbody>
</table>

Peer to Peer Review

Doctors may schedule a peer review with a HAP Empowered Health Plan medical director to discuss the denial at any time during the authorization and appeal process by calling (248) 663-3879, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Appeal levels

- HAP Empowered Medicaid contracted and noncontracted providers have one appeal level.
- HAP Empowered MI Health Link contracted and noncontracted providers have two appeal levels.

Time frame extension

Extending the appeal time frame is only allowed when the member voluntarily agrees to extend the time to obtain additional information to support the member request.
### Appeals processes

<table>
<thead>
<tr>
<th>Appeal type</th>
<th>Process and Requirements</th>
<th>Applies to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-service</strong>&lt;br&gt;A request to change the decision on any case or service that must be made in whole or in part in advance of the member obtaining medical care or services</td>
<td><strong>Level 1</strong>&lt;br&gt;• When the HAP Empowered Medical Director denies a request for nonurgent, preservice care, written confirmation of the decision is sent to members and providers within 14 calendar days of receipt of the request.&lt;br&gt;• The provider is notified of their appeal rights and procedure.&lt;br&gt;• The provider has up to 60 calendar days to file an appeal.&lt;br&gt;• Pre-service appeals must be submitted in writing to the address or fax number above.&lt;br&gt;• If the HAP Empowered Medical Director can't reverse the adverse determination, a physician not involved in the initial denial reviews the case. The physician reviewer will be the same specialty as the requesting physician with similar credentials and licensure.&lt;br&gt;• The appeal will be resolved within 30 calendar days of the request for appeal.&lt;br&gt;• Written notification will be sent to the member and provider within two calendar days of the decision.&lt;br&gt;• Procedures for additional levels of appeal are provided to the member when the adverse determination is upheld.</td>
<td>All HAP Empowered plans</td>
</tr>
<tr>
<td><strong>Level 2</strong>&lt;br&gt;• Second-level appeal is sent automatically to the Independent Review Entity for review.</td>
<td>HAP Empowered MI Health Link only</td>
<td></td>
</tr>
<tr>
<td>Appeal type</td>
<td>Process and Requirements</td>
<td>Applies to</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Post service</td>
<td>A request to change a decision on any review for care or services that have already been received.</td>
<td>All HAP Empowered plans</td>
</tr>
</tbody>
</table>
| **Level 1**       | • When the HAP Empowered medical director denies the post service request, written confirmation of the decision is sent to the member and provider within 14 calendar days of receipt of the request.  
  • The provider is notified of their appeal rights and procedure.  
  • The provider has up to 60 calendar days to file an appeal.  
  • Post service appeals must be submitted in writing to the address or fax number above.  
  • If the HAP Empowered medical director can't reverse the adverse determination, a physician not involved in the initial denial will review the case. The physician reviewer will be the same specialty as the requesting physician with similar credentials and licensure.  
  • The appeal will be resolved within 60 days of the request for appeal.  
  • Written notification will be sent to the provider within two calendar days of the decision.  
  • Procedures for additional levels of appeal are provided to the provider when the adverse determination is upheld.                                                                 |                                    |
| **Level 2**       | • When the denial for post service first level appeal is upheld by the HAP Empowered physician reviewer, written confirmation of the decision is sent to members and providers within 60 calendar days of receipt of the request.  
  • Requests for second-level appeal must be submitted in writing and received within 60 days of the first-level appeals decision.  
  • The HAP Empowered medical director reviews the second-level appeal.  
  • If the HAP Empowered medical director can't reverse the adverse determination, the Quality Improvement Committee physicians will convene to review the appeal.  
  • The appeal will be resolved within 60 days of the request for second-level appeal.  
  • Written notification is sent to the provider within two calendar days of the decision.  
  • Providers have the right to request an administrative hearing by an administrative law judge for any adverse determination.                                                                 | HAP Empowered MI Health Link only  |
<table>
<thead>
<tr>
<th>Appeal type</th>
<th>Process and Requirements</th>
<th>Applies to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited (preservice)</td>
<td>A request to change an urgent care request where the decision could:</td>
<td>All HAP Empowered plans</td>
</tr>
<tr>
<td></td>
<td>• Seriously jeopardize the life or health of the member</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Jeopardize the member’s ability to regain maximum function</td>
<td></td>
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<tr>
<td></td>
<td>• Subject the member to severe pain, not managed without the requested care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When the HAP Empowered medical director denies the request for urgent care, written confirmation of the decision is sent to members and providers within 72 hours of receipt of the request.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The member, or their authorized representative, may file an expedited appeal for a denied urgent care request.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The member must submit the appeal within 60 days.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• All requests concerning admissions, continued stay or other emergency service related appeals are considered for expedited appeal.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered will complete the entire expedited appeal process within 72 hours of receipt of the appeal request.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Verbal notification is given within 72 hours of receipt of the appeal request.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Written notification is given within three calendar days of the appeal request.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Due to the time frame requirements to complete two level reviews, each level will be completed by a HAP Empowered provider in the same or similar specialty, independent of each other (i.e., not partners in the same group).</td>
<td></td>
</tr>
</tbody>
</table>
Section 12: Appeals and Grievance information for Members

HAP Empowered offers the following products:

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<thead>
<tr>
<th>Product</th>
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<td>Medicaid</td>
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<tr>
<td></td>
<td>• HAP Empowered Children’s Special Health Care Services</td>
<td>Oakland, Sanilac,</td>
</tr>
<tr>
<td></td>
<td>• HAP Empowered Healthy Michigan Plan</td>
<td>Shiawassee, St. Clair,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tuscola and Wayne</td>
</tr>
<tr>
<td>HAP Empowered</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
</tr>
<tr>
<td>MI Health Link</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

Below is the information we provide to members in their handbook regarding filing a grievance and appeal.

We want you to be happy with our service. We comply with applicable federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, or sex. If you are unhappy, you can file a grievance. If you feel discriminated against, you can file a grievance.

Grievance examples include:
- Quality of health care services, including safety issues
- Access and availability of care
- Attitude and service of providers, office staff, or HAP Empowered staff
- Benefits or claims payment

Use this address to file a grievance in person with HAP Empowered:
HAP Empowered
2050 S. Linden Rd.
Flint, MI 48532

Or, mail a grievance or appeal in writing to:
HAP Empowered
P.O. Box 2578
Detroit, MI 48202

We also have a Grievance Analyst to help you. This can be done over the phone, in writing, or in person. We offer interpretation services to help you in any language.
- The Grievance Analyst can help you write a grievance
- Your doctor or an authorized person may file a grievance for you
- A letter of receipt will be sent within five days
- All grievances are thoroughly investigated
- You will get a response in writing 30 days from the grievance date

Appeals
Pre-Service/Post-Service Grievances
- You can file a pre-service or post-service grievance if a covered health care service has been denied, suspended, terminated, or reduced
- You have 60 calendar days from receiving the denial to file an appeal
- You can do this in person, in writing, or by telephone. The Appeal Coordinator can help you
- You can include an authorized representative in the appeals process. You can bring information you feel will help us make a better decision
A decision will be mailed 30 calendar days from the day we receive your appeal for a pre-service request. Please allow 60 days for a post-service request.

Ten calendar days are allotted to collect medical records and information. This applies if the member requests an extension or if HAP Empowered can show the delay is in the member's interest.

You can request a State Fair Hearing after getting notice that your pre-service or post-service grievance adverse determination was upheld.

You can request a State Fair Hearing within 120 days of the denial of a final decision.

Call HAP Empowered at (888) 654-2200 (TTY: 711). Or, call the State of Michigan at (800) 642-3195 to have a hearing request form (DCH-0092) sent to you. Fill out the form and return it to the address listed.

If you are unhappy with our decision or we don't give a decision within 30 days, you can request an external review from the Department of Insurance and Financial Services (DIFS). Your request must be in writing and sent to:

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220 Lansing, MI 48909-7720

**Expeditied Pre-Service Grievance**

If a doctor thinks the 30-calendar-day time frame will harm your health or body functions, your pre-service grievance will be an expedited request. Expedited appeals are handled in 72 hours.

**External Review by the Department of Insurance and Financial Services (DIFS)**

You can ask for an external review if you don't get an answer within 30 calendar days. You can also do this if you are unhappy with the decision HAP Empowered made. Write to DIFS at:

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220 Lansing, MI 48909-7720

You must appeal in writing to the DIFS within 60 calendar days of getting a decision. You must complete the grievance/appeal process within the health plan before asking for review from the DIFS. The Appeal Coordinator will explain the external review process. We can also mail the external review forms to you. DIFS will send your appeal to an Independent Review Organization (IRO) for consideration, as necessary. A decision will be mailed to you within 14 calendar days of accepting your appeal.

Are you unhappy with our final decision? Do you want your appeal request to be expedited? You have 10 calendar days to file an appeal to DIFS.

If we are going to reduce or stop a service we already approved, you can keep getting benefits during the appeal and state fair hearing process. You must meet these criteria to do so:

- The appeal must be filed within 10 days of the date the denial letter was mailed
- You must ask to keep the service

The service will stop if:

- You withdraw your appeal
- You do not ask for a state fair hearing within 10 days of getting the denial letter
- A state fair hearing decision is made against you
- The authorization ends or authorized service limits are met
Section 13: Pharmacy

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
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<td>Macomb and Wayne</td>
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</table>

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Pharmacy drug plan coverage

HAP manages prescription drug benefits but uses a pharmacy benefit manager to process pharmacy claims.

To request a coverage determination or prior authorization for a medication or for questions related to drug programs, please call HAP Pharmacy Care Management at (313) 664-8940 and select option 3.

Helpful numbers and links for providers

<table>
<thead>
<tr>
<th>For</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Pharmacy Care Management</td>
<td>(313) 664-8940 Monday-Friday, 8:00 a.m. to 4:30 p.m.</td>
</tr>
<tr>
<td>Specialty and Home Delivery Pharmacy (Pharmacy Advantage)</td>
<td>(800) 456-2112 Monday-Friday, 7 a.m. to 7 p.m.</td>
</tr>
<tr>
<td>Completed prior authorization forms for: HAP Empowered Medicaid and HAP Empowered MI Health Link members</td>
<td>Fax: (313) 664-5460</td>
</tr>
<tr>
<td>Completed prior authorization forms for: Commercial, Qualified Health Plan and Medicare members</td>
<td>Fax: (313) 664 8045</td>
</tr>
<tr>
<td>Formulary for HAP Empowered MI Health Link</td>
<td>hap.org/empoweredmihealthlink</td>
</tr>
<tr>
<td>Formulary for HAP Empowered Medicaid</td>
<td>hap.org/empoweredmedicaid</td>
</tr>
<tr>
<td>Formularies for Commercial, Qualified Health Plan, Medicare and HAP Empowered Duals</td>
<td>hap.org/prescriptions</td>
</tr>
</tbody>
</table>

Drug formulary

The formulary is a list of covered drugs. Drugs on the formulary may have some restrictions, including:

- **Prior authorization criteria:** Specific member information and criteria must be met prior to payment.
- **Step therapies:** Medications noted with an ST are medications that require the trial and failure of other formulary medications prior to payment for the drug marked ST.
- **Quantity limits:** Medications noted with a QL are subject to certain quantity limits.
- **Exception requests:** Some medications may not be listed on the formulary. Providers and members may request an exception to the formulary.

Formulary changes

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 Empowered MI Health Link Medicare-Medicaid Program (MMP)

Formulary

- The 2019 HAP Empowered MI Health Link formulary can be found at hap.org/empoweredmihealthlink. You can search for drugs alphabetically or by type of drug. The drug formulary may change annually on January 1 and throughout the year.
- You can obtain a printed formulary by calling Customer Service at (888) 654-0706.
- The MMP formulary is the same as the HAP Medicare Part D drug formulary with an “ADD” file. The ADD file is a list of over-the-counter drugs and some other drugs not covered under Medicare Part D but covered under the Medicaid portion of the MMP benefit. Please note:
  - NEW!! Starting January 1, 2019, 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.
  - Effective January 1, 2019, 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.

Prior authorization or exception request

- To request a coverage determination (for prior authorization or an exception), please complete a Request for Medicare Prescription Drug Coverage Determination Form. It can be found by going to hap.org/empoweredmihealthlink.
- For the best patient experience, please review the drug formulary prior to writing a prescription for a new drug. If the drug has restrictions, please complete the request by fax or telephone with supporting documentation.
- If the request is not approved in advance, there may be a delay for the member in obtaining their medication from the pharmacy.
- Contact information:

<table>
<thead>
<tr>
<th>For</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faxed requests for prior authorization or exceptions</td>
<td>Fax: (313) 664-5460</td>
</tr>
<tr>
<td>Provider Prior Authorization Line</td>
<td>Phone: (313) 664-8940, option 3</td>
</tr>
</tbody>
</table>
Opioid dispensing rules for HAP Empowered MI Health Link members

Health Alliance Plan (HAP) employs opioid dispensing rules that align with the Center for Medicare and Medicaid Services (CMS) policy and guidance. These include safety edits at the pharmacy and a drug management program.

The purpose of the opioid safety edits and drug management program is to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the beneficiary's opioid use is appropriate and medically necessary. Plan sponsors are expected to implement these safety edits and conduct the drug management program in a manner that minimizes any additional burden on prescribers, pharmacists, and beneficiaries.

Opioid point of sale (POS) pharmacy safety 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 per day, and
   - There is more than one opioid prescriber in the previous six months.
   This rejection ensures care is being coordinated among 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 opioid naïve patients**
   - Opioid claims are limited to a seven-day supply when prescribed for opioid-naïve patients, e.g., for acute pain. An opioid naïve patient is identified at the dispensing pharmacy based on the prescription claims history of opioids dispensed. If a beneficiary has not had opioid prescriptions filled in the previous 108 days, the rule set assumes that an opioid is being prescribed to an opioid naïve beneficiary for treatment of acute pain. The pharmacy **cannot** override this edit.

3. **Multiple long-acting opioid medications**
   - If a beneficiary has overlapping prescriptions for two long-acting opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that the drug therapy is appropriate.

4. **Concomitant use of benzodiazepines**
   - If a beneficiary has overlapping claims for benzodiazepine and opioid medications, the new prescription will reject. Pharmacies may override this rejection at the point of sale after confirming with the prescriber that concomitant use is appropriate.

Drug Management Program (DMP)

The Drug Management Program helps ensure that beneficiaries use their prescription opioid medications safely. A beneficiary may be eligible for enrollment in the DMP based on the following criteria:

1. Aggregate opioid prescriptions exceed 90 mg MME for any duration during the past six months, AND
2. The beneficiary has three or more prescribers contributing to opioid claims in past six months, AND
3. The beneficiary has three or more pharmacies contributing to the opioid claims in the past six months, OR
4. More than five prescribers contribute to opioid claims regardless of the number of pharmacies dispensing opioids in the past six months.
Beneficiaries who meet the prescription claims criteria undergo a second review for any potential exclusions based on medical criteria. The DMP may not apply to beneficiaries who are residents of a long-term care facility, in hospice care or receiving palliative or end-of-life care, are being treated for active cancer-related pain or have sickle cell disease.

Beneficiaries who meet prescription claims criteria and do not have medical exclusions undergo case management coordinated by a pharmacist to determine whether enrollment in the DMP is appropriate. This is a collaborative process with the prescribers of opioids and may also include HAP’s professional staff of care management nurses, social workers, behavior health experts, or physician medical directors.

If a beneficiary is at risk for overuse, misuse or abuse of opioid prescription medications, HAP may limit access to opioids and/or benzodiazepines and/or opioid potentiators (e.g. gabapentin and pregabalin) by utilizing a variety of opioid control tools:

- Requiring the beneficiary to obtain all prescriptions for opioid medications from one pharmacy.
- Requiring the beneficiary to get all prescriptions for opioid medications from one doctor.
- Limiting the amount of opioid medications covered in a specified time period.

Any Dual Eligible member (D-SNP or MMP) with a coverage limitation under Part D will have that same drug or quantity restriction under the Medicaid benefit.

HAP communicates in writing with beneficiaries and prescribers in advance of putting any limitations or restrictions in place. Members and prescribers have rights to appeal these decisions.

The dispensing pharmacy or a HAP pharmacist may contact you about a beneficiary’s opioid prescription(s) to determine if opioid use is appropriate and medically necessary. During normal business hours, your office will be contacted, or you may be paged. After hours contact will follow your after-hours process as instructed by telephonic recordings or answering services.


Additional resources to explain federal governmental programs to manage the opioid epidemic are posted here: https://www.cms.gov/About-CMS/Story-Page/prescribing-opioids.
HAP Empowered Medicaid

Formulary

- For Medicaid, Healthy Michigan Plan, MIChild and Children’s Special Health Care Services, HAP administers the State of Michigan Common Formulary. This list of covered drugs is common across all contracted Medicaid health plans. It’s developed and maintained by the Michigan Department of Health and Human Services.
- The Common Formulary, required under Section 1806 of Public Act 84 of 2015, was created to streamline drug coverage policies for Medicaid and Healthy Michigan Plan members and providers.
- The Common Formulary includes covered prescription drugs and over-the-counter drugs. The list also contains drugs that are “carved out” and covered under Medicaid Fee-For-Service (FFS). Pharmacies know the process for billing the health plan or FFS. You can find the formulary at hap.org/empoweredmedicaid.
- You can obtain a printed formulary by calling Customer Service at (888) 654-2200.

Prior authorization or exception request

- To prescribe a drug that requires prior authorization, please complete a Request for Prior Authorization Form. Visit hap.org/empoweredmedicaid.
- To request an exception to the formulary, please complete a Formulary Exception Form. Visit hap.org/empoweredmedicaid.
- For the best patient experience, please review the drug formulary prior to writing a prescription for a new drug. If the drug has restrictions, please complete the request (by fax or telephone) with supporting documentation.
- If the request is not approved in advance, there may be a delay for the member in obtaining their medication from the pharmacy.
- Contact information:

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<tr>
<td>Prior Authorization Line</td>
<td>Phone: (313) 664-8940, option 3</td>
</tr>
</tbody>
</table>

Medications covered under the medical benefit

- The Common Formulary includes drugs covered as a pharmacy benefit only.
- Medications used in a physician’s office may be covered under the medical benefit. For example:
  - Intrauterine devices
  - Physician-administered injectable drugs
  - Some vaccines
Section 14: Quality Management

HAP Empowered offers the following products:

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Quality Management Program for HAP Empowered Medicaid including HAP Empowered CSHCS and HAP Empowered HMP

HAP Empowered has an ongoing Quality Assessment and Performance Improvement Program (QAPI) for HAP Empowered Medicaid members including HAP Empowered CSHCS and HAP Empowered HMP. The program is designed to:

- Promote and improve the delivery of member medical and health care services consistent with our mission and goals.
- Objectively and systematically monitor and evaluate the appropriateness of clinical and nonclinical member care and services.

HAP Empowered pursues opportunities to improve care and services and resolve identified problems. HAP Empowered, PCPs and specialists have a role in monitoring, maintaining and improving the quality of care and services.

QAPI effectiveness is evaluated annually. You can find a copy of the QAPI program, including progress on our annual goals and the annual evaluation by:

- Visiting hap.org/empoweredproviders, then Quality program.

Ongoing monitoring of care and services is performed through a review of:

- Administrative data
- After-hours care surveys
- Appointment wait time surveys
- Complaints and grievances
- Consumer and provider surveys
- Medical records
- On-site facility reviews
- Utilization data

Preventive and Clinical Care Guidelines

HAP Empowered uses the Michigan Quality Improvement Consortium’s Guidelines for preventive and clinical care. These guidelines include:

- Preventive care from birth to age ≥ 50
- Prenatal and postpartum care
- Clinical and chronic care including:
  - Asthma
  - Cancer screening
  - Depression
  - Diabetes
  - Hypertension
  - Otitis media
  - Stroke
  - Tobacco cessation

You can find a link to the guidelines when you visit hap.org/empoweredproviders, then select Care guidelines.
Quality Management Program for HAP Empowered MI Health Link

HAP Empowered has an ongoing continuous quality improvement program (CGIP) for HAP Empowered MI Health Link members. The program is designed to:

- Promote and improve delivery of member medical and health care services consistent with our mission statement and goals.
- Objectively and systematically monitor and evaluate the appropriateness of clinical and nonclinical member care and services.

HAP Empowered will pursue opportunities to improve upon the care and services and resolve identified problems. All departments, primary care and high-volume specialist providers are involved in monitoring, maintaining and improving the quality of care and services.

CQIP effectiveness is evaluated annually. You can find a hard copy of the CQIP including progress on our annual goals and the annual evaluation by:

- Visiting hap.org/empoweredproviders, then HAP’s quality program.

Ongoing monitoring of care and services is performed through review of:

- Administrative data
- After hours care surveys
- Appointment wait time surveys
- Complaints and grievances
- Consumer and provider surveys
- Medical records
- On site facility reviews
- Preventive and clinical care guidelines

HAP Empowered uses the Michigan Quality Improvement Consortium’s Guidelines for preventive and clinical care. Examples of some of these guidelines:

- Asthma
- Cancer screening
- Depression
- Diabetes
- Hypertension
- Otitis media
- Preventive care from birth to age ≥ 50
- Prenatal and postpartum care
- Stroke
- Tobacco cessation

You can find a link to the guidelines when you hap.org/empoweredproviders, then select Care guidelines.

Member medical records

- HAP Empowered does not generate, maintain or store medical records.
- HAP Empowered providers are responsible for the patient’s medical record.
- All information in the record is confidential.
- HAP Empowered members have access to their medical record.
- HAP Empowered does not allow employers to access health information about their employees that is implicitly or explicitly identifiable without consent or unless mandated by law.
- HAP Empowered members can review their medical record in the presence of their primary care provider during a mutually convenient appointment time.
- The PCP determines the extent to which a member may amend their record. Note: members cannot change certain information, such as laboratory and x-ray results.
- The member or guardian must sign a consent for release of information when they request their records to be released to another party. If a member can't give consent, their legal guardian can on their behalf. The guardian has the same rights as the member to request and review the information in the medical record.
• Medical record information will not be released without appropriate written authorization from the member unless legally mandated.
• While safeguarding member confidentiality, HAP Empowered and participating providers shall release information regarding HAP Empowered members to other health care providers to render the necessary medical care in cases of emergency.
• HAP Empowered will release information otherwise considered confidential to certain entities to protect the health and safety of the public whenever such release is required by law.
• Confidential information is not disclosed to anyone except the person for whom the information was intended.
• HAP Empowered does not release information that explicitly or implicitly identifies the member for purposes other than treatment, payment or health care operations without an explicit authorization from the member.
• HAP Empowered Compliance is responsible for creating and annually reviewing confidentiality policies and the practices regarding the collection, use and disclosure of medical information.

Medical record maintenance policy
The goal of this policy is to ensure the medical care and services provided to the patient are documented appropriately and in a standardized, industry-accepted manner. To promote continuity and quality of member care, HAP Empowered requires all participating providers to maintain their HAP Empowered patient charts in a manner that meets all of the following requirements and ensures the medical record information is organized and readily available when needed.

General medical record maintenance requirements
HAP Empowered requires that:
• Participating providers maintain a detailed and comprehensive medical record of all services provided by the PCP and the medical services received by its members.
• These records are maintained in a manner that:
  - Provides a basis for managing patient care
  - Provides inter and intraoffice communication of patient related data
  - Documents total and complete health care
  - Allows patterns to surface that will alert physicians and health care providers to the patient's health care needs
  - Conforms to professional medical practice
  - Permits effective professional review
  - Facilitates a system for follow-up treatment
• Participating providers have sufficient staff, facilities and equipment to maintain clinical records that are:
  - Complete and accurately documented
  - Readily accessible
  - Organized to facilitate the retrieval and compilation of information
• Providers designate a person to ensure clinical records are maintained, completed and preserved.
• Providers follow their contractual agreement for medical record maintenance.
• HAP Empowered has a medical chart audit process to evaluate compliance with medical record standards.
• Periodic audits are done of member medical records for member safety, medical record studies, provider credentialing and peer review studies. Feedback is provided to providers on their performance.
• HAP Empowered ensures the compliance of its medical record policy by including the summary requirements in its provider manual.
• Patient files are kept in a secured area and locked when appropriate personnel are unavailable.
• Policies and procedures are created and used for privacy, security, business responsibility and records management as it relates to electronic medical records.
• HAP Empowered providers follow HIPAA guidelines for the use and release of medical records and privacy standards for paper and electronic medical records.
• HAP Empowered provider contracts ensure the confidentiality of the clinical record is maintained.
• Providers maintain a single unit clinical record for each member according to accepted professional standards and practices.
• Charts be organized to easily find lab, x-rays, consultations, hospitalizations and physical and history records.
• The provider organizes and stores medical records in a manner that will ensure and maintain confidentiality and facilitate review and retrieval of the clinical information.
• All entries are legible.
• Medical record documentation is in English only.

Medical record content, organization and filing requirements
HAP Empowered providers are required to meet the following guidelines:
• Each clinical record must be a single unit record for one individual.
• Each page within the record must identify the patient by name and a medical record ID and Medicaid ID number.
• Each unit clinical record must be organized, and each page must be attached to the file.
• Allergies and allergic reactions must be clearly noted in a prominent location both on the outside of the chart and within the medical record, so the allergy status is clearly visible during each record entry. At each encounter, ask the patient their allergy status and then update the record. The abbreviations NKA, for no known allergy and NKDA, for no known drug allergy may be used.
• All forms must be completed in their entirety with all blank spaces marked with an N/A for not applicable.
• Documentation throughout the clinical record is done in a consistent format. Example: SOAP format. Writing must be legible and in English.
• The vaccination and immunization status must be documented and complete in each patient’s chart.
• Patient histories, both initial and interval, shall include at a minimum:
  – Significant past medical conditions, serious accidents and illnesses
  – Significant past surgical and invasive procedures
  – Pertinent family history and high-risk factors
  – For members who are 18 years and younger, past medical history that includes, at a minimum, prenatal care, birth, operations and childhood illnesses
  – Problem list identifying chronic conditions and major health issues
  – Outpatient and emergency care
  – Specialist referrals
  – Ancillary care
  – Current medications, including over-the-counter medications
  – Lifestyle habits including the use of cigarettes, alcohol and substances
  – Preventive services and risk screening
• Documentation of each patient encounter will include at a minimum:
  – Reason for the visit or chief complaint
  – Diagnosis or diagnostic impression
  – Studies or tests ordered and performed
• Therapies or treatments ordered and performed
• Detailed documentation of the patient exam and findings
• Patient instructions
• Patient disposition at the end of the encounter and physician recommendations for further care and follow up
• Documentation of any prescription or nonprescription medications prescribed and dispensed to the patient, including samples
• All record entries must be author-identified with name, title, date and signature of the servicing provider.
• Patient identification information including name, age and date of birth, sex, marital status and emergency contact person must be clear and easily located in the clinical record.
• Addresses, phone numbers, employer name and phone number and insurance information must be verified and updated at each encounter.
• Clinical records must include the results of any appropriate age-specific, sex-specific or other type-specific screenings.
• Advance Directives shall be displayed in a prominent part of the record. Indicate if patient has executed an advance directive.
• The physician's review of laboratory, diagnostic, ancillary services (home health agencies, nursing home, physical therapy, etc.) reports and consultation reports shall be reviewed in a timely manner—within 30 days from receipt—and must include:
  - Date of the review
  - Physician’s signature
  - Appropriate actions noted. Note: the PCP must obtain a copy or a summary of care such as OB care or consultant’s care from the referring physician.
• Inpatient health facilities discharge summaries must be dated, signed by the physician and filed in the chart at least 60 days from the date of discharge.

Confidentiality guidelines
The confidentiality of the medical records of members must be maintained. The following requirements ensure enrollee privacy:
• All information contained in the record is treated as confidential.
• No information is released from a medical record without the written permission of the patient.
• An appropriate release of medical information must be signed and placed in the medical record at the time of the release of the records.
• Each provider site is responsible for maintaining medical records of members and for the proper release of the medical information.
• Members can view the information in their records with the PCP at a mutually convenient time.
• Members can only view their personal records and cannot change any medical information contained therein. If requested, they may put a dated, signed note in the record.
• Patient files must be kept in a secured area and locked when appropriate personnel are unavailable.
• The medical records of the HAP Empowered members are confidential. Employees and contractors shall protect the privacy of the patient information unless otherwise required by law.

Requirements for the release of records
• Medical records are to be released only with proper authorization by the patient, parent, legal guardian or subpoena.
• An appropriate release of medical information must be signed and placed in the medical record at the time of the release of the records.
• Medical information will not be released to the patient except through the patient’s attending physician.
Clinical information is not to be released by telephone except in emergency situations where it is immediately needed by outside physicians to properly care for a patient. In such cases, the information is to be released only by the attending physician.

No information is released from a medical record without the written permission of the patient.

Requirements for copies of records
Upon appropriate written request for copies of medical records by an enrollee, or the enrollee’s parent or guardian, as appropriate, a photocopy of the requested medical record is sent to the authorized requester. The original copies of all medical records are maintained as required by federal and state law.

Record access, storage and retrieval requirements
- The clinical files of HAP Empowered members shall be made available to the Michigan Department of Public Health, the Michigan Department of Health and Human Services authorized staff or its designees and the Center for Medicare and Medicaid Services at their written request.
- Per contract, HAP Empowered has immediate access to all enrollee records.
- If HAP Empowered requests copies of charts, providers will not receive any additional reimbursement for copying the records.
- Current records must be maintained in such a manner that there is immediate access.
- HAP Empowered follows Michigan Public Health Code Act 368 of 1978, Section 333.16213 and the requirement to maintain medical records for seven years.
- The provider's signature on the contract is acknowledgment and acceptance of HAP Empowered medical record policy requirements.
- The medical records of members that change PCPs must be forwarded within 10 days of a release of information request.

Purged records requirements
- Records can be purged from charts if they are at least three years old.
- If a chart becomes too thick to handle, over 1.5 inches, a second chart can be started. Purge the older records into the second chart and maintain the most current information in the first chart.
- Purged charts must be identified on the outside cover with their volume number, such as volume 1 of 3.
- All member identification must be on all volumes of all charts. Purged records that are less than three years old must be maintained in the active filing system or in another on-site area that is readily accessible.
- Purged records that are less than three years old must be available within 24 hours when requested.
- Purged records over three years old must be available within 48 hours when requested.
- Purged records should be logged for quick access. The log should note exactly what records were purged, the date they were last purged and their exact storage location. When requested, the provider must make these records available to HAP Empowered.
Medical record evaluation requirements

- As a component of QAPI, medical record evaluations and audits are conducted using the criteria from the medical record policy. All new primary care provider sites undergo a medical record evaluation as part of the initial credentialing and qualifying process.
- The HAP Empowered audit representative discusses the results of the record audits with the provider to resolve any problems and assists the provider with their corrective action plan.
- Results of the audit and compliance to the corrective action plan are reviewed upon recredentialing at the HAP Credentialing subcommittee or more often if deemed necessary. Appropriate action will be taken if the provider does not follow the corrective action plan.

Health outreach programs

We have outreach programs to help our members stay healthy. The programs below are for members in all HAP Empowered plans.

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
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</table>
| 24/7 NurseLine                 | HAP Empowered members have access to a 24/7 health information line to help with questions about medical care. Nurses are ready to answer questions any time, day or night. The NurseLine provides trusted, physician-approved information to help guide members' health care decisions. A registered nurse helps with:  
  - Choosing appropriate medical care  
  - Finding a doctor or hospital  
  - Understanding treatment options  
  - Achieving a healthy lifestyle  
  - Learning how take medication safely  
  To use the NurseLine, members can call (877) 394-0665. |
| Health education materials     | HAP Empowered has the following educational materials available for members:  
  - Asthma  
  - Colorectal cancer  
  - Controlling weight  
  - Depression  
  - Diabetes  
  - Domestic violence  
  - Healthy eating  
  - High blood pressure  
  - High cholesterol  
  - Immunizations  
  - Lead poisoning  
  - Preventive health guidelines  
  - Sexually transmitted diseases  
  - Stroke  
  - Well-child care  
  - Well-woman care |
| iStrive® for Better Health     | HAP Empowered members can manage their health with iStrive for Better Health. It's our digital wellness tool powered by WebMD health services. It can help them:  
  - Take an online health assessment.  
  - Learn more about health issues like asthma, being tired all the time, depression and more.  
  - Check their progress with health trackers.  
  - Reach their goals for fitness, weight, healthy eating, stress and quitting tobacco  
  - Self-management programs:  
    - Asthma  
    - Back pain  
    - Coronary artery disease  
    - Exercise  
    - Hypertension  
    - Nutrition  
    - Coronary artery disease  
    - Exercise  
    - Pregnancy  
    - Preventive care  |

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<table>
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</thead>
</table>
| Preventive health reminders                  | HAP Empowered mails these preventive health reminders to members that may be due for services:  
  • Cervical cancer screening  
  • Child and adolescent vaccines  
  • Colorectal cancer screening  
  • Comprehensive diabetes care  
  • Glaucoma screening  
  • Human papillomavirus (HPV) vaccines  
  • Lead testing  
  • Mammogram screening  
  • Well-child and adolescent visits                                                                                                                                                                          |
| Smoking cessation program                    | 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 or health plan referral. To refer a member to the program, call 1-800 QUIT NOW (784-8669). For more information, call (888) 654-2200. |
| Weight Watchers® Discount Program            | HAP Empowered members can purchase a 12-week Weight Watchers pass at a discounted rate. They just need to show their HAP Empowered member ID card at participating meeting locations. For more information or to find a meeting location, members can call: 1-888-3Florine or visit www.weightwatchers.com. |

The programs below are for HAP Empowered Medicaid only including HAP Empowered Children’s Special Health Care Services and HAP Empowered Healthy Michigan Plan

| Maternal Infant Health Program               | The Maternal Infant Health Program is for pregnant women and their babies, up to one year of age. This program helps pregnant members and infants get the proper food, support, and transportation for health services. It also encourages getting prenatal care, well-child care and scheduled vaccinations. Services include:  
  • Prenatal teaching  
  • Childbirth education classes  
  • Nutritional support and education  
  • Newborn baby assessments  
  • Help with personal problems that may complicate pregnancy  
  • Referrals to community resources  
  • Help with transportation to pregnancy-related appointments  
  • Support to quit smoking  
  
  To refer a member, please call (248) 663-3889.                                                                                      |
| Maternity Program                           | The HAP Empowered Maternity Program helps members achieve a healthy pregnancy. The goal of this program is early recognition of potential problems and education on healthy lifestyles.  
  
  A nurse specializing in high-risk pregnancy care will contact the member by phone to discuss their pregnancy and general health. The nurse will determine if there are any risks for early delivery or other pregnancy risks and provide education and support. For more information or to enroll, members can call (248) 663-3889. |
Healthy Michigan Plan Health Risk Assessment Instructions for Providers

Within 60 days of enrollment, Healthy Michigan Plan members are encouraged to schedule an appointment with their primary care provider and complete an annual health risk assessment. Members receive an HRA in their welcome packet.

Below is the process for completing the HRA.

- HAP Empowered partners with Genesee Health Plan to process HRAs for HAP Empowered members.
- Genesee Health Plan staff contacts the member to complete sections one, two and three. They also help members schedule their first PCP appointment if needed. Note: If the member brings their HRA directly to your office, please complete your portion and fax it to Genesee Health Plan at (844) 225-4602.

Primary care provider responsibilities
Primary care providers need to complete section four of the HRA. Here are the steps.
- Enter the member’s results.
- Agree on a healthy behavior with the member.
- Sign the primary care provider attestation. All three parts of section four must be completed for the attestation to be considered complete.

HRA submission and incentives
HAP Empowered offers a $25 incentive for primary care providers 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 call (844) 214-0870.
Section 15: Vaccines, MCIR & Reporting Communicable Diseases

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
</table>
| HAP Empowered Medicaid       | • Traditional Medicaid  
                                    • HAP Empowered MIChild  
                                    • HAP Empowered Children’s Special Health Care Services  
                                    • HAP Empowered Healthy Michigan Plan | Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne |
| HAP Empowered MI Health Link | Integrated Care for Medicare and Medicaid Dual Eligible                | Macomb and Wayne                                            |

The material in this section applies to all plans unless otherwise noted.

Vaccines

State law requires providers who administer vaccines to HAP Empowered Medicaid members to obtain the vaccines through the Vaccines for Children program. This is a federal program that makes vaccines available to immunize children age 18 and under who are Medicaid eligible. Vaccines can be obtained free of charge from local health departments.

Requirements for reporting to the Michigan Care Improvement Registry

Providers who administer immunizations are required to report them to the MCIR.

For questions, registration, resources and technical assistance, visit mcir.org. MCIR can also help you improve your immunization rates by running batch reports and monthly immunization recall letters.

Requirements for reporting to the local health department

The state and the HAP Empowered provider contract require providers to report communicable diseases to the local health department.

The Alliance for Immunization in Michigan

The Alliance for Immunizations in Michigan was formed in 1994 to focus on a broad spectrum of immunization issues in Michigan. The initial focus was to reduce missed opportunities to immunize by emphasizing provider education.

The AIM coalition’s efforts were combined into what became known as the AIM Provider Tool Kit. The tool kit is a comprehensive resource for immunization management, patient education, and other high-quality information, such as:

- Catch-up schedules
- Storage information
- Vaccine information sheets

The AIM tool kit can be found at aim toolkit.org.
Section 16: Continuity of Care

HAP Empowered offers the following products:

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<tr>
<td></td>
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<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
</tr>
</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

While in good standing, if a PCP or specialist terminates their contract with HAP Empowered, they may continue to serve their HAP Empowered members to ensure continuity of care. Upon contract termination, HAP Empowered will send the provider a list of their HAP Empowered patients who are:

- In an active course of treatment for an acute episode of chronic illness or an acute medical condition. An active course of treatment is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.
- In the second or third trimester of pregnancy.
- Terminally ill.

If the provider has any HAP Empowered patients who meet the above criteria and is willing to continue treating them on a fee-for-service basis, the provider should follow the process below:

- Identify the patient on the list and document the reason for continuing their care.
- Fax the list back to HAP Empowered at (248) 663-3780.
- HAP Empowered will send a confirmation letter to the provider that outlines the continued treatment conditions for each member that the provider agrees to continue treating.
- The provider will be allowed to continue treatment as a non-par provider with appropriate prior authorization for up to 90 calendar days for:
  - Members in active treatment for an acute or chronic medical condition
  - Members through the acute phase of the condition being treated
  - Members through the postpartum period of six weeks postdelivery for women in the second and third trimester of pregnancy
  - A terminally ill member for the remainder of their life
- You must share information regarding the treatment plan with HAP Empowered.
- You must follow the HAP Empowered health utilization management policies and procedures.
- You can’t charge or balance bill the member for services.
- You will be reimbursed at current Medicaid fee-for-service rates.

If the provider is not willing to continue treating the member, HAP Empowered will work with the provider and the member to develop a transition plan to a new PCP or specialist.
Section 17: Model of Care – HAP Empowered MI Health Link Only

HAP Empowered offers the following products:

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The target population for HAP Empowered MI Health Link Program consists of Medicare and Medicaid eligible individuals, defined as Medicare beneficiaries who are also eligible for full Medicaid benefits. The service area for the HAP Empowered MI Health Link product is Macomb and Wayne Counties in Michigan.

Specially tailored services geared toward the most vulnerable population

HAP Empowered understands how vulnerable the HAP Empowered MI Health Link population is and therefore, has added benefits specific to their known unique needs. These value-added services and benefits include:

- A $0 copay for generic and brand drugs
- Care coordination— A nurse or social worker helps the beneficiary navigate the managed care system and attain optimal health. All beneficiaries get a health risk assessment and inter-disciplinary plan of care.
- Health and Wellness Programs - Includes smoking cessation, preventive health outreach for services due such as vaccinations and colorectal cancer screening and disease management programs for diabetes, asthma and hypertension.
- A 24/7 health information line.
- An emergency response service benefit for high risk individuals. Persons must meet certain criteria and must be approved by the medical director.
- Podiatry for medically necessary foot care.
- Vision care - One routine eye exam every two years and up to one pair of glasses, including lenses and frames, every two years.
- A hearing test.
- Dental care - includes an oral exam, fluoride treatment, X-rays and cleaning.

The additional services that HAP Empowered provides to our most vulnerable beneficiaries depend on the beneficiary’s needs and goals. The following examples show some of the vulnerable beneficiary categories and the additional services for which they are eligible:

- Frail: In-home physical therapy and occupational therapy assessments and treatment, transportation to and from medical appointments, in-home safety assessment and emergency response system.
- Disabled: In-home physical therapy and occupational assessments and treatment, transportation to and from medical appointments, in home safety assessment and emergency response system.
- End-stage renal disease: Nutrition counseling, transportation to and from dialysis and medical appointments, educational materials on cooking, renal disease and medications, and a medication reconciliation program.
- Beneficiaries near the end of life: Hospice information, home health aides, nursing care in home, transportation to medical appointments, emergency response system.

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• Beneficiaries with multiple and complex conditions: The beneficiary’s personal care coordinator works with them to navigate the managed care system and attain optimal health, emergency response system, health and wellness programs including smoking cessation, preventive health outreach for services such as vaccinations and colorectal cancer screening and disease management programs for diabetes.

**Integrated Care Bridge or Electronic Care Bridge**

HAP Empowered maintains an Integrated Care Bridge to facilitate timely and effective information flow between the plan, provider, MiHIN and the PIHPs. The Care Bridge can directly exchange information between all members of the healthcare team for more efficient care.

**Care coordination**

Every beneficiary is assigned to a HAP Empowered care coordinator based on the beneficiary’s assigned risk level and individual needs. HAP Empowered will allow the beneficiary or his or her authorized representative a choice in the selection of a HAP Empowered care coordinator.

The care coordinator can be a registered nurse or licensed social worker with experience, education and training who interacts with the special-needs population.

The RN care coordinators have experience in a variety of settings such as acute care, long term care, home care, behavioral health, infusion centers, social work and Area Agencies on Aging to meet the needs of the HAP Empowered MI Health Link population. The SW care coordinator is a master’s level social worker eligible for State of Michigan certification as a Certified Social Worker. They have knowledge of community resources and problems unique to the Medicare and Medicaid population, such as that acquired during one to two years of work experience. They have a professional level of analytical skills to analyze and solve problems and develop viable intervention plans.

Care coordinators report to the Manager of Health Services and are responsible for:

• Conducting, collecting and reviewing the health risk assessment, including analyzing and stratifying the beneficiary’s health care needs based on the HRA
• Contacting beneficiary and reviewing the HRA with them
• Identifying any medical or social impediments to care
• Determining the beneficiary’s ability to follow a prescribed plan of care
• Initiating and implementing a plan of care with attainable goals in conjunction with all health care providers and community agencies
• Modifying the plan as necessary through monitoring and re-evaluation to accommodate changes in treatment or progress
• Contacting the beneficiary on a predetermined schedule to evaluate interventions
• Presenting questionable cases to the medical director for review
• Entering authorizations for approved services into the system per HAP Empowered procedures
• Assuring maintenance and sharing of records and reports
• Assuring HIPAA compliance
• Maintaining paper-based and electronic information systems
The HAP Empowered care coordinator will use the results of the Level I and Level II assessment, when indicated, to develop a person-centered Individual Integrated Care and Supports Plan with the member and ICT chosen by the member. The plan of care will include a review and analysis of the members:

- **Current health status:** Including fall risk, multiple chronic conditions such as diabetes, chronic obstructive pulmonary disease, congestive heart failure and cancer.
- **Clinical history:** Including disease onset, hospitalizations, treatment history, medications, past surgeries, psychiatric conditions, and acute exacerbations due to nonadherence to medications and polypharmacy.
- **Activities of daily living:** Including functional ability to perform ADLs, identified deficiencies in vision, hearing or speech limitations, toileting, incontinence issues, bathing, transferring and mobility including fall risk, eating and swallowing and dressing. It includes assessment of instrumental activities of daily living such as housework, shopping, phone use and money management.
- **Mental health status:** Including psychosocial and cognitive functions such as checking for orientation to person, place and time, wandering issues, threat to self or others and displaying unsafe or extreme bizarre habits. This includes checking for depression, using the screening tool and a history of other psychological conditions.
- **Life planning:** Can, when appropriate, help member complete a living will, advance directive and power of attorney and forward those documents to the PCP.
- **Cultural and religious limitations or preferences:** Including language, treatment choices and facilitation of access to culturally acceptable health care for the beneficiary, such as informing beneficiary of providers who are located close to their home and speak the same language.
- **Caregiver resources:** Including family involvement and identification of caregiver who can participate in developing and implementing plan of care. Communication occurs with the beneficiary and if one has been identified, their caregiver.
- **Benefits:** This includes eligibility issues and financial barriers. Can help identify available community resources and special programs for treatment of conditions including hospice. The care coordinator ensures that referrals are for covered services and facilitates accessing these services. They also educate the beneficiary on the benefits for both Medicare and Medicaid and help resolve any LIS eligibility issues. The case manager facilitates the coordination of the member to work with Michigan Medicare/Medicaid Assistance Programs (MMAPS) in our service area to also help them understand their benefits.
- **Case management plan with short and long-term goals:** Upon completion of the HRA and the welcome call, the care coordinator works with the beneficiary to develop short term goals that can be achieved within three to six months and long-term goals that can be achieved within nine to twelve months. The goals are mutually agreed upon with the care coordinator, the beneficiary and, with consultation, with the PCP. They are based on immediate needs the beneficiary identifies, including their preferences for care and their future goals to improve their health status. These goals include the member's life goals.
- **Additional resources:** Additional resources may be identified during the care plan development. For example, for fall risk or mobility issues, additional resources may include physical therapy, a home safety evaluation and vision and hearing testing. The Care Manager communicates these additional resources to the PCP.
- **Transition of care plan:** When a member's care is transitioned to another setting, such as transfer to hospital or skilled nursing facility, the care plan is adjusted to reflect their current environment and outcome possibilities.
- **Near end of life issues:** The plan of care in CCMS includes the documentation of completion of the member's advance directives and power of attorney. Add-on services include MMAP counselors, hospice counselors and other disease related foundations.
• Barriers: These may include issues with understanding medical instructions, motivation to change, finances and transportation. The care coordinators discuss the plan of care by phone and send the member the ICT brochure. It is written at a sixth-grade reading level to help them understand the information. The beneficiary receives a welcome packet that informs them of the Medicare and Medicaid benefits. They receive a welcome call from the Customer Service representatives who answer their questions and discuss the Medicaid and Medicare benefits. The free transportation benefit is discussed with beneficiaries when they enroll to help eliminate transportation barriers. All contact with members are meant to motivate them to follow the plan of care. While their financial costs for medical care are covered through either Medicare or Medicaid, financial incentives are offered for completion of preventive services such as mammograms.

• Follow-up schedule: Includes documentation of appointments such as counseling, specialty physician and wound clinic to reflect member’s adherence to the plan. Appointment scheduling, attendance and follow-up are documented in McKesson CCMS system. Appointment results and referral provider recommendations are also documented in the CCMS system. For example, if a PCP provides a home care referral for wound dressing changes and IV infusion of antibiotics, the care coordinator facilitates the referral for that care and sets up the arrangements with wound care and IV infusion. The care coordinator would document wound dimension over time, give the member self-care instructions and update the PCP on the member’s status. This would also be reflected in the plan of care and in CCMS.

• Self-management plan: Includes monitoring symptoms, activity, BP, blood sugars, etc. The member’s self-management is an integral part of the care plan. The care coordinator confirms the member understands how to monitor symptoms related to their disease process. Referrals to home care are made to assist in educating the members on self-management activities such as monitoring blood pressure, sugar level, daily weights, temperature and wound appearance. It includes education on reporting symptoms to their PCP.

• Progress assessment: Upon completion of the HRA, the HAP Empowered care coordinator works with the member to develop short-term goals (ones that can be achieved within three to six months) and long-term goals (ones can be achieved within nine to twelve months). The goals are mutually agreed upon with the care coordinator, the member and the PCP. They are based on the immediate needs identified by the member, including member preferences for care and future goals to improve their health status.

The timeframe for reevaluation is individualized based on the member’s plan of care. Automatic prompts are displayed in the reminder log in the McKesson CCMS system based on the timeframes identified in the member’s care plan. If the member does not meet a goal, the goal is revised, or a new goal is established with the member, based on their input. An annual, comprehensive reevaluation is done after the annual HRA is completed.
Interdisciplinary Care Team

The member is the center of the Interdisciplinary Care Team. The HAP Empowered care coordinator ensures that the member has access to and input in the development of an Integrated Care Team to ensure the integration of medical, behavioral health, psychosocial care and LTSS based on the HRA. The ICT is person-centered, built on the member’s specific preferences and needs, and delivers services with transparency, individualization, accessibility, respect, linguistic and cultural competence and dignity.

The ICT honors the member’s choice about their level of participation. This choice will be revisited periodically by the care coordinator as it may change. The care coordinator will include a person familiar with the member’s needs, circumstances and preferences when the member cannot participate fully in or report accurately to the ICT. It is the member’s right to determine the appropriate involvement of other members of the ICT based on the needs identified in the HRA, in accordance with applicable privacy standards.

The care coordinator and the member are responsible for setting and facilitating ICT meetings and facilitating communication among ICT members. LTSS and PIHP support coordinators will be members of ICTs, as applicable, to encourage communication and collaboration between ICOs, PIHPs and other providers. The HAP Empowered care coordinator is responsible for assuring the ICT process, but the member may request his or her LTSS or PIHP supports coordinator remain the main point of contact about their care.
Section 18: Philosophy of Care

HAP Empowered offers the following products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Program</th>
<th>Service area (counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Empowered Medicaid</td>
<td>• Traditional Medicaid</td>
<td>Genesee, Huron, Lapeer, Macomb, Oakland, Sanilac, Shiawassee, St. Clair, Tuscola and Wayne</td>
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<tr>
<td></td>
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<td>HAP Empowered MI Health Link</td>
<td>Integrated Care for Medicare and Medicaid Dual Eligible</td>
<td>Macomb and Wayne</td>
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</tbody>
</table>

The material in this section applies to all plans unless otherwise noted.

HAP Empowered health care providers will deliver services consistent with these philosophies:

- **Person-centered planning:** The principles of person-centered planning are:
  - Each member has strengths, and the ability to express preferences and to make choices.
  - The member’s choices and preferences shall always be honored and considered, if not always granted.
  - Each member has gifts and contributions to offer to the community, and can choose how supports, services and treatment may help them utilize their gifts and make contributions to community life.
  - Person-centered planning processes maximize independence, create community connections and work towards achieving the individual’s dreams, goals and desires.
  - A person’s cultural background shall be recognized and valued in the decision-making process.

- **Self-determination:** All individuals, regardless if they have a disability, have the civil right to live the way they want to live. The principles of self-determination are:
  - Freedom to decide how one wants to live his or her life.
  - Authority over a targeted amount of dollars.
  - Support to organize resources in ways that are life enhancing and meaningful to the individual.
  - Responsibility for the wise use of public dollars and recognition of the contribution individuals across disability and aging can make to their community.

- **Recovery:** An individual's journey of healing and transformation to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. It’s not the role of providers to make decisions for members, but to provide education about the possible outcomes that may result from various decisions.

- **Independent living:** Living just like everyone else and having opportunities to make decisions that affect one’s life, being able to pursue activities of one’s own choosing, and being limited only in the same ways as one’s nondisabled neighbors.

HAP Empowered health care providers are accountable for:

- Member satisfaction.
- Health care access to comprehensive and quality medical care and preventive services.
- Promoting sharing responsibility for health care decisions with members and their families and caregivers.
- Providing culturally competent care by listening and making accommodations for patients' diverse beliefs and practices.
- Being aware of their own assumptions, including those related to the culture of medicine, and attempting a posture of cultural humility and respect toward those who hold different and perhaps conflicting assumptions from their own.
Section 19: Confidentiality, Notice of Privacy Practices, Fraud, Waste and Abuse, Whistleblower Protection

HAP Empowered offers the following products:

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The material in this section applies to all plans unless otherwise noted.

Confidentiality policy

HAP Empowered Health Plan will ensure that employees, primary care providers and participating providers or physicians, through their contracts, hold confidential all information obtained through examination, care or treatment of members or patients. HAP Empowered Health Plan will only divulge such information with appropriate authorization, by law or as medically or administratively necessary to provide services to our members. HAP Empowered Health Plan does not share any member-specific information with employers. Measures to protect the records from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure will be taken by the responsible persons. Any record that contains clinical, social, financial or other data on a member will be maintained in strictest confidence. Only authorized persons with a need to know have access to confidential information. The Quality Improvement Committee reviews and approves the confidentiality policies and annual compliance training occurs with the Health Insurance Portability and Accountability Act.

The State Medicaid Agencies, Department of Health and Human Services, manages the Medicaid recipient’s routine consent to release information during their application for Medicaid. HAP Empowered Health Plan does not enroll members. This function is performed by the State of Michigan. The routine consent covers future, known or routine needs for use of personal health information, such as for treatment, coordination of care, quality assessment and measurement including member surveys, accreditation and billing. The State of Michigan does not require any special consent. HAP Empowered Health Plan practitioners are required to use a release of information form when members wish to have their records copied or released.

HAP Empowered Health Plan protects the confidentiality of information about members consistent with the needs to conduct business without divulging more information than is necessary for treatment, payment and operations.

Information that is held confidential includes personal health information such as name, date of birth, address, gender, medical record information, claims, benefits and other administrative data that are personally identifiable. This includes all forms of PHI, oral, written and electronic forms of member information. If a member is unable to give consent, the member’s legal guardian may authorize the release of personal health information and have access to information about the patient.

Empowered Health Plan associates sign a confidentiality statement upon employment.
Notice of privacy practices

We're committed to protecting your privacy. Safeguarding information about you and your health is very important to us. This notice tells you how your health information may be used and shared and who can see it.

HAP
Alliance Health and Life Insurance Company®
HAP Empowered Health Plan, Inc.
Effective Oct. 1, 2018

Your protected health information
PHI stands for protected health information. PHI can be used to identify you. It includes information such as your name, age, sex, address and member ID number, as well as your:

- Physical or mental health
- Health care services
- Payment for care

You can ask HAP to give your PHI to people you choose. To do this, fill out our release form.

Your privacy
Keeping your PHI safe is important to HAP. We're required by law to keep your PHI private. We must also tell you about our legal duties and privacy practices. This notice explains:

- How we use information about you
- When we can share it with others
- Your rights related to your PHI
- How you can use your rights

When we use the term "HAP," "we" or "us" in this notice, we’re referring to HAP and its subsidiaries. These include Alliance Health and Life Insurance Company and HAP Empowered Health Plan, Inc

How we protect your PHI
We protect your PHI in written, spoken and electronic form. Our employees and others who handle your information must follow our policies on privacy and technology use. Anyone who starts working for HAP must state that they have read these policies. And they must state that they will protect your PHI even after they leave HAP. Our employees and contractors can only use the PHI necessary to do their jobs. And they may not use or share your information except in the ways outlined in this notice.

How we share your PHI
We only share your information with those who must know for:

- Treatment
- Payments
- Business tasks

Treatment
We may share your PHI with your doctors, hospitals or other providers to help them:

- Provide treatment. For example, if you’re in the hospital, we may let them see records from your doctor.
- Manage your health care. For example, we might talk to your doctor to suggest a HAP program that could help improve your health.
Payment
We may use or share your PHI to help us figure out who must pay for your medical bills. We may also use or share your PHI to:

- Collect premiums
- Determine which benefits you can get
- Figure out who pays when you have other insurance

Business tasks
As allowed by law, we may share your PHI with:

- Companies affiliated with HAP
- Other companies that help with HAP’s everyday work
- Others who help provide or pay for your health care

We may share your information with others who help us do business. If we do, they must keep your information private and secure. And they must return or destroy it when they no longer need it for our business. It may be used to:

- Evaluate how good care is and how much it improves. This may include provider peer review.
- Make sure health care providers are qualified and have the right credentials.
- Review medical outcomes.
- Review health claims.
- Prevent, find and investigate fraud and abuse.
- Decide what is covered by your policy and how much it will cost. But, we are not allowed to use or share genetic information to do that.
- Do pricing and insurance tasks.
- Help members manage their health care and get help managing their care.
- Communicate with you about treatment options or other health-related benefits and services.
- Do general business tasks, such as quality reviews and customer service.

Other permitted uses
We may also be permitted or required to share your PHI:

With you
- To tell you about medical treatments and programs or health-related products and services that may interest you. For example, we might send you information on how to stop smoking or lose weight.
- For health reminders, such as refilling a prescription or scheduling tests to keep you healthy or find diseases early.
- To contact you, by phone or mail, for surveys. For example, each year we ask our members about their experience with HAP.

With a friend or family member
- With a friend, family member or other person who, by law, may act on your behalf. For example, parents can get information about their children covered by HAP.
- With a friend or family member in an unusual situation, such as a medical emergency, if we think it’s in your best interests. For example, if you have an emergency in a foreign country and can’t contact us directly. In that case, we may speak with a friend or family member who is acting on your behalf.
- With someone who helps pay for your care. For example, if your spouse contacts us about a claim, we may tell him or her whether the claim has been paid.
With the government
- For public health needs in the case of a health or safety threat such as disease or a disaster.
- For U.S. Food and Drug Administration investigations. These might include probes into harmful events, product defects or product recalls.
- For health oversight activities authorized by law.
- For court proceedings and law enforcement uses.
- With the police or other authority in case of abuse, neglect or domestic violence.
- With a coroner or medical examiner to identify a body, find out a cause of death or as authorized by law. We may also share member information with funeral directors.
- To comply with workers' compensation laws.
- To report to state and federal agencies that regulate HAP and its subsidiaries. These may include the:
  - U.S. Department of Health and Human Services
  - Michigan Department of Insurance and Financial Services
  - Michigan Department of Health and Human Services
  - Federal Centers for Medicare and Medicaid Services
- To protect the U.S. president.

For research or transplants
- For research purposes that meet privacy standards. For example, researchers want to compare outcomes for patients who took a certain drug and must review a series of medical records.
- To receive, bank or transplant organs, eyes or tissue.

With your employer or plan sponsor
We may use or share your PHI with an employee benefit plan through which you get health benefits. It is only shared when the employer or plan sponsor needs it to manage your health plan.

Except for enrollment information or summary health information and as otherwise required by law, we only share your PHI with an employer or plan sponsor if they have guaranteed in writing that it will be kept private and won’t be used improperly.

To use or share your PHI for any other reason, we must get your written permission. If you give us permission, you may change your mind and cancel it. But it will not apply to information we’ve already shared.

Organized health care arrangement
HAP and HAP affiliates covered by this Notice of Privacy Practices and Henry Ford Health System and its affiliates are part of an organized health care arrangement. Its goal is to deliver higher quality health care more efficiently and to take part in quality measure programs, such as the Healthcare Effectiveness Data and Information Set. HEDIS is a set of standards used to measure the performance of a health plan. In other words, HEDIS is a report card for managed care plans.

The Henry Ford Health System organized health care arrangement includes:
- HAP
- Alliance Health and Life Insurance Company
- HAP Empowered Health Plan, Inc.
- HAP Preferred, Inc.
- Henry Ford Health System
Henry Ford’s organized health care arrangement lets these organizations share PHI. This is only done if allowed by law and when needed for treatment, payment or business tasks relating to the organized health care arrangement.

This list of organizations may be updated. You can access the current list at hap.org/privacy or call us at (800) 422-4641 (TTY: 711). When required, we will tell you about any changes in a revised Notice of Privacy Practices.

Your rights
These are your rights with respect to your information. If you would like to exercise any of these rights, please contact us. The contact information is in the “Who to contact” section at the end of this document. You may have to make your requests in writing. You have the following rights:

Right to see your PHI and get a copy
With some exceptions, you have the right to see or get a copy of PHI in records we use to make decisions about your health coverage. This includes our enrollment, payment, claims resolutions and case or medical management notes. If we deny your request, we'll tell you why and whether you have a right to further review.

You may have to fill out a form to get PHI and pay a fee for copies. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to ask us to change your PHI
If we deny your request for changes in PHI, we'll explain why in writing. If you disagree, you may have your disagreement noted in our records. If we accept your request to change the information, we'll make reasonable efforts to tell others of the change, including people you name. In this case, the information you give us must be correct. And we cannot delete any part of a legal record, such as a claim submitted by your doctor.

Right to know about disclosures
You have the right to know about certain disclosures of your PHI. HAP does not have to inform you of all PHI we release. We are not required to tell you about PHI shared or used for treatment, payment and business tasks. And we do not have to tell you about information we shared with you or based on your authorization. But you may request a list of other disclosures made during the six years prior to your request.

Your first list in any 12-month period is free. However, if you ask for another list within 12 months of receiving your free list, we may charge you a fee. We'll tell you if there are fees in advance. You may choose to cancel or change your request.

Right to know about data breaches that compromise your PHI
If there is a breach of your unsecured PHI, we'll tell you about it as required by law or in cases when we deem it appropriate.

Right to ask us to limit how we use or share your PHI
You may ask us to limit how we use or share your PHI for treatment, payment or business tasks. You also have the right to ask us to limit PHI shared with family members or others involved in your health care or payment for it. We do not have to agree to these limits. But if we do, we'll follow them – unless needed for emergency treatment or the law requires us to share your PHI. In that case, we will tell you that we must end our agreement.
Right to request private communications
If you believe that you would be harmed if we send your PHI to your current mailing address (for example, in a case of domestic dispute or violence), you can ask us to send it another way. We can send it by fax or to another address. We will try to meet any fair requests.

You have a right to get a paper copy of this notice.
See our contact information below.

Changes to the privacy
We have the right to make changes to this notice. If we make changes, the new notice will be effective for all the PHI we have. Once we make changes, we'll send you the new notice by U.S. mail and post it on our website.

Who to contact
If you have any questions about this notice or about how we use or share member information, mail a written request to:
    HAP and HAP Empowered Health Plan Information Privacy & Security Office
    One Ford Place, 2A
    Detroit, MI 48202

You may also call us at (800) 422-4641 (TTY: 711).

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us. Contact the Information Privacy & Security Office above or HAP's Compliance Hotline at (877) 746-2501 (TTY: 711). You can stay anonymous. You may also notify the secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Reviewed: November 2008, November 2009, October 2011

Reporting Fraud, Waste and Abuse
HAP Empowered is committed to the prevention, detection, and correction of any criminal conduct.

Any HAP Empowered associate (member, employee, provider, first tier and downstream related entity and their governing bodies) must share this commitment to remain compliant, lawful and ethical conduct.

The HAP Compliance Special Investigations Unit (SIU) is dedicated to detecting, preventing and investigating all reported issues of potential, suspected or known cases of fraud, waste and abuse and issues of non-compliance resulting from fraudulent and abusive actions committed by providers, contractors, subscribers and employees.

- Fraud: When a person knowingly tells a lie that could lead to an unauthorized benefit.
- Waste: When a person misuses benefits and costs the health plan or the Medicaid program extra money.
- Abuse: When a provider gives advice or treatment that’s not in line with sound business or medical practices. This could lead to extra costs to the Medicaid program or the provider being paid for services that are not necessary.
### Examples of provider fraud and abuse
- Billing for services not actually performed
- Falsifying a patient’s diagnosis
- Prescribing unnecessary medications to patients
- Upcoding for expensive, medically unwarranted services

### Examples of member fraud and abuse
- Lying to get unnecessary medical or pharmacy services
- Loaning their ID card to a friend or family member
- Changing a prescription or going to multiple doctors for the same prescription
- Asking for transportation for a non-covered benefit

Waste occurs when services are over-utilized resulting in unnecessary costs to the health care system due to the misuse of resources.

All reported cases of suspected fraud, waste and abuse are monitored and handled by the HAP Office of Compliance and Special Investigations Unit (SIU).

If you suspect any provider, member, employee or contractor of HAP Empowered of potential fraud, waste or abuse of Medicare or Medicaid assets, please contact us immediately. We have a 24-hour, toll-free compliance hotline. You can also mail your concern. Please see information below. The report can be filed anonymously so you are not required to leave your name or any contact information.

- **Phone:** (877) 746-2501
- **Mail:** HAP Empowered Health Plan Compliance Officer  
  P.O. Box 2578  
  Detroit, MI 48220

You may also report your concern to Medicaid, Michigan Department of Health and Human Services, Office of Inspector General by:

- **Phone:** 1-855-MI-FRAUD (643-7283)
- **Mail:** MDHHS-OIG  
  P.O. Box 30062  
  Lansing, Michigan 48909
- **Visiting:** Michigan.gov/fraud

**Whistleblower protection**

As discussed in more detail in the Compliance Program and the policies, employees are responsible for internally reporting compliance issues including issues that raise false claims concerns, fraudulent activity or noncompliance to the code of conduct. It is the policy of the company that no employee who makes a report of alleged wrongdoing will be subjected to reprisal, harassment, retribution, discipline or discrimination by company or any of its employees or agents based on having made the report. Any employee or agent who engages in any such reprisal, harassment, retribution, discipline or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by the company.

The Michigan Whistleblowers’ Protection Act provides protection to employees who report a violation or suspected violation of state, local or federal law.

The Michigan Medicaid False Claims Act provides protection for employees who initiate, assist or participate in a proceeding or court action under this law or who cooperate or assist with investigations conducted under this law.

The Federal False Claims Act contains protections for employees who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in False Claims Act cases.
**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](https://www.cms.gov). Click Medicare, then, under Medicare – General Information, click on **Beneficiary Notices Initiative (BNI)**, then **Medicare Outpatient Observation Notice (MOON)**.