Midwest Health Plan

Provider Newsletter
July 2019

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HAP Midwest integration with hap.org

On July 1, we integrated the HAP Midwest website with **hap.org**. You now have one system for claims, remittance advices, authorizations, member eligibility and more through a secure provider portal. Below are instructions for accessing the portal.

If	Then
You already have a login and password for provider portal	1. Visit **hap.org.** 2. Log in with your username and password.
You don't have a login and password for provider portal	You can: • Self-register by visiting **hap.org** and selecting *Register Now.* or • Call **(866) 766-4708**
Note: Vendor ID and password are required to access remittance advice.	

For more information on the integration, visit the Provider Newsroom. Go to **hap.org/providers** and select *Provider Resources; Medicaid and MI Health Link providers; Newsletters and key information* and then *HAP Midwest Integration Update*.

HAP Empowered

Earlier this year, the plans we offer through HAP Midwest Health Plan, Inc. became HAP Empowered plans. These plans include:

- HAP Empowered Medicaid
- HAP Empowered Healthy Michigan Plan
- HAP Empowered MI Child Program
- HAP Empowered Children's Special Health Care Services program
- HAP Empowered MI Health Link

Only our plan name changed. Members are still with HAP Midwest Health Plan, Inc. and their coverage didn't change. **Providers are contracted and paid through HAP Midwest Health Plan.**

Important contacts

For	Contact
Claims questions	**(888) 654-2200** and follow the prompts
• Adding providers to your office • Office or remittance advice address changes	**provider_contracting@hap.org** or **provider_development@hap.org**
Provider contracting	**(866) 766-4708** or **provider_development@hap.org**
Provider services	**(866) 766-4708** or **prelweb1@hap.org**
Fee schedules Providers are reimbursed at the Medicaid fee schedule.	**Michigan.gov/mdhhs** Details about Medicaid, assistance programs, billing and reimbursement and other provider-specific information.

Physician incentive disclosure

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

Pay for Performance Program for primary care physicians

HAP Midwest has a Pay for Performance Program for PCPs. For more information, log in at **hap.org** and select *P4P for PCPs-Medicaid and MI Health Link* under *Quick Links*.

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.

Michigan Care Improvement Registry

Per your contract with HAP Midwest Health Plan and Public Act 91 of 2006, all immunization providers are required to report childhood immunizations to the Michigan Care Improvement Registry. This affects immunizations administered to persons born Jan. 1, 1994 to present.

If you need information on reporting or access, call **(888) 217-3903** or visit **mcir.org.** They can also help you improve your immunization rates by using MCIR to run batch reports and monthly immunization recall letters.

Reporting communicable diseases

The state and the HAP Midwest 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 **aimtoolkit.org**.

Healthy Michigan Plan health risk assessment completion instructions

HAP Midwest Health Plan offers a $25 incentive for primary care physicians who complete and return a health risk assessment for their HAP Empowered Healthy Michigan Plan patients. This incentive payment is part of the Pay for Performance Bonus Program. To be eligible, PCPs must:

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

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

You can also submit HRAs through CHAMPS. For instructions, visit **michigan.gov/mdhhs**. Select *Assistance Programs*; *Health Care Coverage*; *Healthy Michigan Plan*, then *Health Risk Assessment*.

Medicaid provider enrollment in CHAMPS requirement for prescribers

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

On October 1, 2019, CHAMPS **prescriber** edits go into effect, including all health care providers who can prescribe medications. The MDHHS has issued the following deadline:

- **For dates of service on or after October 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. These pharmacy claims will reject at the point-of-service with a hard edit and message to the pharmacy: "Prescriber Not Enrolled in State Medicaid Program."

The MDHHS developed a letter to explain this issue to beneficiaries who are receiving prescriptions from a non-CHAMPS enrolled prescriber. HAP Empowered will mail this letter to impacted beneficiaries on September 1.

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

Medicaid Prescription Drug Therapy

The Michigan Department of Health and Human Services is taking steps to streamline Medicaid's drug coverage policies. Currently, about one-half of prescription drugs are carved out from managed Medicaid health plans and covered through fee-for-service Medicaid. In October, the MDHHS will be carving in many drugs that are dispensed at the pharmacy and are currently carved out. This will simplify coverage for providers and beneficiaries. Some drugs are part of certain MDHHS program initiatives and will continue to be carved out.

There will be a transition process to prevent disruption to beneficiaries, and prior authorizations that are currently in effect will remain in effect through the end date of the authorization. The MDHHS will provide further details later this year. We'll share more information when details are finalized by MDHHS.

Assistance with opioid prescribing

Do you have questions or need assistance with opioid management? HAP was involved in developing and endorsing provider education for opioid management for the Genesee County Opioid Prevention Project at **https://knowmoregenesee.org**. This information was developed for Genesee County, but these resources are available and helpful to all providers:

- Information about how to become a medication-assisted treatment (MAT) provider
- Information and training resources
- Information about opioid legislation and MAPS
- Opioid prescribing guidelines and educational resources
- Opioid education and prevention-proper disposal of opioid prescriptions, signs of misuse and overdose
- National, state and local resources for assistance related to opioids

HAP Empowered MI Health Link opioid programs

Point of sale pharmacy edits

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

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

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

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

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

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

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

HAP Empowered MI Health Link Drug Management Program

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

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

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

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

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

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

HAP Empowered Medicaid and HAP Empowered MI Health Link Drug Formularies

You can find drug formularies, along with updates and changes, on **hap.org**. Information includes:

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

You can search the formulary to check the status of a specific drug or look at a drug category. You can also view or print the complete formulary document. A printed copy of the drug formulary and related documents are also available upon request.

We post 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, we'll notify affected members and their prescriber.

HAP Empowered Medicaid and HAP Empowered MI Health Link pharmacy prior authorization requests contact information

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

Access and Availability Standards

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

Medicaid Government Program		
Topic	**Standard**	**Measurement Tool**
Availability of Practitioners: HAP Midwest Health Plan will ensure the availability of primary and key specialty practitioners for its members.		
Number of primary care practitioners • General and internal medicine • Family practice • Pediatricians	Ratio of PCPs to members: 1:500	On an annual basis, HAP Midwest reviews and updates the ratios of PCP's to membership, per the MDHHS Medicaid Contract.
Number of key specialty practitioners (high volume) • OB-GYN • Top two specialties based on high-volume claims data	Ratio of practitioners to members: 1:4,000	On an annual basis, HAP Midwest will compute the ratios of specialists to membership using provider and member data from the claims systems. Membership is defined as the total enrolled population, or relevant population for OB-GYN (female members).
Number of high impact practitioners • Oncology	1:4,000	On an annual basis HAP Midwest will compute the ratio of high-impact specialists to membership, using provider and member data from claim systems.
Geographic access: Distance to PCPs, specialists and hospital services. Specialists include: • OB-GYN • Top two specialties based on high-volume claims data	PCPs, pediatricians, and specialist services will be 30 minutes/30 miles for non-rural and 40 minutes/40 miles for rural from a member's home. Hospital services will be 30 minutes/30 miles for non-rural and 60 minutes/60 miles for rural from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software, provider data from the claims systems per the MDHHS Medicaid Contract.
Geographic access: distance to high impact specialists • Oncology	Non-rural: A high-impact practitioner will be 40 minutes/40 miles from a member's home. Rural: A high-impact practitioner will 60 minutes/60 miles from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software, provider data from the claims systems per the MDHHS Medicaid Contract.

Medicaid Government Program		
Topic	**Standard**	**Measurement Tool**
Outpatient behavioral health*	Outpatient behavioral health* services will be 30 minutes/30 miles for non-rural and 75 minutes/75 miles for rural from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software, provider data from the claims systems per the MDHHS Medicaid Contract.
Accessibility of Services: Service will be provided "in the appropriate time frame."		
Appointment lead time: primary care		Performance will be monitored in the annual Access to Care Survey conducted among PCPs and specialty practices, the Consumer Assessment of Healthcare Providers and Systems Survey and the After-Hours Telephone Access Survey per the MDHHS Medicaid Contract.
• **Preventive (regular) or Routine Care** – care provided in asymptomatic situations to prevent the occurrence or progression of conditions	Within 30 days of request	Performance will be monitored in the annual Access to Care Survey conducted among PCP and specialty practices and CAHPS Survey per the MDHHS Medicaid Contract.
• **Non-urgent Symptomatic care** – care provided in symptomatic non-urgent conditions	Within seven days of request	Performance will be monitored in the annual Access to Care Survey conducted among PCPS and specialty practices and CAHPS Survey per the MDHHS Medicaid Contract.
• **Urgent care** – care for serious, but nonemergency injury or illness	Same or next day (within 48 hours)	Performance will be monitored in the annual Access to Care Survey conducted among PCPs and specialty practices and CAHPS Survey per the MDHHS Medicaid Contract.
• **After hours care**	Physicians or their designee shall be available by telephone seven days a week, 24 hours per day.	Performance will be monitored in the annual After-Hours Telephone Access Survey per the MDHHS Medicaid Contract.
• **Emergency services**	Immediately – seven days a week, 24 hours per day.	Performance will be monitored in the annual After-Hours Telephone Access Survey per the MDHHS Medicaid Contract.

Medicaid Government Program		
Topic	**Standard**	**Measurement Tool**
• **Wait time in the office** - How long before the member is seen by the provider after checking in with the receptionist?	Less than 30 minutes	Performance will be monitored in the annual Access to Care Survey conducted among PCPs and specialty practices.
Accessibility of services: Service will be provided "in the appropriate time frame."		
Appointment lead time: High-Volume Specialist and High-Impact Specialist		
• **Acute specialty care (non-urgent with symptoms)**	Within five days of request	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.
• **Specialty care (routine without symptoms)**	Within six weeks of request	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.
• **Urgent care** – care for serious, but nonemergency injury or illness	Same or next day (< 48 hours)	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.
Accessibility of services: Service will be provided "in the appropriate time frame."		
Appointment lead time: behavioral health*		
• **Routine care**	Within 10 days of request	Performance will be monitored in the annual Access to Care Survey conducted among specialist practices or available data reported by provider organizations per the MDHHS Medicaid Contract.
• **Non-life threating emergency**	Within six hours of request	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.

Medicaid Government Program		
Topic	**Standard**	**Measurement Tool**
• **Urgent care** – care for serious, but nonemergency injury or illness	Same or next day (< 48 hours)	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.
Accessibility of Services: Service will be provided "in the appropriate time frame."		
Appointment lead time: dental		
• **Emergency dental services**	Immediately seven days a week, 24 hours per day	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.
• **Routine care**	Within 21 days of request	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.
• **Preventive services**	Within six weeks of request	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.
• **Urgent care** – care for serious, but nonemergency injury or illness	Within 48 hours	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.
• **Initial appointment**	Within eight weeks of request	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.

*Behavioral health is limited to covered services.
All days are business days.

MI Health Link Government Program		
Topic	**Standard**	**Measurement Tool**
Availability of Practitioners: HAP Midwest Health Plan will ensure the availability of primary and key specialty practitioners for its members.		
Number of primary care practitioners • General and internal medicine • Family practice • Pediatricians	Ratio of PCPs to members **Minimum 33 providers**	On an annual basis HAP Midwest will use the ratio of the combination of PCPs to membership, per the MI Health Link Three-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table. Membership is defined as the total enrolled population.
Number of key specialty practitioners • OB-GYN • Top two specialties based on high-volume claims data	Ratio of practitioners to members OB-GYN minimum two providers Top two specialties minimum number of providers per the Health Service Delivery Network Adequacy Standards Criteria Reference Table	On an annual basis HAP Midwest will use the ratio of the combination of high-volume specialists to membership, per the MI Health Link Three-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table. Membership is defined as the total enrolled population, or relevant population for OB-GYN (female members).
Number of high-impact practitioners • Oncology	Ratio of practitioners to members oncology minimum 4 providers	On an annual basis HAP Midwest will use the ratio of high-impact specialists to membership, per the MI Health Link Three-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table.
Geographic access: Distance to PCPs, Specialists and Hospital Services. Specialists include: • OB-GYN • Top two specialties based on high-volume claims data	PCPs and pediatricians will be 10 minutes/5 miles from a member's home. OB-GYN will be 30 minutes/15 miles from a member's home Hospital services will be 20 minutes/10 miles from a member's home.	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the claims systems per the MMP Three-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table.

MI Health Link Government Program		
Topic	**Standard**	**Measurement Tool**
Geographic access: distance to high impact specialists • Oncology	Oncology will be 20 minutes/10 miles from a member's home	HAP Midwest will conduct an annual analysis using GeoNetworks software and provider data from the claims systems per the MI Health Link Three-Way Contract with guidance from the CMS MMP HSD Criteria Reference Table.
Accessibility of Services: Service will be provided "in the appropriate time frame."		
Appointment lead time: primary care		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.
• **Preventive (regular) and routine care** – care provided in asymptomatic situations to prevent the occurrence or progression of conditions	Within 30 days of request	Performance will be monitored in the annual Access to Care Survey conducted among PCP and specialist practices and CAHPS Survey.
• **Non-urgent symptomatic care** – care provided in symptomatic non-urgent conditions	Within 24 hours	Performance will be monitored in the annual Access to Care Survey conducted among PCP and specialist practices and CAHPS Survey per the MI Health Link Three-Way Contract.
• **Urgent care** – care for serious, but nonemergency injury or illness	Within 24 hours	Performance will be monitored in the annual Access to Care Survey conducted among PCP and specialist practices and CAHPS Survey per the MI Health Link Three-Way contract.
• **After-hours care**	Physicians or their designee shall be available by telephone seven days a week, 24 hours per day.	Performance will be monitored in the annual After-Hours Telephone Access survey per the MI Health Link Three-Way Contract.
• **Emergency services**	Immediately seven days a week, 24 hours per day.	Performance will be monitored in the annual After-Hours Telephone Access survey per the MI Health Link Three-Way Contract.

MI Health Link Government Program		
Topic	**Standard**	**Measurement Tool**
• **Wait time in the office**- How long before the member is seen by the provider after checking in with the receptionist?	Less than 30 minutes	Performance will be monitored in the annual Access to Care Survey conducted among PCP and specialist practices.
Accessibility of Services: Service will be provided "in the appropriate time frame."		
Appointment lead time: high volume specialist and high impact specialist		
• **Acute specialty care (non-urgent with symptoms)**	Within 24 hours	Performance will be monitored in the annual Access to Care Survey conducted among specialist practices or available data reported by provider organizations per the MI Health Link Three-Way Contract.
• **Specialty care (routine without symptoms)**	Within six weeks of request	Performance will be monitored in the annual Access to Care Survey conducted among specialist practices or available data reported by provider organizations.
• **Urgent care**–care for serious, but nonemergency injury or illness	Within 24 hours	Performance will be monitored in the annual Access to Care Survey conducted among specialist practices or available data reported by provider organizations per the MI Health Link Three-Way Contract.

Questions about HAP Midwest Health Plan?

You can always call us at **(888) 654-2200** for more information. We also have the following information posted online at **hap.org/providers**. Select *Provider Resources* then *Medicaid and MI Health Link* providers. If you prefer a hard copy, call the number listed above and we'll mail it to you.

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