HAP Medicare Complete Duals (HMO D-SNP)
Frequently Asked Questions for Providers

The following information is specific to the 2024 HAP Medicare Complete Duals (HMO D-SNP) plan.

Important! Are you participating – what you need to know?

- **Providers contracted with HAP Medicare HMO products are participating in our D-SNP network.**
- Providers contracted with HAP Medicare plans and open to new patients are required to see our D-SNP members.
- Primary care physicians are not required to become a HAP CareSource Medicaid participating provider.
- The member can't be held responsible for the remaining balance that Medicaid would cover.
- When a HAP Medicare provider sees a D-SNP member, they may not be the HAP CareSource Medicaid PCP on record. **The provider only needs to be listed as the HAP Medicare PCP.**

General

1. **What is a Dual Eligible Special Needs Plan?**
   - A dual special needs plan, or D-SNP, is a special type of Medicare Advantage HMO plan that provides health benefits to members who qualify for Medicare and are eligible for Medicaid services in their state.
   - These members often have special health care needs such as chronic conditions. Most members have an income below the federal poverty line and receive extra help from the government to help pay for their health care costs, including health insurance premiums and prescription drugs.
   - These members are often transient, meaning they do not have a permanent residence and may stay with family members who can help care for them. Some may live in an institutionalized care facility.

Service Area

1. **What is the HAP Medicare Complete Duals (HMO D-SNP) service area?**
   Members must reside in a county where a D-SNP plan is offered by their health plan to be eligible. HAP offers a D-SNP plan in Genesee, Macomb, Oakland, and Wayne counties.

Provider Network

1. **What is the HAP Medicare Complete Duals (HMO D-SNP) provider network?**
   Providers contracted with HAP Medicare HMO products are participating in our D-SNP network. Members may only see providers in our D-SNP network.

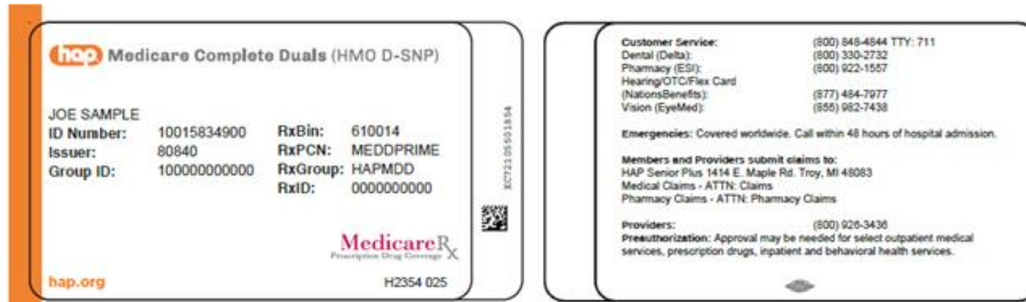
2. **Are members required to have a primary care physician (PCP)?**
   Yes, members must select a network provider to be their PCP. We will auto-assign a PCP if one is not selected.

3. **What if the member's PCP is not a Medicaid participating provider?**
   The PCP is not required to become a HAP CareSource Medicaid participating provider. The member cannot be held responsible for the remaining balance that Medicaid would cover.

4. **Are all providers required to see our D-SNP members?**
   Providers contracted with HAP Medicare plans and open to new patients are required to see our D-SNP members.

ID Cards

1. **What do member ID cards look like?**
   D-SNP members will carry the HAP Medicare Complete Duals (HMO D-SNP) ID card below. They also have a state-issued Medicaid ID card. They should show both cards each time they visit their doctor or facility.



Member Eligibility

1. **What are the eligibility requirements to join HAP Medicare Complete Duals (HMO D-SNP)?**
   - Must be eligible for Medicare; entitled to Part A and enrolled in Part B; 65 and older or under 65 with certain disabilities, or special needs
   - Must be eligible for full Medicaid benefits
     - Note: Members can enroll in the HAP CareSource Medicaid plan or enroll in another carrier's Medicaid plan or have a fee-for-service Medicaid plan with the State

   We accept members with these Dual designations:
   - FBDE: Full Benefit Dual Eligibles
   - SLMB Plus: Specified Low-Income Beneficiaries
   - QMB Plus: Qualified Medicare Beneficiary
   - Members must reside in 4 county service area: Genesee, Wayne, Oakland or Macomb

2. **When can a member enroll in a D-SNP?**
   D-SNP members have a Special Enrollment Period (SEP) which allow them to enroll, disenroll or switch plans. This is a period of time that may occur due to a qualifying life event at any time of the year. For the full list of qualifying events, you can contact the plan, call Medicare, or visit the Medicare website.

3. **What if a member loses eligibility?**
   If a member loses their Medicaid eligibility, our plan will continue to cover Medicare benefits for a grace period of up to 90 days. This grace period begins the first day of the month after we learn of the loss of eligibility. If at the end of the 90-day grace period, Medicaid eligibility has not been regained and the member has not enrolled in a different plan, we will disenroll the member from our plan. They will be enrolled back in Original Medicare.

   We may also contact the member to assist them in enrolling in a HAP Medicare Advantage Prescription Drug Plan with affordable cost shares and premiums.

4. **Do D-SNP members have to enroll in HAP CareSource Medicaid?**
   HAP Medicare Complete Duals (HMO D-SNP) members are not required to enroll in HAP CareSource Medicaid. If members also chose HAP CareSource for their Medicaid plan, HAP will coordinate benefits for both plans. Members will receive a HAP CareSource ID card and a HAP Medicare Complete Duals (HMO D-SNP) ID card.

Verifying the PCP

To verify the PCP, you can:

- Call **(866) 766-4661**
- Log in at **hap.org** and select *Member Eligibility.*

Member Benefits

1. **What services and benefits are covered in our D-SNP plan?**
   - All benefits covered under Original Medicare.
   - Supplemental benefits vary by plan and can include:
     - Non-emergency transportation
     - Meal programs
     - Over-the-counter (OTC) products
     - Hearing aids
     - Eyewear
     - Emergency response system for eligible members to maintain independence and safety
     - Fitness
     - Up to 8 hours of companion care for eligible members
     - Flex Card for food, home safety modifications, dental services, pest control, and utilities
     - Extra help for diabetics
   - Members may only see providers in the HAP D-SNP network. No out-of-network benefits exist for this plan except for emergencies, and urgently needed services when the network is not available, and cases in which HAP authorizes use of out-of-network providers.

Billing and Claims

1. **Can a provider balance bill a member?**
   No. Providers may not balance bill D-SNP members who do not have cost share responsibility (including Qualified Medicare Beneficiary only members). Members who lost their Medicaid eligibility may have a cost share. To confirm member eligibility, you can:
   - Visit the CHAMPS web portal at **milogintp.michigan.gov**
   - Call CHAMPS Provider Support at **(800) 292-2550, option 5, then 2**

   Important! D-SNP is a Medicare Advantage plan. The PCP is not required to become a HAP CareSource Medicaid participating provider. The member can't be held responsible for the remaining balance that Medicaid would cover.

2. **Should a provider bill Medicare or Medicaid first?**
   Providers should bill Medicare first. Federal rules dictate that Medicaid is the payer of last resort. For both plans, when Providers receive their HAP CareSource remittance advice, they may bill Medicaid for any remaining balance. Actual payment level depends on the state payment policies. Providers may be required to be enrolled in the state Medicaid program to bill the state Medicaid agency for eligible services. HAP does not coordinate the secondary payment. **Members should never be balanced billed.**

3. **What member ID number should a provider use to submit electronic claims?**
   Use the *ID Number* on the member's HAP Medicare Complete Duals (HMO D-SNP) ID card.

Case Management

1. **Do members receive case management services?**
   Members enrolled in a D-SNP plan have an Interdisciplinary Care Team (ICT), which includes physicians and care coordinators that work together to help each member receive the most appropriate, highest quality of care. Each member has an Individualized Care Plan (ICP) based on the results of their comprehensive Health Risk Assessment (HRA). The HRA must be performed by a nurse or care coordinator within 90 days of enrolling in a D-SNP.

Provider Requirements

1. **Do providers need additional training to see D-SNP members?**
   The Centers for Medicare & Medicaid Services requires D-SNP plans to:
   - Have an approved model of care
   - Conduct initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis. Information on our model of care training can be found here.

2. **What information are providers required to submit?**
   To support Healthcare Effectiveness Data and Information Set (HEDIS) initiatives, be sure to submit encounter data for the Care for Older Adults (COA) measure. Requirements include:
   - Advanced Care Planning (CPTII: 1157F, 1158F)
   - Functional Status Assessment (CPTII: 1170F)
   - Medication Review (CPTII: 1159F and 1160F must both be submitted on the same claim, same day)
   - Pain Screening (CPTII: 1125F, 1126F)

Contacts and Resources

Claims and Reimbursement	
• Claims status and appeals • EFT form	• Call HAP at **(866) 766-4661** • Log in at **hap.org** and select *Claims*
Fee schedules	• Visit Michigan.gov/mdhhs and search for *Provider Specific Information* • Call HAP at **(866) 766-4661**
EDI setup	Contact your clearing house and give them our payer ID 38224
Eligibility and Benefits	
Eligibility, benefits copay and deductible information	• Log in at **hap.org** and select *Member Eligibility* • Call HAP at **(866) 766-4661** • CHAMPS: Visit **milogintp.michigan.gov** Call **(800) 292-2550**, option 5, then 2
Prior Authorizations	
Prior authorization requirements	Log in at **hap.org**; select *Procedure Reference List* under *Quick Links*
Submitting authorization requests and checking status	Log in at **hap.org** and select *Authorizations*
Online Applications	
Access online applications	Visit **hap.org**; select *Log In*, *Register now*, *Provider*
Portal access issues	**Forgot username or password:** Visit **hap.org**; select *Log in*; *Provider*; *Forgot username*; *Forgot password?* Still need help? Email **providernetwork@hap.org** and include all the information below. • Type 1 and Type 2 NPI • Tax ID • Provider name • Full contact information (address, phone, email)
Changes to existing provider information	
• Billing and office address changes • Tax ID changes • Terminations from HAP • Changes to patient accepting status • Provider type or specialty changes or additions • Transferring networks • W-9 changes	Complete the *Provider Change* form. You can find it in two places when you visit **hap.org**: • *I'm a Provider*; *Provider resources*; *Forms and other information* • *Contact; Provider; Demographic changes, training & education; contracting & credentialing* Simply download the form, complete it and then email it to **providernetwork@hap.org**. Note: If you are part of a physician organization/physician hospital organization, do not send form directly to HAP. All changes must be submitted from your PO/PHO organization.
General	
• Contract questions • Credentialing status • Provider office training	Email **providernetwork@hap.org** and include: • Type 1 and Type 2 NPI • Tax ID
Your Network Partners	
For a list of Provider Services Administrators by network: • Log in at **hap.org**; select *Quick Links*, then *Important Contact Information for Providers*	