WORKING WITH HAP CARESOURCE™

HEALTH PARTNER ORIENTATION

HAP CareSource
HAP CareSource MI Health Link
HAP CareSource Marketplace Plan

HAP CareSource™

Table of ***Contents***

HAP CARESOURCE PARTNERSHIP

HAP CareSource™

Delivered with Heart by CareSource

A Partnership with ***Heart***

HAP CareSource is a joint venture between CareSource and Health Alliance Plan (HAP) of Michigan. HAP and CareSource are coming together to provide expansive and high-quality health care coverage to more Michigan residents through a combined Medicaid offering and Health Care Marketplace.

At HAP CareSource, we recognize a true partnership can only exist when we listen to and understand your needs. We are dedicated to partnering with you in the most effective way to improve member outcomes and make it easier for you to care for out members.

Our goal is to drive value by helping providers deliver positive health outcomes for vulnerable people in Michigan while effectively managing costs.

THANK YOU FOR JOINING OUR TEAM!

Our *Mission*

MISSION

HAP CareSource is committed to providing excellence in our managed care product lines for our members through fiscally responsible programs that ensure access to and the delivery of cost-effective and high-quality medical services.

PLEDGE

- Make it easy for you to work with us
- Partner with providers to help members make healthy choices
- Direct communication
- Timely and low-hassle medical reviews
- Accurate and efficient claims payment

HAP CareSource Medicaid, HAP CareSource Marketplace, and HAP CareSource MI Health Link will change the way health care is delivered in Michigan!

Collaborative Focus

- Emphasis on quality-based improvements
- Value-based purchasing
- Creating uniform systems to ease administrative burden
- Addressing all barriers to access
- Patient-Centered Medical Home (PCMH) support
- True commitment to improving the lives of Michigan

Our *Plans*

HEALTHY MICHIGAN PLAN

A low-cost health insurance program

- Michigan residents ages 19-64 years
- Income at or below 133% of the federal poverty level
- Do not qualify for or enrolled in Medicare or any other Medicaid program
- Not pregnant at the time of application
- For more information, visit Healthy Michigan Plan

CHILDREN'S SPECIAL HEALTH CARE SERVICES

Children and select adults with special health care needs.

- Michigan residents under age 26
- US citizen or documented/legally admitted non-citizen
- Qualifying medical condition
- For additional details please visit Children's Special Health

MI HEALTH LINK

Medicare plus Medicaid coverage

- Michigan residents ages 21 years and over
- Fully eligible for Michigan Medicaid and enrolled in Medicare
- Live in eligible counties

MARKETPLACE

- Plans purchased by individuals for themselves and their families from the health insurance, available to those who don't have access to health insurance through employer-sponsored plans.

- Reduced premiums or cost-sharing; pediatric vision; optional adult vision and fitness

WORKING WITH HAP CARESOURCE

HAP CareSource™

Communicating with HAP CareSource | ***Contact List***

	MEDICAID	MI HEALTH LINK	MARKETPLACE PLAN
Provider Services (all times are E.T.)	**1-833-230-2102** Monday through Friday 8 a.m.-6 p.m.	**1-833-230-2159** Monday through Friday 8 a.m.-6 p.m.	**1-833-230-2101** Monday through Friday 8 a.m.-6 p.m.
Utilization Management Fax	1-844-432-8931 NICU Fax: 1-833-230-2036	1-844-633-0399	1-844-676-0372
Provider Portal	HAPCareSource.com/Providers/Provider-Portal		
Electronic Funds Transfer	ECHO® Health, Inc. Enrollment: 1-888-834-3511 Customer Service: 1-833-629-9725 Fax: **440-835-5656**		
Electronic Claims Submission	Use Availity clearinghouse CS Payer ID: **MIMCDCS1**	Use Availity clearinghouse CS Payer ID: **MIMCRCS1**	Use Availity clearinghouse CS Payer ID: **MICS1**
Claim Address	HAP CareSource Attn: Claims Department P.O. Box 1186 Dayton, OH 45401		
Member Services (all times are E.T.)	1-833-230-2053 Monday-Friday 8 a.m.-8 p.m.	1-833-230-2057 Monday-Friday 8 a.m.-8 p.m.	1-833-230-2099 Monday-Friday 7 a.m.-7p.m.
Care Management	1-844-217-1357	1-833-230-2057	1-833-230-2064

Provider ***Resources***

WEBSITE

HAPCareSource.com

- Downloadable Provider Manual
- Newsletters and Network Notifications
- Formularies
- Covered benefits
- Quick reference guides
- And more!

PROVIDER SERVICE CENTER

AVAILABLE 8 A.M. TO 6 P.M., EASTERN TIME

MEDICAID	MI HEALTH LINK	MARKETPLACE PLAN
1-833-230-2102	1-833-230-2159	1-833-230-2101

- Check member eligibility
- Check member benefit limits
- Request a prior authorization
- Help find a specialist
- Learn more about our quality program
- Arrange interpretation services for members
- Answer any questions!

Expectations *for Care*

- Provide services in accordance with the recommended service program including the amount, frequency, duration and scope of each service
- Primary Care Providers (PCPs) must ensure 24-hour availability for your HAP CareSource members by telephone
- Notify HAP CareSource of any demographic changes prior to the effective date of the change immediate notice required, depending on the type of change (refer to the Provider Manual)
- Attest to provider directory information quarterly
- Provide appropriate notification to terminate, in accordance with your provider agreement
- Do not balance bill HAP CareSource members
- Comply with the NCQA and our contract requirements for provider access standards
- Provide medical records upon request
- Submit claims or corrected claims within appropriate timeframes days from the date of service or discharge
- Treat HAP CareSource members with respect

Please refer to your contract and the HAP CareSource Provider Manual for more information on provider expectations and responsibilities.

Our ***Responsibilities***

- Ensure an effective member/provider appeal and grievance process
- Provide support for every provider through the Provider Services call center
- Comply with all state and federal regulations
- Pay clean claims per contract requirements
- Coordinate benefits for members with primary insurance

PLEASE REFER TO YOUR CONTRACT AND THE HAP CARESOURCE PROVIDER MANUAL FOR MORE INFORMATION ON PROVIDER EXPECTATIONS AND RESPONSIBILITIES.

Provider ***Referrals***

It is important that members use in-network providers and facilities whenever possible. In-network providers are better connected with HAP CareSource and have ready access to member information. **Our members do not need a written referral to see in-network providers**, thus reducing your administrative burden**.**

Referring Doctor – Document the referral in the medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist – Document in the medical record that the member was referred to you for services. Referral numbers are not required on claims submitted for referred services. Documentation in the medical record should contain the number of visits or length of time of each referral.

Standing Referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period. The period must be at least one year to be considered a standing referral.

Referrals to Out-of-Network Providers – A member may be referred to an out-of-network provider if they need medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get prior authorization (PA) from our health plan before sending a member to an out-of-network provider

Referrals for Second Opinions – Providers or members may request a second opinion at no additional cost to the member if the service was obtained in network.

Provider Network & *Eligibility*

IN-NETWORK REFERRALS

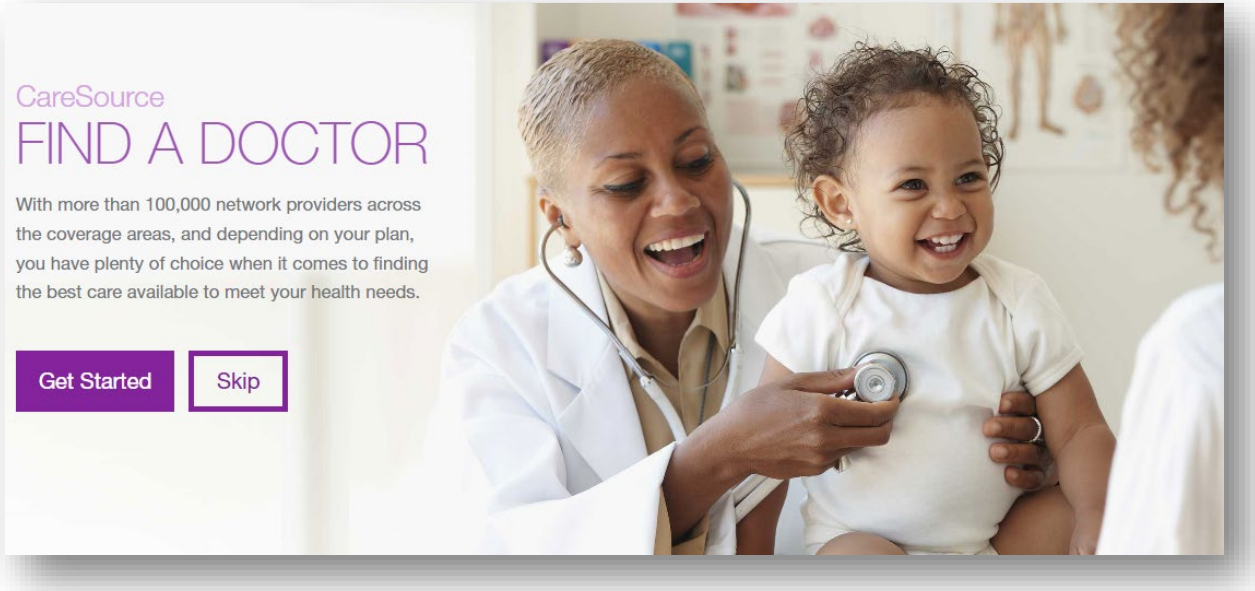
To ensure coverage of services, confirm that you refer members to other in-network providers. Use our Find-a-Doctor tool at **HAPCareSource.com** to help you locate a participating HAP CareSource provider by plan.

OUT OF NETWORK SERVICES

Out-of-network services are NOT covered unless they are emergency services, covered by the No Surprises Act, or prior authorized by HAP CareSource.

MEMBER ELIGIBILITY

Be sure to ask to see each member's HAP CareSource ID card and **verify their eligibility** via the HAP CareSource Provider Portal prior to each service rendered.

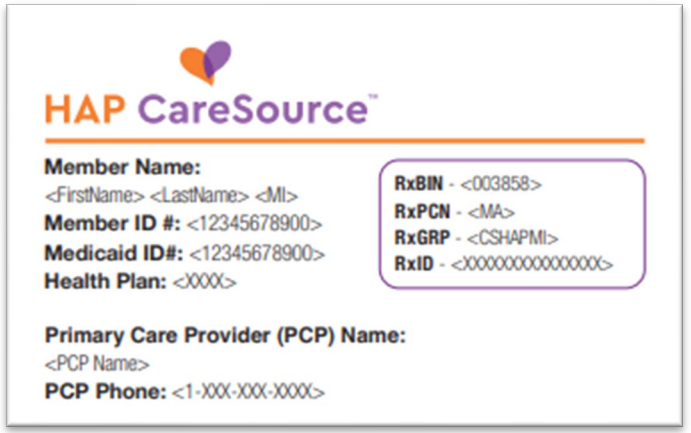


Identifying a HAP CareSource ***Medicaid Member***

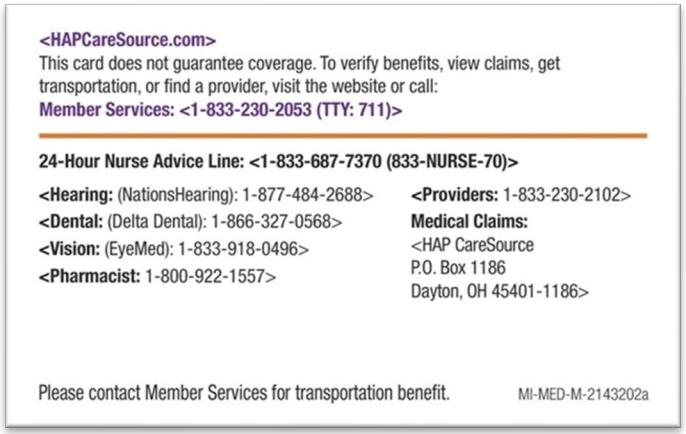
MEMBER ID CARDS

The member ID card is used to identify a HAP CareSource member. However, having a member ID card does **not** guarantee eligibility or benefits coverage. Please verify member's eligibility prior to each service rendered.

Michigan Medicaid ID Card
This card indicates the member is enrolled in Michigan Medicaid.



FRONT



BACK

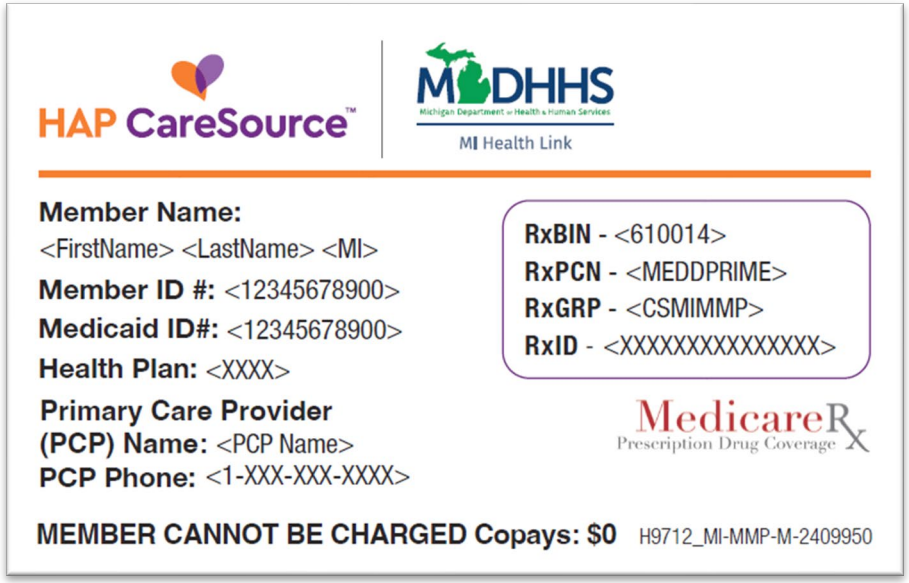
HAP CareSource Member ID Card
This card is used to identify a HAP CareSource member. This care provides important identifying information as well as plan contact information.

Use our secure Provider Portal or call Provider Services at **1-833-230-2102** to check member eligibility.

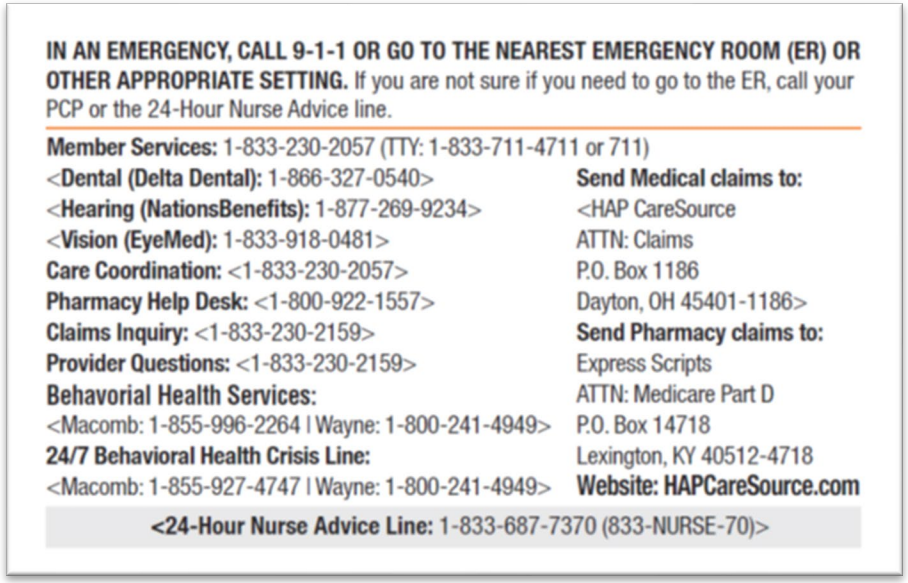
Identifying a HAP CareSource *MI Health Link Member*

MEMBER ID CARDS

The member ID card is used to identify a HAP CareSource MI Health Link member. However, having a member ID card does **not** guarantee eligibility or benefits coverage. Please verify member's eligibility prior to each service rendered.



FRONT



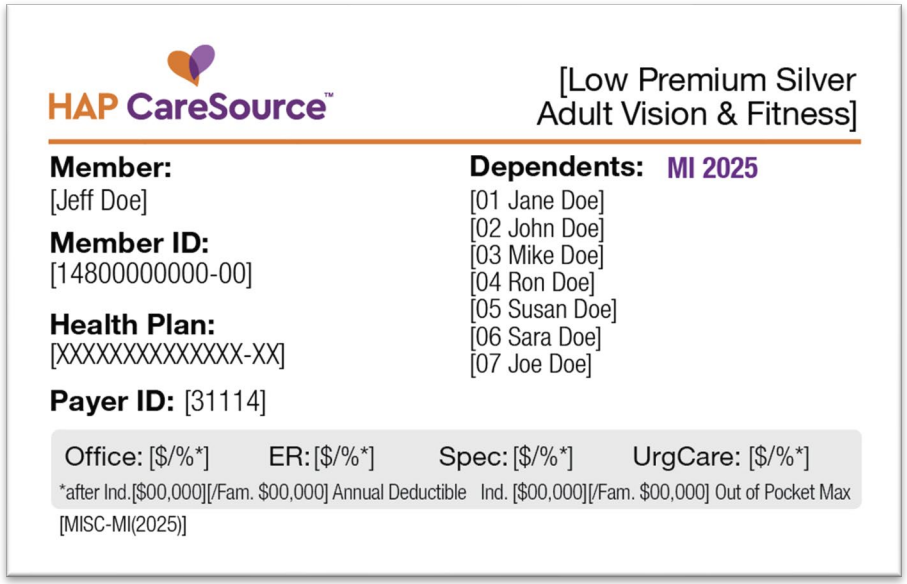
BACK

Use our secure Provider Portal or call Provider Services at **1-833-230-2159** to check member eligibility.

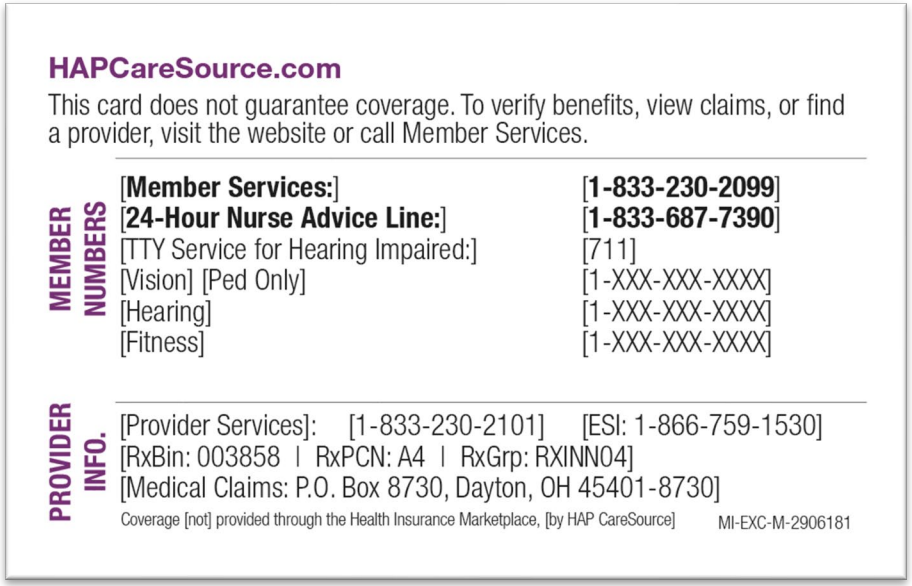
Identifying a HAP CareSource ***Marketplace Member***

MEMBER ID CARDS

The member ID card is used to identify a HAP CareSource member. However, having a member ID card does **not** guarantee eligibility or benefits coverage. Please verify member's eligibility prior to each service rendered.



FRONT



BACK

Use our secure Provider Portal or call Provider Services at **1-833-230-2101** to check member eligibility.

Marketplace Member | *Financial Responsibility*

ANNUAL DEDUCTIBLE, COPAYMENTS & COINSURANCE

These costs are applicable for most covered services. It is up to the provider to collect these amounts at the time of service.

BALANCE BILLING

Network providers **may not** balance bill HAP CareSource members for covered services.

Member *Communications*

HELP YOUR PATIENTS UNDERSTAND THEIR COVERAGE

Encourage members to visit **HAPCareSource.com**, where they can access:

- <MyCareSource.com Member Portal or MyLife>
- Searchable online formulary and prescription cost calculator
- Find-a-Doc tool
- Information on Coverage and Benefits
- Member Handbook
- Total Cost Navigator
- Forms and more

For more information, visit: **HAPCareSource.com/members**.

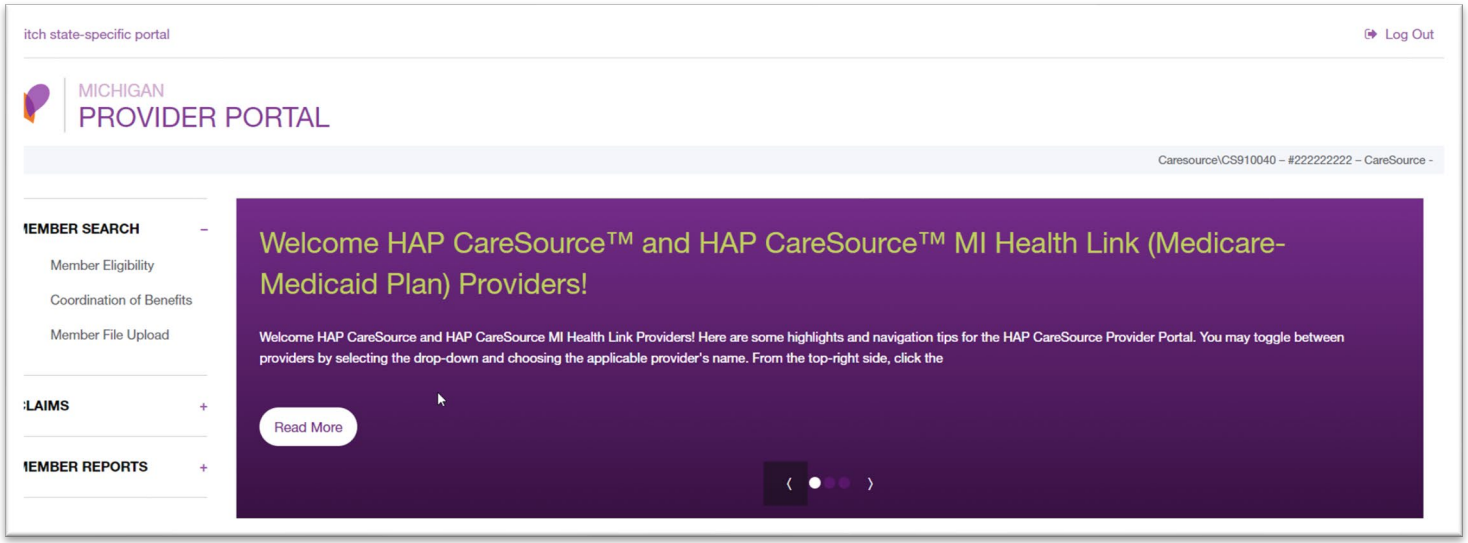
PROVIDER PORTAL

HAP CareSource™

Time-Saving *Tools*

At HAP CareSource, we make it easier for you to do business with us – 24 hours a day, seven days a week with our free, secure HAP CareSource Provider Portal.

- Member Eligibility & Termination
- Claims Information
- Coordination of Benefits
- Payment History
- Explanation of Payment
- Prior Authorization
- Care Treatment Plans
- Care Management Referrals
- Member Profile
- Clinical Practice Registry
- Resources & Training



Single ***Sign-On***

TWO PORTALS, ONE SIMPLE SIGN-ON!

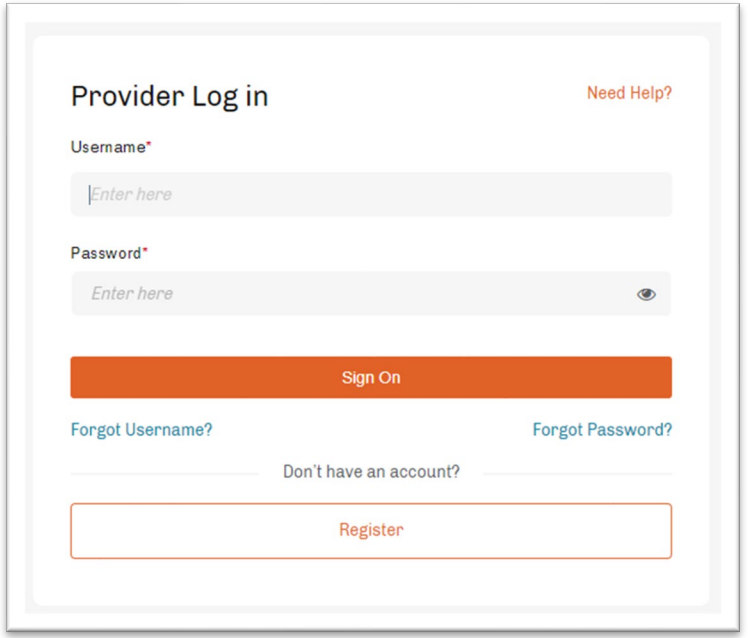
Both CareSource and HAP offer the benefit of a provider portal. We offer single sign-on from the HAP Portal to the HAP CareSource Provider Portal to streamline your operations.

- Visit HAPCareSource.com and click Login > **Provider in MI** at the top right corner.
- Follow the instructions on the screen.

REGISTER – IT'S EASY!

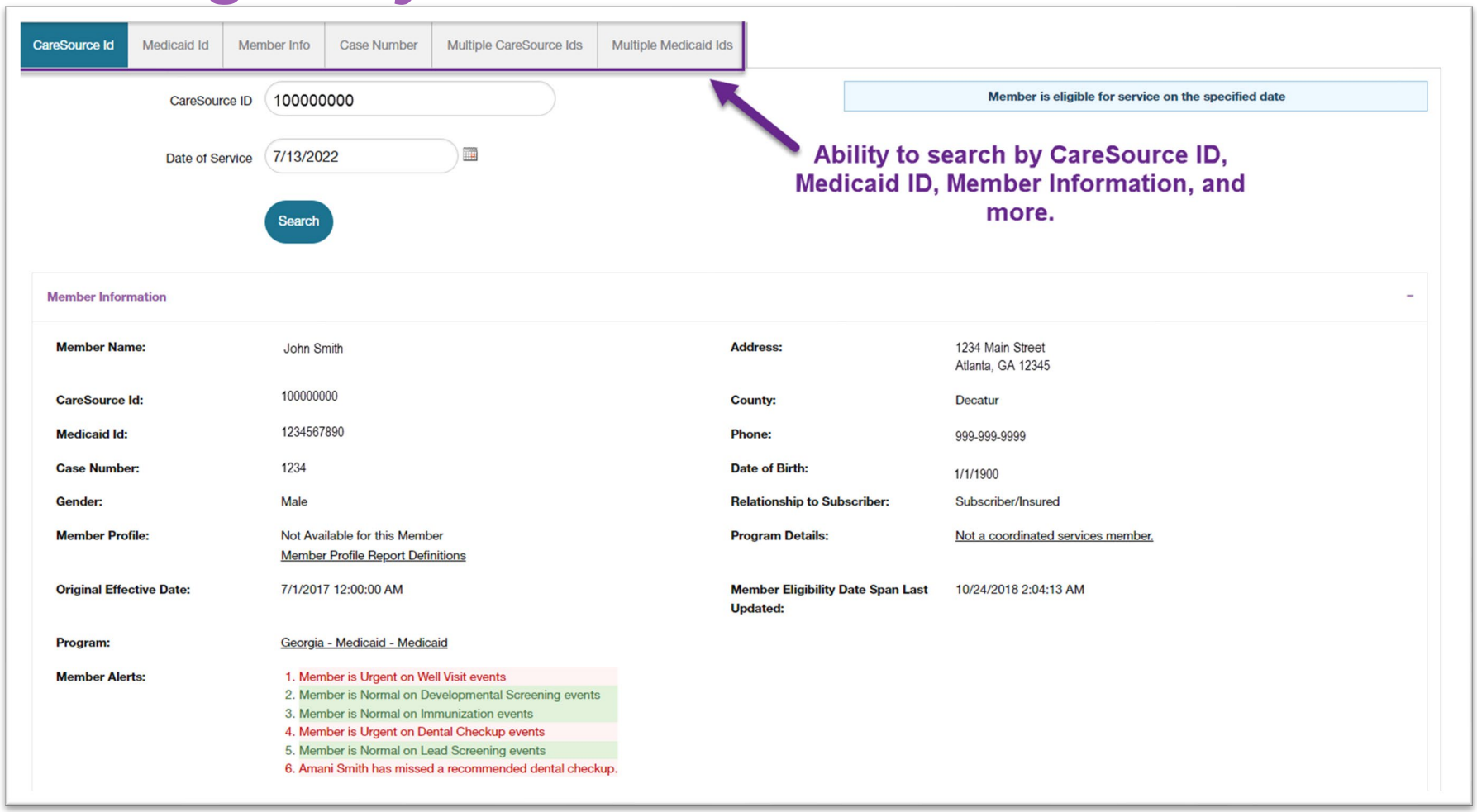
You will access the HAP CareSource Provider Portal through the HAP Portal.

- Only one username and password to remember for both portals.
- Current users of the HAP Portal can log in at hap.org.
- New users to the HAP Portal will need to self-register.

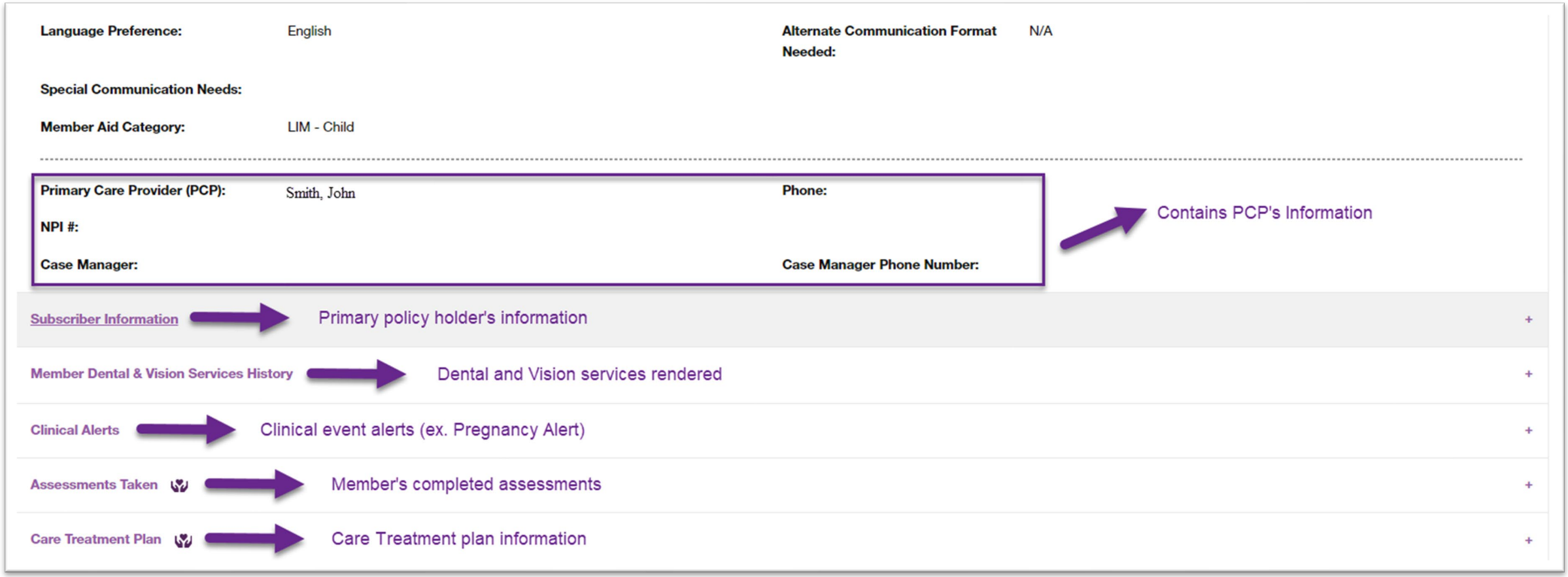


The first time you access the HAP CareSource Portal, you will need to ***set up the Multifactor Authentication.***

Member *Eligibility*



Member *Eligibility*



Updating the ***Provider Directory***

Please be sure your office address, phone, fax, etc. are up to date in the National Plan & Provider Enumeration System or NPPES. Pharmacy benefit managers typically use DEA and NPPES systems to send required patient-level notices, such as transition letters and approval or denial letters.

Providers should submit provider adds, demographic or status changes and terminations by going to https://www.hap.org/providers/contact-info and scrolling to “Demographic Changes”.

Questions? Please contact our Provider Services team.

MEDICAID: **1-833-230-2102**

MI HEALTH LINK: **1-833-230-2159**

MARKETPLACE PLAN: **1-833-230-2101**

SUBMITTING CLAIMS

HAP CareSource™

Submitting *Claims*

In general, HAP CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. For more information on our claims process, visit **HAPCareSource.com** > Providers > Claims.

For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file are up to date.

See our **Provider Manual** for full details on our claim submission process.

INFORMATION TO INCLUDE

- Member name
- Member address
- HAP CareSource member ID number
- Member date of birth
- Place of service – use standard CMS Health Care Finance Administration (HCFA) location codes
- ICD-10 diagnosis code(s)
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable
- Units, where applicable (anesthesia claims require minutes)
- Date(s) of service
- Prior authorization number, where applicable
- National Provider Identifier (NPI) Federal Tax ID number (TIN) or provider Social Security number
- Use nine-digit zip code

Claims ***Submissions***

SUBMISSION PROCESS

Providers can submit claims through our secure, online Provider Portal at **HAPCareSource.com** > Provider Portal .Providers can submit claims along with any documentation, track payments and more.

CLEARINGHOUSES

For electronic data interchange (EDI) transactions, HAP CareSource accepts electronic claims through our clearinghouse, Availity. Providers can find a list of EDI vendors online at: www.availity.com/ediclearinghouse.

Who Can Submit Claims Via the Provider Portal?

- Traditional providers
- Community partners and delegates
- Health homes

What Types of Claims Can Be Submitted?

- Professional medical office claims
- Institutional claims
- Behavioral health claims

Claims Payments | ***Sign up for EFT***

HAP CareSource™

EFT

ECHO offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Claims webpage at **HAPCareSource.com** > Providers > Provider Portal > Claims, for additional information about getting paid electronically and enrolling in EFT.

Visit Enroll to complete your enrollment online. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the HAP CareSource Provider Portal.

Notice: **Email notifications are not sent when a deposit/payment is made.**
Deposits/payments are made twice weekly.

APPEALS, DISPUTES AND GRIEVANCES

HAP CareSource™

Appeals, Disputes and Grievances ***Overview***

Term and Definition	Who May File	How to Submit	Time Frame/Resolution
Dispute - Disagreement of payment decision made by HAP CareSource	Provider or Member	HAP CareSource Provider Portal or mail	File within 60 days of original denial or claim rejections Decision within 30 calendar days.
Claims Appeal - Provider disagreement with denial	Provider	HAP CareSource Provider Portal or mail	Submit with appeal letter and medical records within 60 days of the original denial date. Decision within 30 calendar days.
Clinical Appeal - • **Pre-Service**: a request to change the decision on any case or services that must be made in whole or in part in advance of the member obtaining medical care or services. • **Expedited Pre-Service**: A request to change an urgent care request where the decision could seriously jeopardize the life or health of the member, jeopardize the member's ability to regain maximum function or subject the member to sever pain, not managed without the requested care. • **Post-Service**: a request to change a decision on any review for care or services that have already been received.	Provider	HAP CareSource Provider Portal, fax or mail	Pre-Service: 60 days to file appeal with member written consent Decision within 30 days. Expedited (Pre-Service): Member or authorized representative may submit an expedited appeal. Appeal must be submitted within 10 calendar days. Member consent is required. Decision will be made within 72 hours Post -Service: 60 calendar days to file appeal from date of initial denial letter. 30 calendar days for a decision
Grievance - Expression of dissatisfaction about any matter other than an action subject to Appeal.	Provider or Member	HAP CareSource Provider Portal, call or mail	Decision within 90 days

Claim Appeals *and Disputes*

HAP CareSource™

ALL CLAIMS APPEALS MUST BE:

- Submitted within 60 calendar days from the date of claim denial
- Submitted via one of these methods
  - HAP CareSource Provider Portal
  - **HAPCareSource.com** > Providers > Tools & Resources > Forms > Provider Appeal Form
    - Fax: 937-396-3492
    - Mail: HAP CareSource
      Attn: Grievances and Appeals
      P.O. Box 1025
      Dayton, OH 45401-1025

CLAIM DISPUTES

HAP CareSource also offers a claim payment dispute process. Additional information pertaining to claim appeals and claim payment disputes can be found in the Provider Manual or on **HAPCareSource.com**.

- As a HAP CareSource provider, you may submit a dispute or appeal for a member or on your own behalf.
- The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- Providers must obtain a member's written consent to appeal an Adverse Benefit Determination on their behalf.
- As a HAP CareSource provider, we may contact you to obtain documentation when a member has filed a request for one of these reviews. HAP CareSource does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.
- For additional information, contact **Provider Services**

Medicaid: **1-833-230-2102** | MI Health Link: **1-833-230-2159** | Marketplace Plan: **1-833-230-2101**

Member Grievances, Appeals and ***State Fair Hearings***

Members have the right to file a grievance or appeal and request a State Fair Hearing or review by an Independent Review Organization, of decisions made by HAP CareSource.

Members are encouraged to call or write to HAP CareSource to let us know of any complaints regarding HAP CareSource or the health care services they receive.

Detailed grievance and appeal procedures are explained in the member handbook and the **Provider Manual**.

HAP CARESOURCE NOTIFIES MEMBERS IN WRITING WHEN A DECISION IS MADE TO:

- Deny or limit authorization of a requested service, including the type or level of service.
- Reduce, suspend or terminate services prior to the member receiving the services previously authorized.
- Deny, in whole or in part, payment for a service.
- Fail to provide services in a timely manner.
- Fail to act within the resolution timeframe.

Members have the right to appeal the actions listed in the letter if they contact HAP CareSource within 60 calendar days from the date of the denial letter. See the **Provider Manual** for additional deadlines and turnaround times associated with the Grievances and Appeals process.

PRIOR AUTHORIZATIONS

HAP CareSource™

Prior Authorization *Services*

SOME SERVICES REQUIRE PRIOR AUTHORIZATION

- Visit procedurelookup.caresource.com - No login required!
- Use dropdown and select appropriate line of business under **Michigan** header.
- For fast authorization processing, HAP CareSource offers **Cite AutoAuth**, an automated evidence-based system. It's quicker than phone or fax! Access it from the Provider Portal.

Find more information on prior authorizations in our Provider Manual, located at **HAPCareSource.com** > Providers > Tools & Resources > Provider Manual

PRIOR AUTHORIZATION SUBMISSION REQUIREMENTS

- Member name and HAP CareSource member ID number
- Provider name, Tax ID and National Provider Identifier (NPI)
- Facility and NPI/Tax ID if applicable to the request
- Anticipated date(s) of service or date of admission for emergent inpatient
- Diagnosis code and narrative
- Procedure, procedure code, treatment or service(s) requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of a service
- Inpatient services need to include whether the service is elective, urgent or emergency, admitting diagnosis, symptoms & plan of treatment

Note: We do not require in-network providers to obtain a prior authorization for an office visit. Information about drug prior authorizations is in the pharmacy section

Prior Authorization ***Submissions***

METHOD	MEDICAID	MI HEALTH LINK	MARKETPLACE PLAN
Provider Portal – Preferred Method	Log in: HAP CareSource Provider Portal From the HAP CareSource Provider Portal, use the Providers > Prior Authorization menu.		
Fax	1-844-432-8931 NICU Fax: 937-396-3499	1-844-633-0399 NICU Fax: 937-396-3499	1-844-676-0372 NICU Fax: 937-396-3499
Phone	**1-833-230-2102**	**1-833-230-2159**	**1-833-230-2101**
Mail	HAP CareSource P.O. Box 1307 Dayton, OH 45401-1307		

MEMBER BENEFITS

HAP CareSource™

Preventive *Care*

Preventive care is recommended for the whole family. HAP CareSource advises members to see their PCP on a routine basis.

PREVENTIVE CARE INCLUDES, BUT IS NOT LIMITED TO:

- Yearly well-care exams including BMI assessment (also counseling for nutrition and physical activity for children)
- Mammograms and cervical cancer screenings for women
- Prostate cancer screenings for men
- Colorectal cancer screenings for adults
- Routine dental and medical exams
- Recommended immunizations
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under the age of 21
- Family planning
- Annual medication review

Behavioral Health ***Services***

HAP CareSource ensures that all members have access to behavioral health resources and that behavioral health is integrated across all interventions.

- Members may **self-refer** to a participating provider for behavioral health services without referral from their PCP.
- PCPs and specialists must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders – or may provide clinically appropriate behavioral health services within their scope of practice.
- Behavioral Health providers are expected to assist members in accessing emergent, urgent and routine behavioral services as required by the member's condition.
- HAP CareSource members have access to specialty Behavioral Health Care Managers for assistance in obtaining both routine and higher complexity health care services.
- We can assist members and PCPs with locating appropriate participating providers and with making appointments for members in need of services.

Covered ***Services Medicaid and MMP***

BENEFITS OVERVIEW

- PCP and Specialist Office Visits
- Emergency Services
- Preventive Services & Screenings
- Inpatient Facility Services
- Outpatient Diagnostic Services
- Home Health Services
- Durable Medical Equipment Services
- Rehabilitation Therapy Services
- Habilitative Services
- Maternity Services
- Dental Services
- Vision Services

MEMBER BENEFITS

- Nurse Advice Line
- Disease Management
- Health and Wellness Education
- Inhalation Therapy
- Pain Management

MEMBER PROGRAMS

- Integrated Care Management
- Transportation (Medicaid and MI Health Link)
- MyStrength and MyLife
- Rewards Programs

Covered ***Services Marketplace***

BENEFITS OVERVIEW

- PCP and Specialist Office Visits
- Emergency Services
- Preventive Services & Screenings
- Inpatient Facility Services
- Outpatient Diagnostic Services
- Home Health Services
- Durable Medical Equipment Services
- Rehabilitation Therapy Services
- Habilitative Services
- Maternity Services
- Vision Service

MEMBER BENEFITS

- Nurse Advice Line
- Disease Management
- Health and Wellness Education
- Inhalation Therapy
- Pain Management

MEMBER PROGRAMS

- Integrated Care Management
- MyStrength and MyLife
- Rewards Programs

Well-Baby/Well-Child *Services*

HAP CareSource offers programs and reward incentives to encourage members to be proactive in their *self-care.*

MATERNAL-CHILD PROGRAMS

- Care4Moms App
- Breast Pumps
- Care Management
- Quit for Two
- Text4Baby
- BUMP
- Educational Resources

INCENTIVE PROGRAMS

- MyKids Rewards
- MyHealth Rewards (adults)

WELLNESS/DISEASE MANAGEMENT

- Kids Wellness
- Asthma Disease Management
- Diabetes Disease Management

Services ***Not Covered***

SERVICE TYPES
Medically unnecessary services
Services received from out of network providers, with specific exceptions
Experimental or investigational services
Alternative or complimentary medicine
Cosmetic procedures
Assisted reproductive therapy

For more details on covered services, visit **HAPCareSource.com**

HAP CareSource ***Vendors***

VENDOR	SERVICE
CSS Health – Clinical Support Services	Pharmacy – Medication Therapy Management
Delta Dental of Michigan – Medicaid and MI Health Link	Routine Dental Benefit
NationsHearing – Medicaid and MI Health Link TruHearing - Marketplace	Routine Hearing Benefit
EyeMed– Medicaid, MI Health Link, and Marketplace	Routine Vision Benefit
MTM – Medical Transportation Management (Medicaid and MI Health Link)	Transportation
Express Scripts	Pharmacy Benefit Manager

Transportation ***Services****

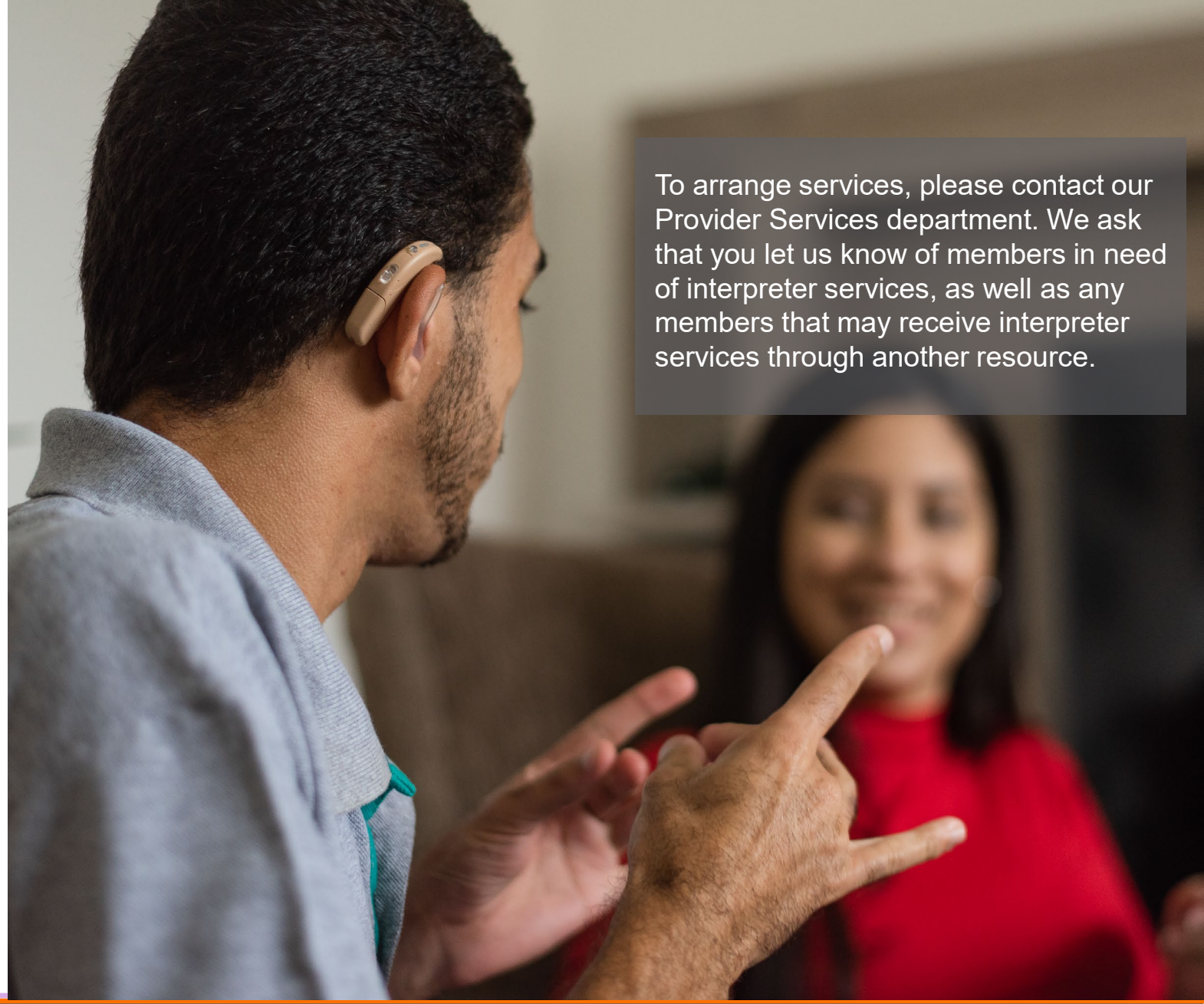
Provider Scheduling Line	1-866-733-8997 Routine reservations accepted 7:00 a.m. to 8:00 p.m., E.T. Monday through Friday After hours: Urgent and discharges are accepted 24/7/365*
Standard Scheduling Timeline	Trips must be scheduled 48 hours (two business days) up to 30 days in advance
Same Day/Sick Visit Instructions	Same-day/sick visit trips available by calling scheduling line above; provider may need to confirm urgency
30 One-Way Trips/15 Round Trips, Less than 30 Miles	Available for all members and renews on an annual basis
Trip Limit	For covered benefits, there are no trip limits

*Calls for urgent and hospital discharges are accepted on national holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas) despite HAP CareSource Customer Service being closed. The caller must tell the IVR they wish to schedule transportation or contact Medical Transportation Management (MTM) directly.

*Available to Medicaid and MI Health Link members only

Translation ***Services***

- Sign and language interpretation
- HAP CareSource offers onsite sign and language interpreters as well as over-the phone (OPI) and video remote interpreting (VRI). Services are available to HAP CareSource members who are hearing impaired, do not speak English or have limited English-speaking proficiency.
- Service is available at no cost to the member or provider.
- As a provider, you are required to identify the need for interpreter services for your HAP CareSource members and to offer appropriate assistance.



To arrange services, please contact our Provider Services department. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Supplemental Benefits ***Overview & Information***

ABOUT OUR BENEFIT MANAGERS

HAP CareSource partners with select vendors to provide expanded benefits and services, including expertise in the services and broadened networks.

These are exclusive relationships for the services considered – meaning our member must use a provider within the benefit manager's network for HAP CareSource to contribute.

See **HAPCareSource.com** for a full listing of benefits in this plan.

Visit HAPCareSource.com for more details on:

- Dental
- Hearing
- Pharmacy
- Vision
- And more

Marketplace Plan ***Supplemental Benefits***

BENEFIT CATEGORY	ELIGIBLE MEMBERS	SERVICES	BENEFIT OVERVIEW	CONTACT
Routine Hearing TruHearing	✓ All Marketplace members	▪ Member Services ▪ Provider network ▪ Claims adjudication	Routine hearing exams and hearing aid discounts	1-866-202-2561
Routine Vision EyeMed	✓ All pediatric members (<19 years of age) ✓ Adults 19+ years of age on dental & vision plans	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ Explanation of Benefits (EOB)	Routine eye exam, glasses, contacts, and other value-added services	1-833-337-3129
Active & Fit American Specialty Health (ASH)	✓ Adults 18+ years of age on dental & vision plans	▪ Member Services ▪ Provider network	No cost shared fitness center access, home health kits, internet tools and education	1-877-771-2746

Note: Refer your HAP CareSource patients to these vendors using the numbers provided

Pharmacy ***Overview***

PHARMACY BENEFIT

HAP CareSource Medicaid covers **all** medically necessary Medicaid-covered, provider-administered drugs and medical supplies. All Medicaid health plans in Michigan utilize the Michigan Preferred Drug List (PDL).

SPECIALTY DRUGS

<Pharmacy Advantage> can provide specialty medications directly to the member or the prescribing physician and coordinate nursing care if required. For more information, visit our Pharmacy webpage at **HAPCareSource.com** > Providers > Education > Pharmacy, selecting the appropriate plan from the dropdown menu.

RESOURCES

- Find authorization requirements and information about submitting authorization requests for prescriptions at **HAPCareSource.com** > Pharmacy.
- The Formulary search tool and prior authorization lists are available on **HAPCareSource.com>** Pharmacy.
- Medication Therapy Management (MTM) allows pharmacists to work collaboratively with physicians to prevent or address medication-related problems, decrease member costs and improve prescription drug adherence.
- See website for additional information.

Pharmacy Benefits | *Marketplace Plan*

MEDICATION COST-SHARING STRUCTURE

Lower tiers = lower drug cost

Tier 0	Tier 1	Tier 2	Tier 3	Tier 4
No member cost share. This tier contains preventive medications.	Contains low-cost generic drugs.	Higher coinsurance or copayment than those in Tier 1. This tier contains preferred non-specialty brand-name drugs.	Higher coinsurance or copayment than those in Tier 2. This tier contains non-preferred non-specialty brand-name drugs.	Higher coinsurance or copayment than those in Tier 3. Drugs generally classified as specialty medications fall into this category.

Visit HAP **CareSource.com >** Pharmacy if you wish to access our full formulary list.

PROVIDERS CARING FOR CHILDREN

HAP CareSource™

Early and Periodic Screening, Diagnostic and Treatment *(EPSDT)*

The EPSDT benefit includes a comprehensive array of preventive, diagnostic and treatment services for Medicaid eligible infants, children and adolescents under age 21.

The EPSDT benefit is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to assure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services.

Refer to the American Academy of Pediatrics (AAP) Bright Futures for the EPSDT periodicity schedule.

REIMBURSEMENT

The program provides reimbursement for preventive health services, interperiodic visits, developmental screenings, brief emotional/behavioral assessments, hearing and vision screenings, and immunizations under the EPSDT benefit.

- Use appropriate preventive medicine CPT codes, diagnosis codes and EPSDT referral indicators to ensure proper payment
- Coding guide is available in the **Provider Manual**.

Early and Periodic Screening, Diagnostic and Treatment *(EPSDT)*

EXAM COMPONENTS

- A comprehensive health, psychosocial and developmental history
- Documentation of vital signs
- An unclothed comprehensive physical examination
- Assessment of growth and nutritional status
- Assessment of social and emotional development
- Assessment of immunization status and provision of appropriate immunizations
- Screening for vision, hearing, lead poisoning and development
- Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance
- Oral health screening, preventive counseling and referral to a dentist for ongoing dental care
- Screening for and if suspected, reporting of child abuse and neglect
- Anticipatory guidance (health education)

PROGRAM REQUIREMENTS

- Initial exams are to be completed within 90 days of enrollment date.
- Newborn initial exams are to be completed within 24 hours of birth.
- Referrals/follow-ups where appropriate based on history and exam findings.
- PCPs must contact members by phone/mail to encourage visits.
- For more information about the EPSDT program, visit the EPSDT webpage at **Medicaid.gov** > Medicaid > Benefits > Early Periodic Screening, Diagnostic and Treatment.

Vaccines for ***Children***

The Vaccines for Children (VFC) program is a federally-funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of a family's inability to pay. Health care providers must register as a VFC provider to receive and administer VFC vaccines.

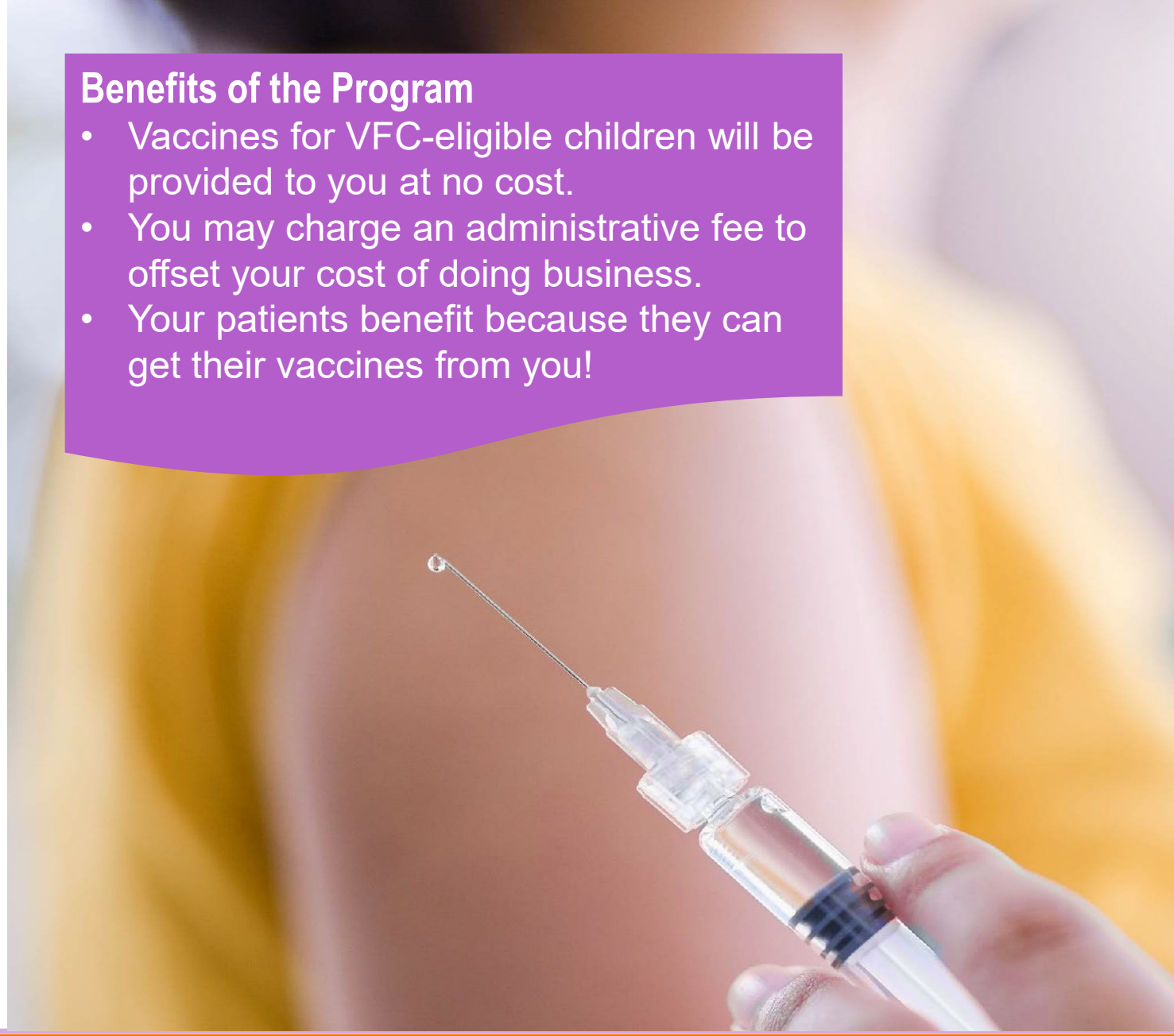
BECOMING A VFC PROVIDER

- Contact your local health department to request enrollment.
- Complete the Michigan Provider Enrollment forms and return them as soon as possible.
- Once you have completed and returned the enrollment forms, prepare for a site visit to review the program's administrative requirements and proper handling and storage of vaccines.
- Visit the Michigan MDHHS VFC Resource Guide for more information.

Thank you for your commitment to a healthier Michigan!

Benefits of the Program

- Vaccines for VFC-eligible children will be provided to you at no cost.
- You may charge an administrative fee to offset your cost of doing business.
- Your patients benefit because they can get their vaccines from you!



QUALITY AND CARE MANAGEMENT

HAP CareSource™

Disease Management *Program*

OUR DISEASE MANAGEMENT PROGRAM

This program is designed to help our members and caregivers understand, self-manage and increase control of their conditions while reducing health care costs.

MEMBER ENGAGEMENT

Continuous Education designed to help members understand their condition and self-manage their chronic condition.

All Ages Engagement covers members of all ages, birth through adulthood.

Active Participation improves the percentage of HAP CareSource members who receive their recommended screenings.

Integrated Program so member has one point of contact for a seamless experience managing all aspects of their health.

PROGRAM CONDITIONS INCLUDE:

- Children's Special Health Care Services (CSHCS)
- Hepatitis C
- Human Immunodeficiency Virus (HIV)
- Sickle Cell Disease (SCD)
- Lead Poisoning

If you have a patient whom you believe would benefit from this program and is not currently enrolled, please call Medicaid: 1**-844-217-1357** | MI Health Link: **1-833-230-2057** | Marketplace: **1-833-230-2064**

Hepatitis C and Chronic Kidney Disease

HEPATITIS C

The Centers for Disease Control and Prevention recommends:

- All adults should be tested for Hepatitis C at least once in their lifetime.
- Persons who are pregnant should be tested for Hepatitis C during each pregnancy.

To learn more about recommended treatment programs and Hepatitis C support, visit the Michigan government website.

CHRONIC KIDNEY DISEASE (CKD)

It is important to test for CKD, especially those who have diabetes and/or hypertension.

Providers can find recommendations and patient resources online.

Care Management *Program*

OUR CARE MANAGEMENT PROGRAM

- All members may choose to engage with Care Management.
- All members are given a complete Health Risk Assessment (HRA) to determine their care management needs.
- Care Managers work with members to create plans of care to support their needs.
- Care Managers also receive alerts of Emergency Department (ED) visits and inpatient stays.

USE OUR PROVIDER PORTAL TO:

- Refer a patient for Care Management
- Identify the Care Manager assigned to a patient
- Find contact information for Care Manager
- Interact with coordination options

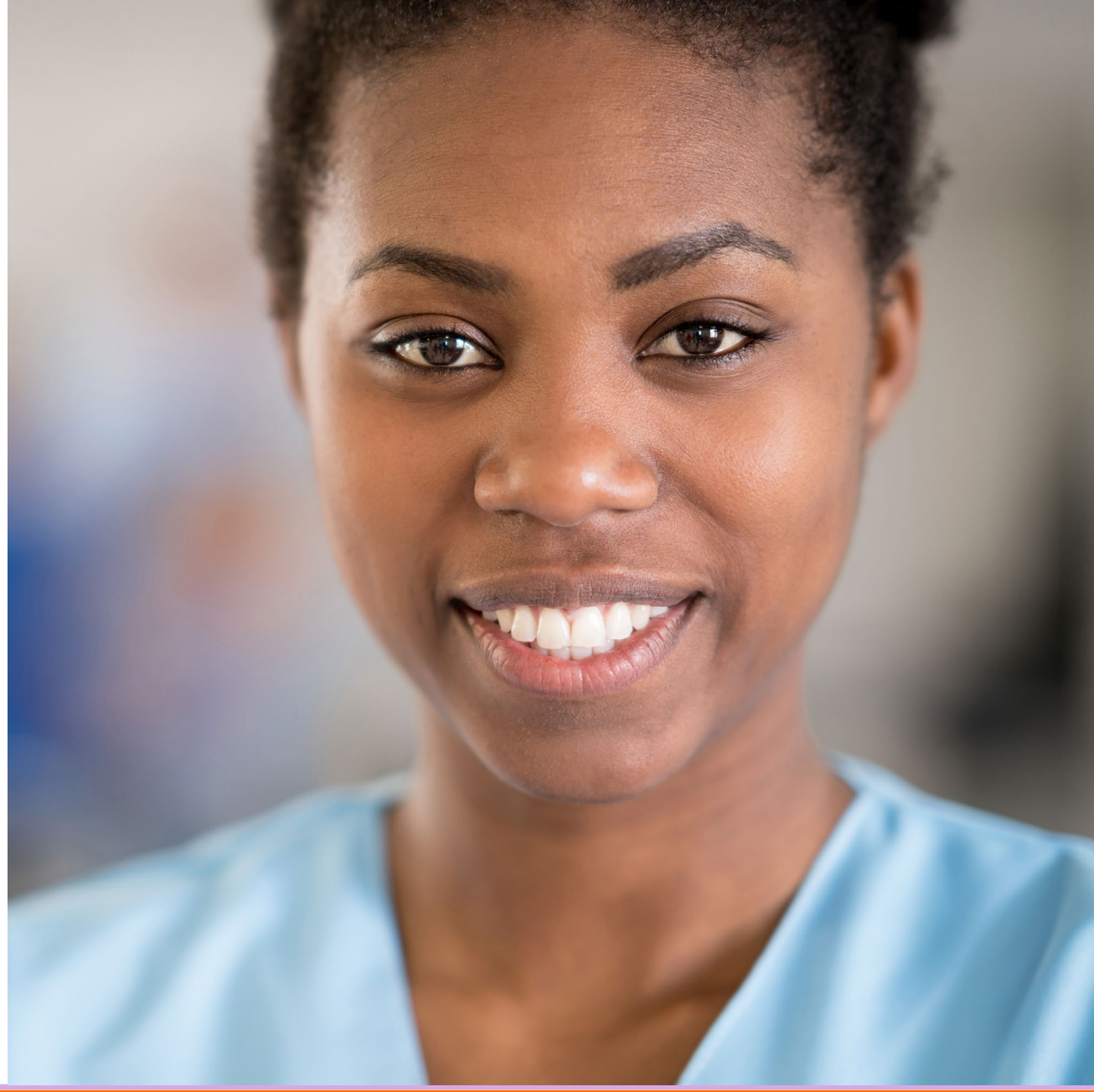
PROVIDERS CAN HELP PATIENTS ENGAGE WITH THEIR CARE MANAGER BY CALLING:

MEDICAID: **1-844-217-1357** | MI HEALTH LINK: **1-833-230-2057**
MARKETPLACE: **1-833-230-2064**

Role of the ***Case Manager***

A licensed health care professional:

- Coordinates a member's health care needs
- Coordinates development of a member's care plan
- Ensures care plan incorporates a member's available benefits and resources
- Connects a member with community support services
- Assists a member in completing HRA
- Assists in closing gaps-in-care
- Assists with transitions of care
- Removes barriers



Care Coordination | ***Marketplace***

DID YOU KNOW THAT YOU CAN REFER YOUR PATIENTS TO OUR CARE COORDINATION PROGRAM?

Our Interdisciplinary Care team offers individualized assistance to address health concerns and resource needs. Your patient will be paired with a Care Manager who will function as a single point of contact to address their health care and health information needs. Patients can connect with their Care Manager via their direct phone line to address coordination needs or answer questions and concerns they may have.

Our Care Managers create personalized programs to address barriers, including:

- Assisting with obtaining necessary medications and supplies
- Providing education for chronic and acute illnesses
- Connecting to community resources
- Explaining insurance benefits and services
- Establishing after-hours supports

To connect your patient to a member of our team, please go to the HAP CareSource Provider Portal, click Providers then Care Management Referral, call us at 1-833-230-2064, or email MarketplaceReferrals@CareSource.com.

Quality *Measures*

HEDIS® MEASURES

HAP CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis and the annual review of the Healthcare Effectiveness Data and Information Set (HEDIS).

HEDIS includes a multitude of measures that look at different domains of care:

- Effectiveness and Experience of Care
- Access and Availability of Care
- Utilization and Risk-Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Data Systems

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Wellness & Prevention

- Childhood vaccinations
- Immunizations for adolescents
- Lead screenings for children
- Breast cancer and cervical cancer screenings
- Well-child visits

Chronic Health Conditions

- Controlling high blood pressure
- Comprehensive diabetes care
- Statin therapy for patients with cardiovascular disease or diabetes

Behavioral Health

- Follow-up after hospitalization for mental illness
- Follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medications

Access to Care

- Children and adolescents' access to primary care providers
- Annual dental visit
- Prenatal and postpartum care

Clinical Practice ***Registry***

The HAP CareSource Clinical Practice Registry is an online tool available to providers to identify and prioritize health care services, screening, and tests for their HAP CareSource members. It is easy to access via the secure HAP CareSource provider portal.

The registry includes information on, but is not limited to, the following measures:

- Adult access
- Asthma
- Breast and cervical cancer screening
- Colorectal cancer screening
- Diabetes care
- ED visits
- Well-care visits

HAP CareSource provides performance reports for these metrics to enhance practice procedures. Reports can be exported to PDF or Excel file for enhanced use.

Identify Gaps in Care

View preventive service history and easily identify HEDIS gaps-in-care to discuss during appointments.

Holistic Care

Receive alerts when HAP CareSource members need tests or screenings, review member appointment histories and view their prescriptions.

Improve Clinical Outcomes

Easily sort your HAP CareSource members into actionable groups for population management.

HAP CareSource MI Health Link | *Quality Management Program*

HAP CareSource MI Health Link has an ongoing Quality Assessment and Performance Improvement (QAPI) Program.

Program Goals:

- Promote and improve delivery of medical and health care services
- Monitor and evaluate the appropriateness of clinical and nonclinical member care and services

Monitoring is performed through review of:

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

Access & Availability ***Standards***

Providers should see members as expeditiously as their condition and severity of symptoms warrant.

Visit https://www.hap.org/providers/provider-resources/forms for a list of Access & Availability standards.

FOR PCPs ONLY

- Provide 24-hour availability to your HAP CareSource patients by telephone seven days a week.
- Patients should be given the means to contact their PCP or back-up provider to be triaged for care.
- It is **not** acceptable to use a phone message that does not provide access to you or your back-up provider, and only recommends emergency room use for after-hours.
- Providers are required to meet response time standards for patient calls after normal business hours.

MEMBER SAFETY

HAP CareSource™

Ensuring Access to ***Equitable Care***

HAP CareSource must ensure that services are provided in a culturally competent manner and promote equitable access to services for underserved or vulnerable populations, such as the following:

- People with limited English proficiency or reading skills
- People of ethnic, cultural, racial, or religious minorities
- People with disabilities
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex
- People who live in rural areas and other areas with high levels of deprivation
- People otherwise adversely affected by persistent poverty or inequality
- Visit our Health Equity web page for additional information

Assess, Identify & Report – *Member Abuse or Neglect*

Critical incidents are defined as any occurrence that results in **injury**, **abuse**, **neglect** or **exploitation** of a beneficiary. Providers must have written policies for documenting and reporting all critical incidents.

INCIDENT REPORTING

Providers are required to ensure the immediate health and safety of members when becoming aware of abuse, neglect or exploitation. The provider's actions may include calling police or EMS, reporting to county Adult Protective Services (APS), or Public Child Services Agency (PCSA) or regulatory agencies.

Providers are required to report these types of incidents to HAP CareSource within 24 hours of becoming aware of the incident.

SUBMIT AN INCIDENT

- To HAP CareSource: Any provider-related concerns should be relayed to the HAP CareSource Member Services who will report the incident per internal processes.

  Medicaid: **1-833-230-2053** | MI Health Link: **1-833-230-2057** | Marketplace: **1-833-230-2099**

- To MDHHS: Call Centralized Intake at 855-444-3911
- Report child abuse or neglect to MI Bridges

CRITICAL INCIDENTS WHICH MUST BE REPORTED INCLUDE, BUT ARE NOT LIMITED TO:

- Life-threatening injuries
- Allegations of staff misconduct
- Allegations of abuse or neglect
- Participant leaving facility without permission
- Allegations of sexual activity between beneficiaries and providers

ASSESSMENT RESOURCES:

- ChildWelfare.gov - Child Abuse & Neglect
- NIA & NIH – Spotting Signs of Elder Abuse
- National Center on Substance Abuse and Child Welfare – Screening & Assessment

PROVIDER EDUCATION AND RESOURCES

HAP CareSource™

Fraud, Waste & ***Abuse***

HELP HAP CARESOURCE STOP FRAUD

Contact us to report any suspected fraudulent activities.

CALL **1-844-415-1272**

FAX 1-800-418-0248

EMAIL Fraud@CareSource.com

MAIL HAP CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

IMPORTANT!
Attest to completing fraud, waste and abuse education by completing this form

COMPLETE THE TRAINING

Options include (but are not limited to):

- Office of Inspector General's training: oig.hhs.gov/compliance/physician-education/
- CMS training: www.cms.gov/Outreach-and-Education/MLN/WBT/MedicareFraudandAbuse/FraudandAbuse/story.html

Clinical Practice *Guidelines*

Clinical practice guidelines (CPGs) are accepted standards of care to promote quality care and better health outcomes.

The Michigan Quality Improvement Consortium (MQIC) Committee of the Michigan Association of Health Plans (MAHP) updates clinical practice guideline (CPGs) for use by health care professionals and health plans and reviews these guidelines on a two-year cycle.

CPGs are available to providers and may be communicated to practitioners through:

- Newsletters and direct mailings
- Provider Manual and **HAPCareSource.com** > Health Links
- And focused meetings with HAP CareSource Health Partner Engagement Specialists.

Health literate member CPGs and other health care resources are available on the member website, covering a broad range of health and wellness topics. Information may also be shared via newsletters or upon member request.

If you would like more information on HAP CareSource Quality Improvement, please call Provider Services at **1-833-230-2102**.

Community of ***Innovation***

Beyond traditional engagement with a provider engagement specialist, providers and stakeholders serving members with complex health needs will have access to our unique Community of Innovation (COI).

FORMAL PARTNERSHIP between a variety of providers and stakeholders that impact member care and provider experience.

SHARED EXPERIENCE with service delivery, barriers, successes, gaps and best practices.

IDENTIFY AREAS OF FOCUS for development of resources, process enhancement and solutioning.

CROSS-FUNCTIONAL TEAMS working together to improve member outcomes and provider experience.

TESTING GROUND for innovations and solutions, acting as a quality assurance measure prior to release.

TRANSFORM THE EXPERIENCE of providers through creative initiatives and foundational solutions developed in partnership.

DEMONSTRATE VALUE through the realization of qualitative and quantitative outcomes.

FOR MORE INFORMATION or to join the COI reach out to Provider Services at
Medicaid: **1-844-217-1357**
MI Health Link: **1-833-230-2057**
Marketplace: **1-833-230-2064**

Who is a Complex Health Member?

Members who display multiple or severe issues such as:

- Co-occurring Behavioral Health and Medical Issues
- Intellectual and Developmental Disabilities (IDD)
- Behavioral Health Concerns
- Social Determinants of Health (SDoH) Needs
- Substance Use Disorder (SUD)
- Involvement with Child Welfare, Juvenile Justice or Long-Term Services and Supports (LTSS) Systems

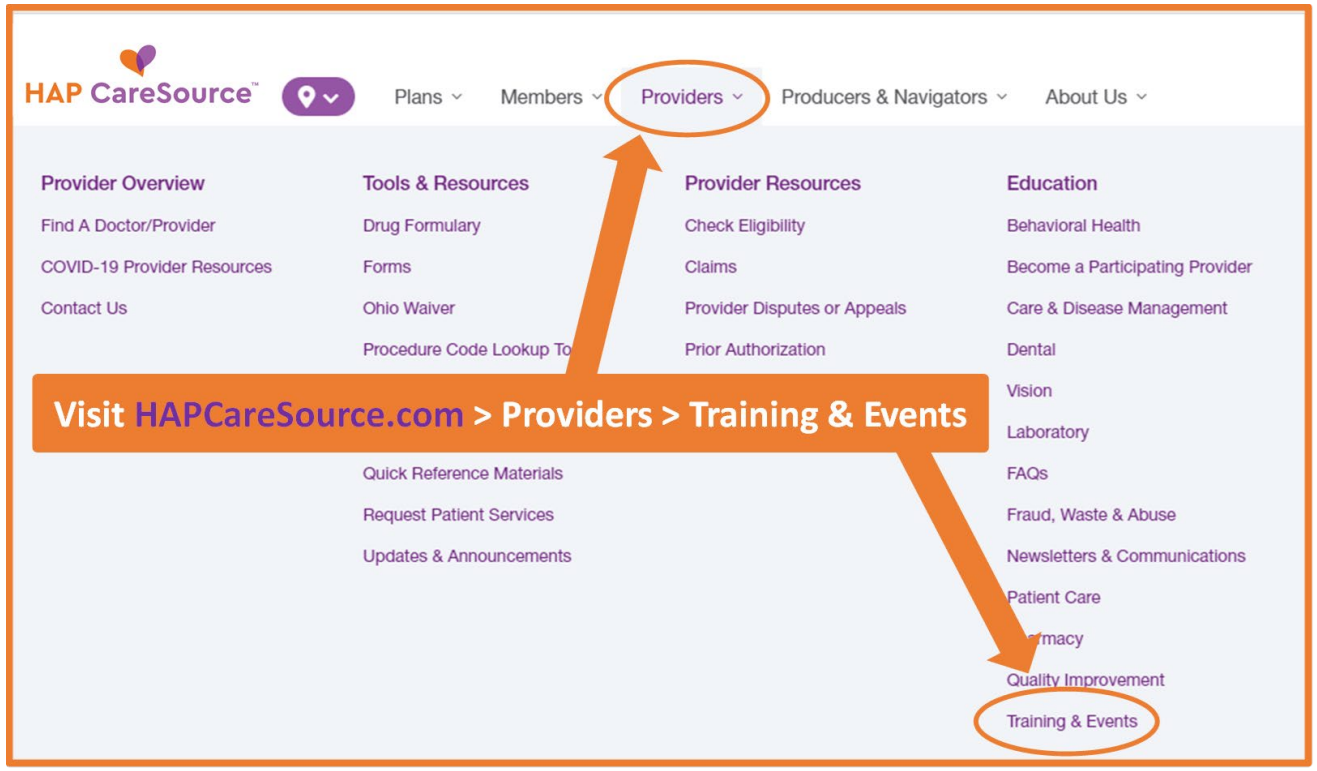
Provider Education ***Series***

The Provider Education Series is available on **HAPCareSource.com** by selecting Providers > <Training & Events>.

The topics for this series are determined by using feedback from providers like you. This custom training series is available on-demand to you or anyone in your practice.

Attest to completing these trainings by completing this form.

Let us know if there is a topic you would like us to add!



Benefits of *Patient Centered Medical Homes (PCMH)*

As we look to reward value and as patients receive care in an increasing number of settings, it is imperative that healthcare systems coordinate care for the patient to provide safe, quality medical care. The PCMH model of care helps to guide this coordination.

PCMH supports meaningful access to care, patient-centered partnerships, mitigation of health disparities, enhanced member health literacy, and improved member health outcomes.

Becoming a *PCMH Provider*

PCMH PROGRAM REQUIREMENTS

There are several nationally recognized organizations that offer PCMH recognition. These recognition programs offer a pathway to effective disease management, increased patient and provider satisfaction, cost savings, improved quality of care, and increased preventive care[1].

HIGHER QUALITY & LOWER COSTS

PCMH models guide improvement through:

- Focus on primary care
- Care coordination
- Decreased use of acute care services
- Improved access
- Performance measurement
- Use of evidence-based care and clinical decision-support

Qualifying PCMH Programs

- **NCQA** – National Committee for Quality Assurance
- **TJC** – The Joint Commission
- **URAC** – Utilization Review Accreditation Commission
- **PGIP** – Physician Group Incentive Program
- **AAAHC** – Accreditation Association for Ambulatory Health Care
- **CARF** – Commission on Accreditation of Rehabilitation Facilities

[1]Centers for Disease Control and Prevention. ""Policy Resources". *cdc.gov*, https://www.cdc.gov/dhdsp/policy_resources/pcmh.htm#:~:text=The%20PCMH%20model%20has%20been,care%2C%20and%20increased%20preventive%20care. Accessed September 13, 2023.

Thank you for helping us care for Michigan's HAP CareSource members!

HAP CareSource™

MI-Multi-P-3145267