HAP CareSource™

Welcome to HAP CareSource

Provider Orientation 2023-2024

About HAP CareSource

A Partnership with *Heart*

Joining Our Strengths

We are joining the strengths of two non-profit organizations to extend and enhance their mission-based legacies by offering comprehensive health coverage, providing access to the best physicians and delivering compassionate care.

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!

Who is hap

A Trusted Health Care Partner for More Than 60 Years

Health Alliance Plan (HAP) is a Michigan-based, nonprofit health plan that provides health coverage to individuals, companies and organizations. HAP serves over half a million members across 23 counties in Michigan, currently providing Medicaid coverage to 43,000 members in Michigan, along with its Medicare Advantage and commercial plans. HAP is a system-owned and physician-led entity of Henry Ford Health and has been National Committee for Quality Assurance (NCQA) accredited since 1993.

What's So Revolutionary?

Since it's start back in 1956, HAP has been revolutionizing the health care industry for the people of Michigan. So, what's so revolutionary? A simple philosophy that preventive health care should be affordable and accessible to anyone regardless of their socio-economic status. Guided by a long-standing belief of affordable access to quality health care, HAP offers benefits, programs and services that other Michigan health plans simply don't have.

Who is CareSource®

Health Care With Heart

Ohio-based CareSource is one of the nation's largest Medicaid managed care organizations serving more than 2.3 million members in seven states including Ohio, Georgia and Indiana.

Administrative Support Services

CareSource will provide administrative and operational support and services to HAP CareSource health care providers. When working with HAP CareSource, you will interact with CareSource services in many ways including when using our Find-a-Doctor provider directory tool, our provider portal or interacting with some of our member services like our CareSource24 Nurse Advice Line. HAP CareSource is here to support you.

Operations Performance

Key Performance Indicator (KPI)	Claims First Pass Accuracy	Financial Accuracy	Claim Average Days to Pay	Prompt Pay Timeliness	Encounters Submitted in 14 Days	Encounter Completeness and Accuracy
Current Rate	**99%**	**99.96**	**10 Days**	**>100%**	**>99.9%**	**>99.9%**

Corporate Headquarters:
Dayton, Ohio

Locations:
Arkansas, Georgia, Indiana, Kentucky, Michigan, North Carolina, Ohio, and West Virginia

Year Established:
1989

Employees:
4,500 employees located across 47 states

Our *Mission*

HAP CareSource™

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 will change the way health care is delivered in Michigan!

Our *Plans*

Healthy Michigan Plan

A low-cost health insurance program for Michigan residents that allows more people to obtain low-cost health care coverage.

- 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

A health care program for children and select adults with special health care needs.

- Michigan residents under age 21
- US citizen or documented/legally admitted non-citizen
- Qualifying medical condition
- For additional details please visit Children's Special Health

Collaborative Focus

- Emphasis on quality-based improvements
- Operational excellence
- Creating uniform systems to ease administrative burden
- Addressing all barriers to access
- NCQA accredited
- True commitment to improvement of life for Michigan members

Your *Responsibilities*

- 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 180 calendar 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 within **15 business days** of receipt
- 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.

Communicating with *Us*

	HAP CareSource
Provider Services – A single contact number for all HAP CareSource member-related questions	**1-833-230-2102**
Hours	**Monday – Friday, 8:00 a.m. to 6:00 p.m., Eastern Time (ET)**
Member Services	**1-833-230-2053**
Hours	**24 hours a day, 7 days a week**

Working with HAP CareSource

Member *Enrollment*

How Does Member Enrollment Work?

Encourage your interested patients to visit the **Michigan Department of Health & Human Services** website, where they can access enrollment information and forms.

Three easy ways to apply

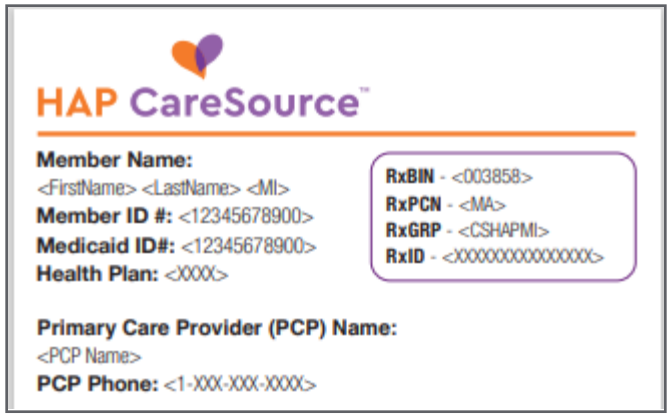
- Complete an application http://www.michigan.gov/mibridges
- Call 1-855-789-5610
- In-person at a local Department of Human Services office

After completing required steps:

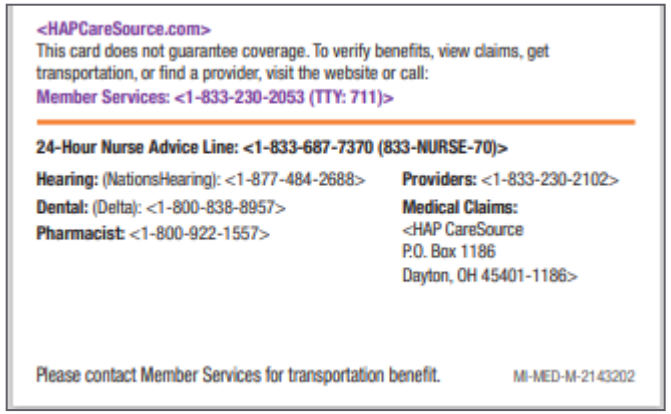
- They may join the Managed Care Organization (MCO) of their choice, or they will be assigned to an MCO
- Have 90 days to make a change

Identifying a HAP CareSource Member

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.

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.

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

Claims ***Submission***

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 in Claims

- 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***

CLEARINGHOUSES

HAP CareSource encourages electronic claim submission as the primary submission method. 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 availity.com/ediclearinghouse. **HAP Payer ID: MIMCDCS1**

SUBMISSION PROCESS

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

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***

HAP CareSource has partnered with ECHO® Health, Inc. to deliver provider payments. ECHO® is a leading provider of electronic solutions for payments to health care providers. ECHO consolidates individual provider and vendor payments into a single ERISA- and HIPAA-compliant format, remits electronic payments and provides explanation of provider payment details to providers.

Enroll with ECHO for payment and choose EFT as your payment preference for HAP CareSource.

Enrollment assistance 1-888-834-3511

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

Claims ***Payments***

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.

Simply complete the enrollment form and fax it back to ECHO Health, HAP CareSource's EFT partner, at **440-835-5656 or visit** Enroll to complete enrollment online. ECHO Health will work directly with you to complete your enrollment in EFT.

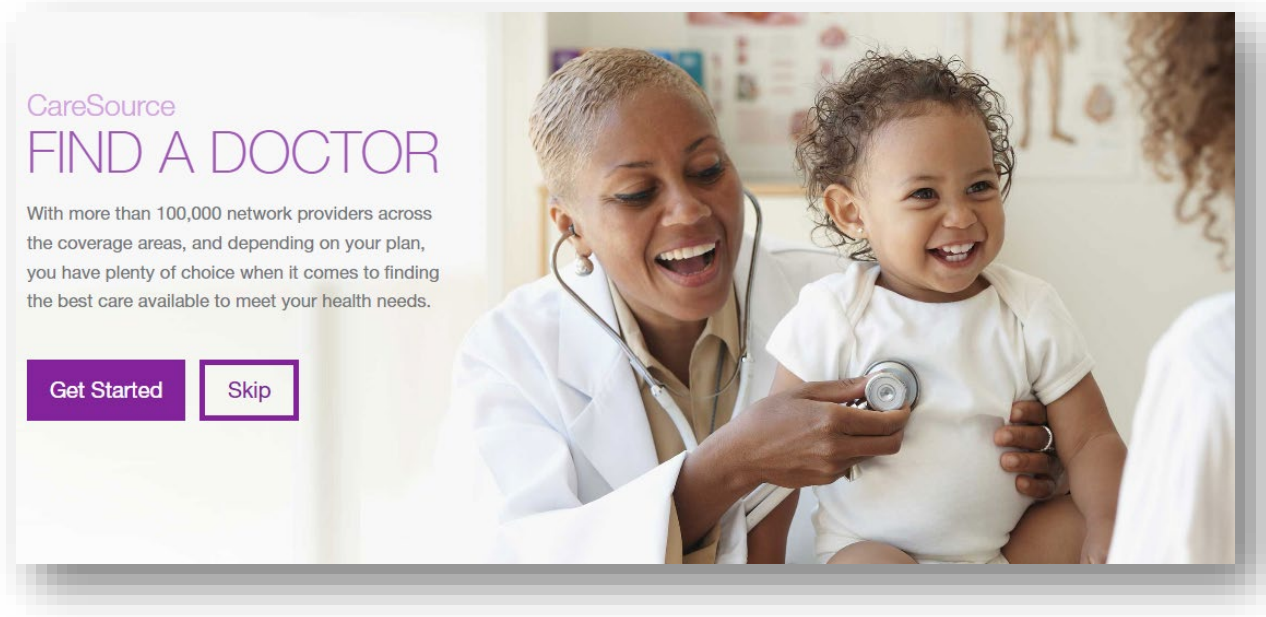
Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the HAP CareSource Provider Portal.

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

Provider Network & *Eligibility*

IN-NETWORK REFERRALS

HAP CareSource Medicaid members choose or are assigned a primary care provider (PCP) upon enrollment. To ensure coverage of services, confirm that you refer members to other in-network providers. Use our **Find-a-Doc** 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** prior to each service rendered.

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 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. Members who meet the definition of Children with Special Health Care Needs (CSHCN) may access specialty care providers directly by 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 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.

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

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.

Provider Disputes and Appeals

- As a HAP CareSource provider, you may submit a dispute or appeal for a member or on your own 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.
- Providers must obtain a member's written consent to appeal an Adverse Benefit Determination on their behalf.
- The HAP CareSource Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- For additional information, contact **Provider Services** at **1-833-230-2102**.

Claim *Appeals*

All appeals must be:

- Submitted within 60 calendar days from the date of claim denial
- Submitted via the HAP CareSource Provider Portal, fax or by paper to:

HAP CareSource
Attn: Grievances and Appeals
P.O. Box 1025
Dayton, OH 45401-1025
Fax: 937-396-3492

Claim appeals can be submitted in writing via the HAP CareSource Provider Portal or on paper at:

HAPCareSource.com > Providers > Tools & Resources > Forms > Provider Appeal Form.

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**.

Access to ***Care***

As a HAP CareSource primary care provider (PCP), you must ensure your practice complies with the following minimum access standards:

- Provide **24-hour availability** to your HAP CareSource members by telephone.
    - Whether through an answering machine or a taped message after hours, patients should have 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 doesn't provide access to you or your back-up provider and only recommends an emergency room after hours.
- Be available to see members at a minimum of **20 hours** per week **per location**.

Access Standards *Time Frames*

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

Type of Care	Standard
Primary Care Providers	
Routine Care	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
Urgent Care	Within 48 hours
After-Hours Care	Physicians or their designee shall be available by telephone 24/7
Emergency Care	Immediately 24/7
In-Office Wait Time	Less than 30 minutes
Non-Primary Care Providers/Specialist	
Acute Specialty Care (including OB/GYN and Oncology)	Within 5 business days of request
Specialty Care	Within 6 weeks of request
Specialty Urgent Care	Within 48 hours
BH: Life-Threatening Emergency	Immediate access to ED services
BH: Non-Life-Threatening Emergency	Immediate access to ED services
BH: Urgent Care	Within 48 hours of request
BH: Initial Routine	Within 10 business days of request

Member ***Communications***

Helping Members Understand Their Coverage

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

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

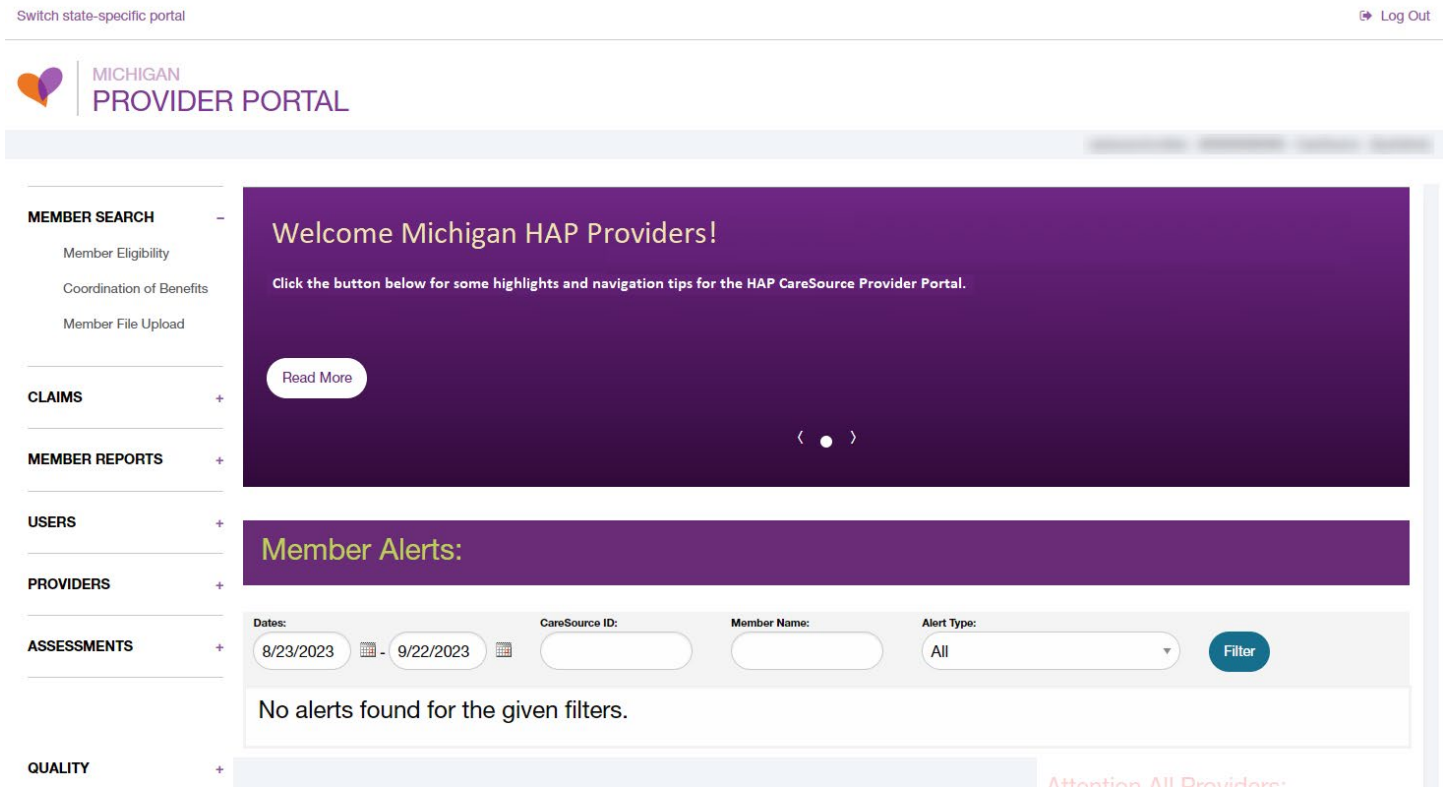
For more information, visit: **HAPCareSource.com/members**.

Provider Portal

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



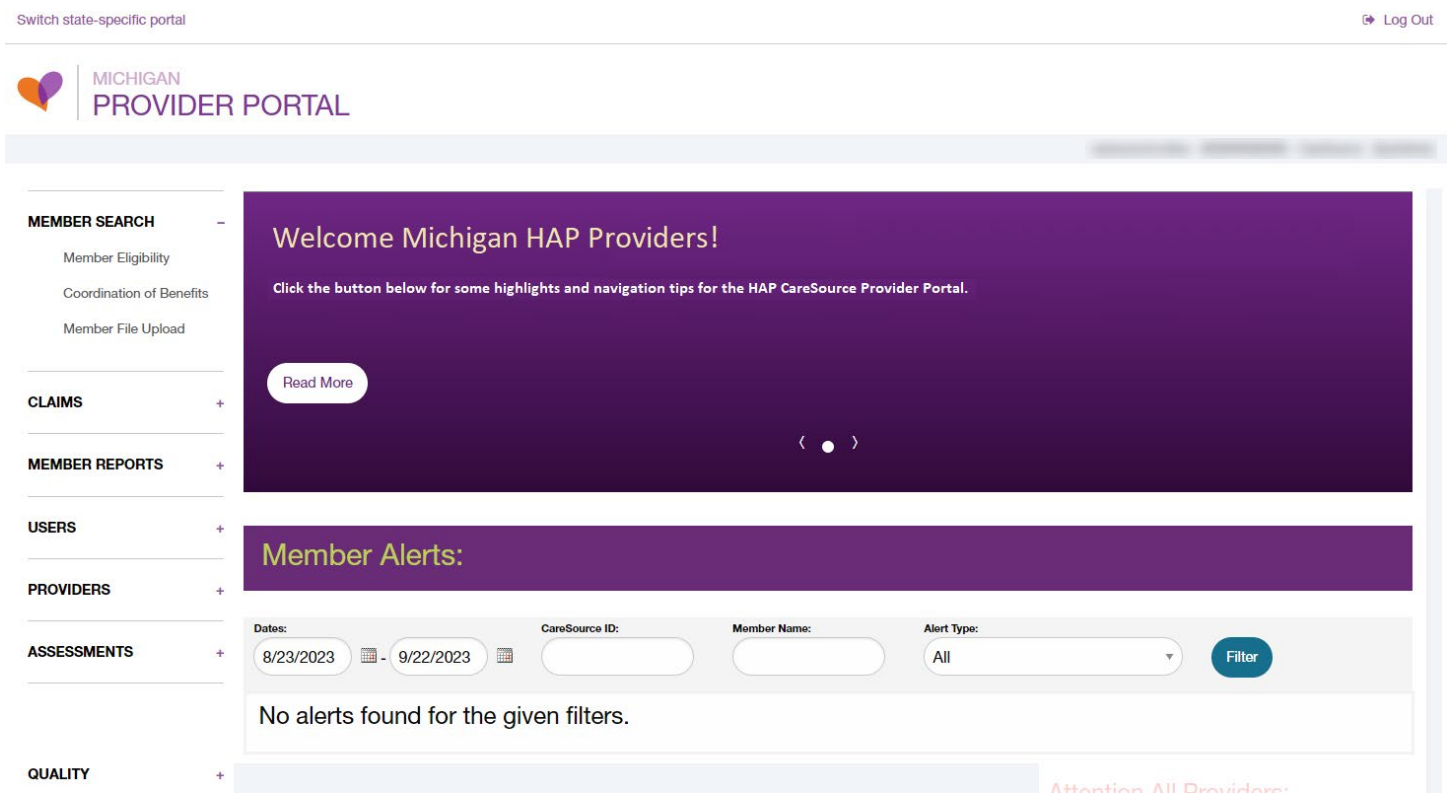
Single ***Sign-On***

Two Portals, One Simple Sign-On!

CareSource and HAP both offer the benefit of a provider portal. To help streamline your operations, we offer single sign-on from the HAP Portal to the HAP CareSource Provider Portal.

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

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

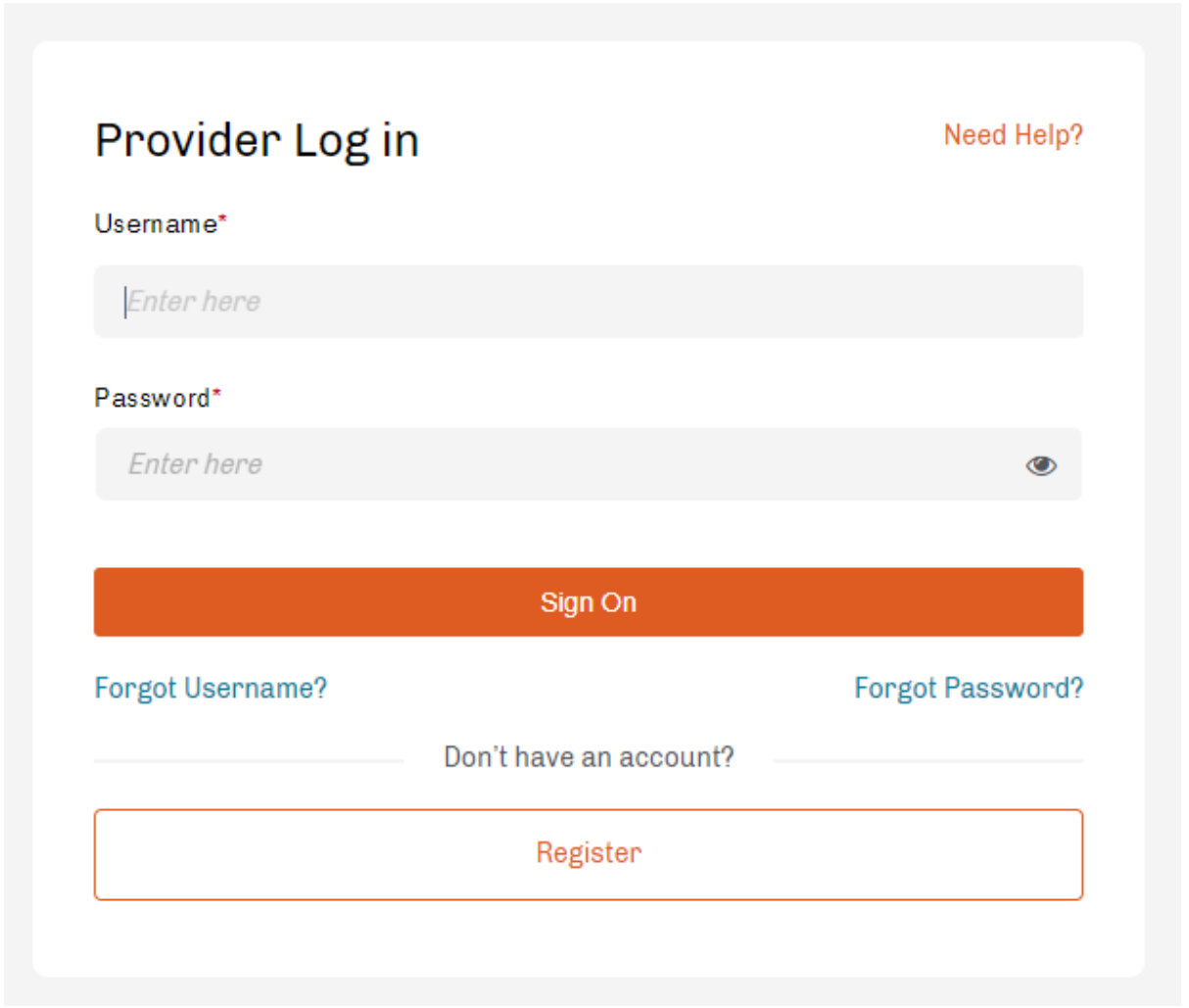


Register for the ***Provider Portal***

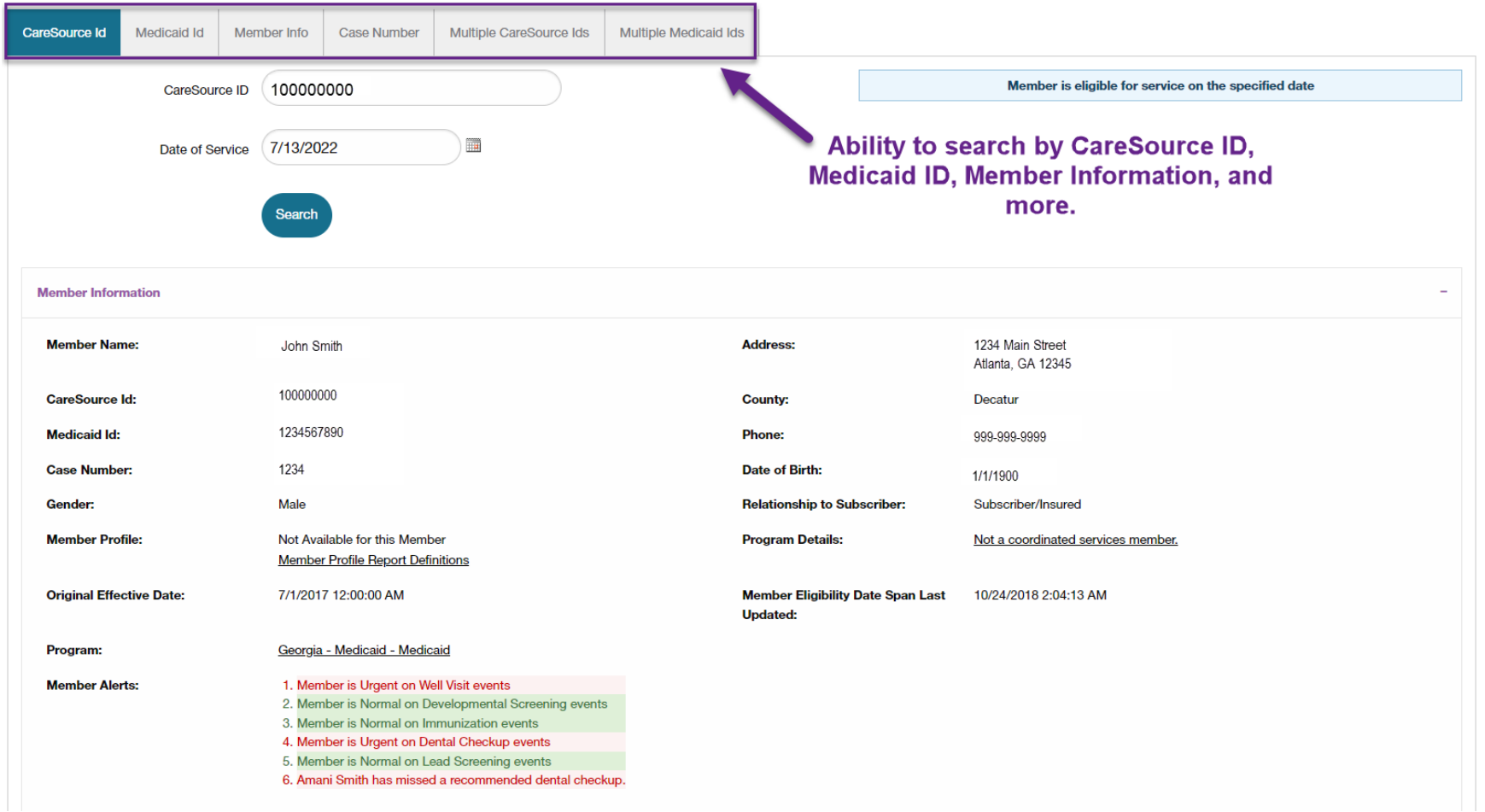
It's easy! You will access the HAP CareSource Provider Portal through the HAP Portal.

- 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 first need to register to use the HAP Portal.
- Once you log in at hap.org, select the **HAP CareSource** link and it will take you right to the secure HAP CareSource Provider Portal*.

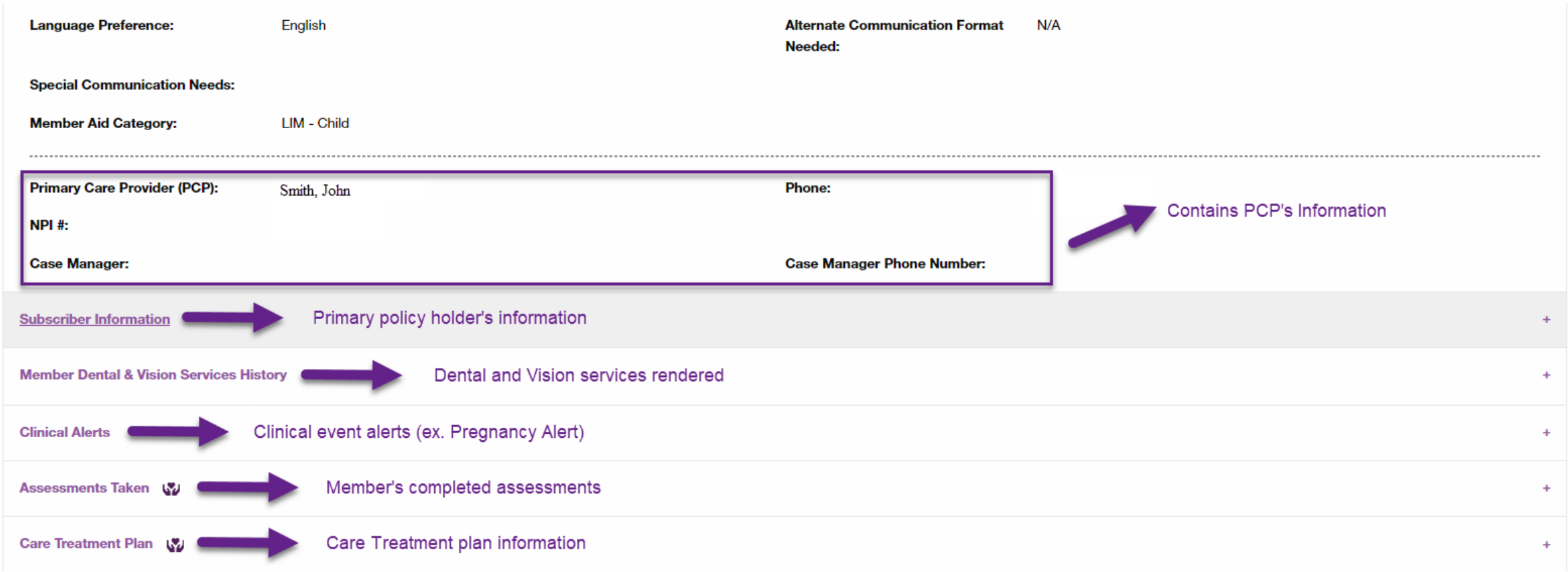
*If you are not registered for the HAP Provider Portal, please self-register and then follow the instructions.



Member *Eligibility*



Member *Eligibility*



Prior Authorizations

Prior Authorization ***Services***

Some services require prior authorization.

Visit procedurelookup.caresource.com - No login required!

Use dropdown and select **Michigan** and appropriate line of business

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.

Prior Authorization ***Submissions***

Method	HAP CareSource
Provider Portal – Preferred Method	Log in: HAP CareSource Provider Portal From the HAP CareSource Provider Portal, use the Providers > Prior Authorization menu.
Email	UMHAPMI@CareSource.com
Phone	Toll Free: **1-833-230-2102**
Fax	Toll Free: 844-432-8931 Local: 937-396-3539
Mail	HAP CareSource P.O. Box 1307 Dayton, OH 45401-1307

Prior Authorization *Information Checklist*

PRIOR AUTHORIZATION SUBMISSION REQUIREMENTS

- Member name and HAP CareSource member ID number
- Provider name and National Provider Identifier (NPI)
- Anticipated date(s) of service
- Diagnosis code and narrative
- Procedure, 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

Be Sure to Select the Correct Product When Submitting Prior Authorizations

Note: We do not require in-network providers to obtain a prior authorization for an office visit.

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

Covered Benefits & Services

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

Covered *Services*

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

ENHANCED BENEFITS

- CareSource 24 Nurse Advice Line
- Disease Management
- Health & Wellness Education
- Inhalation Therapy
- Pain Management

MEMBER PROGRAMS

- Integrated Care Management
- Transportation
- MyStrength
- Babies First® & Kids First *(Beginning Jan. 1,2024!)*

Services ***Not Covered***

Medically unnecessary services
Services received from a non-network providers, with specific exceptions
Experimental or investigational services
Alternative or complimentary medicine
Cosmetic procedures
Assisted reproductive therapy
Maintenance therapy treatments
Routine dental services not provided by a Delta Dental of MI provider
Routine vision services and eyewear not provided by Versant Superior provider
Routine hearing services not provided by a NationsHearing provider

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

Transportation ***Services***

Provider Scheduling Line	1-866-733-8997 Routine reservations accepted 7:00 a.m. to 8:00 p.m., ET Monday – 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.

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

HAP CareSource ***Vendors***

Vendor	Service
CSS Health – Clinical Support Services	Pharmacy – Medication Therapy Management
Delta Dental of Michigan	Routine Dental Benefit
NationsHearing	Routine Hearing Benefit
Superior Vision, by Versant	Routine Vision Benefit
MTM – Medical Transportation Management	Transportation
Express Scripts	Pharmacy Benefit Manager

Providers Caring for Children

Children's Special Health Care Services (CSHCS)

CSHCS is a program within the Michigan Department of Health and Human Services. It is for children and some adults with special health care needs and their families.

CSHCS helps pay for medical care and treatment for certain eligible medical conditions.

CSHCS HELPS PERSONS WITH CHRONIC HEALTH PROBLEMS BY PROVIDING:

- Coverage and referral for specialty services based on the person's health problems.
- Family centered services to support you in your role as primary caretaker of your child.
- Community-based services to help you care for your child at home and maintain normal routines.
- Culturally competent services which demonstrate awareness of cultural differences.
- Coordinated services to pull together the services of many different providers who work within different agencies.

CSHCS covers more than 2,700 physical conditions when certain criteria are met.

Applications are available to download online or by calling your local health department CSHCS office.

Call the CSN Fund at 517-241-7420

Call the CSHCS Family phone line at 800-359-3722

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (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 ensure 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 ensure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services.

Reimbursement

The program provides reimbursement for preventive health services, inter-periodic 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.

Recommendations

The American Academy of Pediatrics (AAP) Bright Futures “Recommendations for Pediatric Health Care” Periodicity Schedule is the periodicity schedule used for EPSDT visits and services.

Early and Periodic Screening, Diagnosis 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)

Exam Frequency

- Birth
- Three to five days
- One and two months
- Four, six and nine months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- After 30 months, one exam per year until age 21

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Exam Requirements & Support

- PCPs receive a monthly list of non-adherent members
- Initial exams are to be completed within 90 days of plan enrollment date
- Initial exams are to be completed within 24 hours of birth for all newborns
- PCP are required to follow-up and/or refer to specialists when history and exam findings identify a need.
- Member roster available on HAP CareSource Provider Portal
- PCPs are required to contact members by phone/mail to encourage visits
- If the PCP is unable to provide all components of the preventive health exam, or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within HAP CareSource's provider network in accordance with HAP CareSource's referral procedures. The member's medical record must indicate where the member was referred.

Screening Support:

- CDC - Child Development
- SWYC - Age Specific Forms
- AAP - Tool Finder
- Health Resources and Administration Services - EPSDT

Vaccines for Children Program

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 State 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.

For more information, visit the Michigan VFC Resource Guide

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!

Trauma-Informed Care

Trauma: An event, series of events, or set of circumstances experienced by an individual that are:

- Physically or emotionally harmful or life-threatening
- Have lasting adverse effects on a person's functioning
- Impact mental, physical, social, emotional or spiritual well-being

Trauma Informed Care:

- Understands the widespread impact of trauma and the potential paths for recovery
- Recognizes the signs and symptoms of trauma
- Responds by fully integrating knowledge about trauma into policies, procedures and practices
- Seeks to actively resist re-traumatization
- Shifts focus from "what is wrong with you" to **"what happened to you"**

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

- Better Understanding My Pregnancy (B.U.M.P.)
- Breast Pumps
- Care4Moms App
- Care Management
- Educational Resources
- Quit for Two
- Text4Baby

Incentive Programs – *Coming Jan. 1, 2024*

- Babies First®
- Kids First

Wellness and Disease Management

- Asthma Disease Management
- Diabetes Disease Management
- Kids Wellness

Pharmacy

Pharmacy ***Overview***

PHARMACY BENEFIT

HAP CareSource 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 for prescriptions at **HAPCareSource.com** > Pharmacy.
- The Formulary search tool and prior authorization lists are available on **HAPCareSource.com.**
- 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.

Pharmacy ***Overview***

Submitting Pharmacy Claims

Claims are submitted to **Express Scripts, Inc**. for processing. The member's ID card will have claims processing information for the pharmacies:

RxBIN: 003858

RxPCN: MA

RxGroup: CSHAPMI

Pharmacy Prior Authorizations

Call: **833-230-2102**
Fax: **866-930-0019**

Member Exception Request form available online

Requests will be evaluated within 72 hours of submission

Care Management & Quality

Care and Disease *Management*

MEMBER EDUCATION

- Coordination with outreach teams who provide topic-specific information

- One-to-one Care Management

CARE MANAGEMENT (CM)

The HAP CareSource CM program assists members in following the plan of care prescribed by their physician. Our CM team work one-to-one with members to help them regain or maintain optimum health or functional capability in the right setting in a cost-effective manner. Participation in case management is voluntary and members can terminate at any time.

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

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

To initiate an evaluation for case management services, contact the CM department at **1-844-217-1357**.

DISEASE MANAGEMENT (DM)

Members receive help finding the appropriate level of care for their condition and are encouraged to actively participate in the patient-provider relationship. This program supports members in the self management of their chronic conditions. DM also has specialty programs for CSHCS, Hepatitis C, HIV, SCD and lead.

If you have a HAP CareSource member whom you believe would benefit from DM and is not currently enrolled, please call **1-844-217-1357.**

Hepatitis C & 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.

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

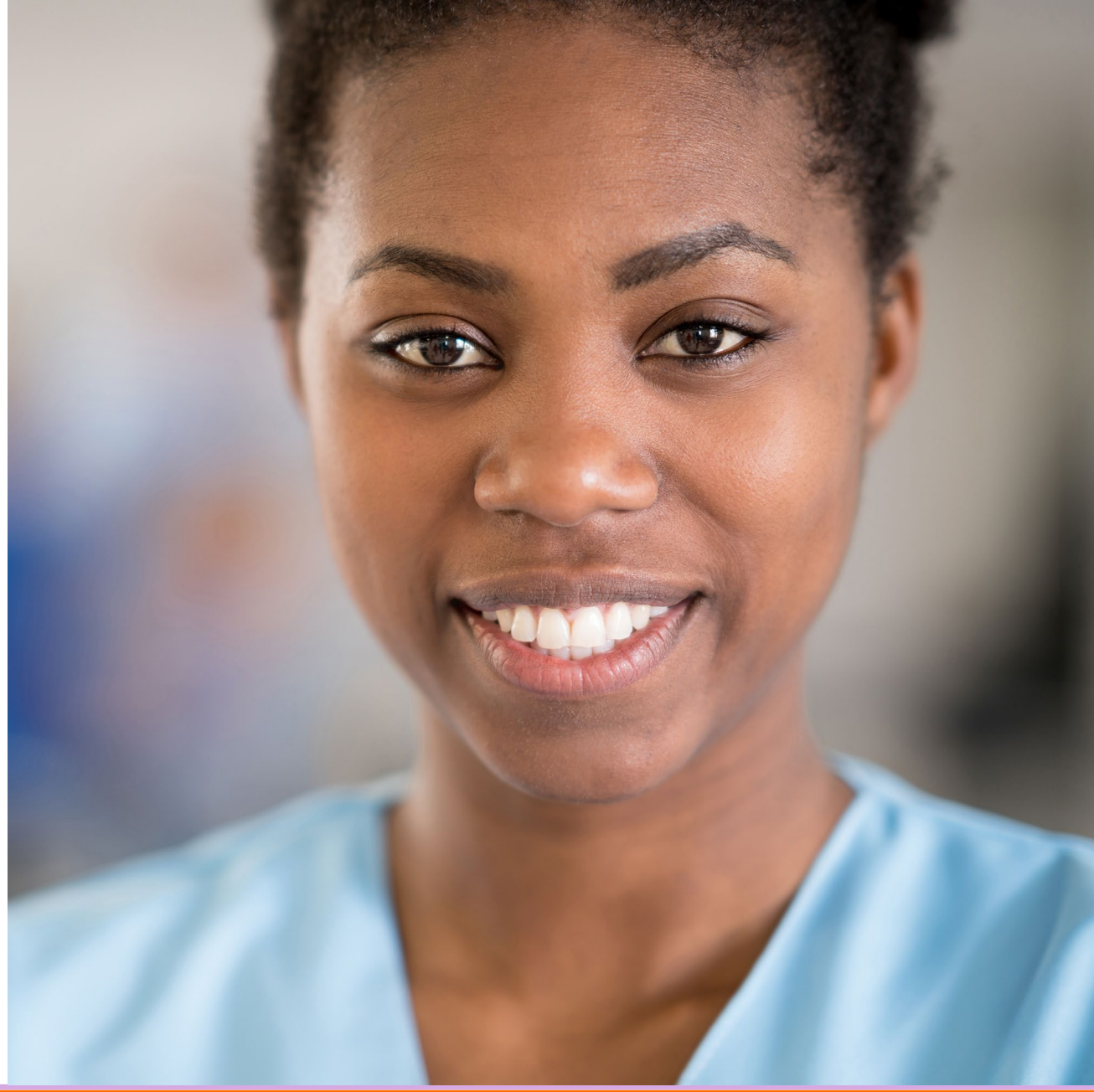
- **NCQA** – National Committee for Quality Assurance
- **TJC** – The Joint Commission
- **URAC** – Utilization Review Accreditation Commission
- **PGIP** – Physician Group Incentive Program
- **AAAHC** – Accreditation Association for Ambulatory Health Care
- **CARF** – Commission on Accreditation of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

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 Health Risk Assessment (HRA)
- Assists in closing gaps-in-care
- Assists with transitions of care
- Removes barriers



HAP CareSource
Health Equity Commitment

At HAP CareSource, we are dedicated to the communities in which we serve and in to making a positive impact in the lives of our members by eliminating health disparities, supporting our organization's health equity initiatives and partnering with community stakeholders to carry out this important work.

Cultural ***Competency***

Providers are expected to deliver services in a culturally competent manner, including:

- Removing all language barriers to service
- Accommodating unique cultural, ethnic and social needs of members
- Understanding that social determinants of health are recognized as significant contributors to member health outcomes and quality of life
- Addressing implicit bias
- Meeting the requirements of all applicable state and federal laws and contractual requirements
- **Maintaining cultural competence in the delivery of services**

RESOURCES

We provide cultural competency training resources in the Provider Manual and online at **HAPCareSource.com**. The National CLAS Standards training provides specific guidelines to assist you in developing a culturally competent practice.

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
- Emergency department (ED) visits
- Well-care visits

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

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

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.**

How to Submit an Incident to HAP CareSource

Any provider-related concerns should be relayed to the HAP CareSource Member Services line **1-833-230-2053**. The call center representative will report the incident per our internal processes.

How to Submit an Incident to the State

MDHHS Centralized Intake: 855-444-3911

Report child abuse or neglect to MI Bridges

Assessment Support:

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

Fraud, Waste & ***Abuse***

Help HAP CareSource stop fraud.

Contact us to report any suspected fraudulent activities.

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

CALL: 1-833-230-2102

EMAIL:
fraud@caresource.com

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

Provider Resources

Provider ***Resources***

WEBSITE

HAPCareSource.com

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

PROVIDER SERVICE CENTER

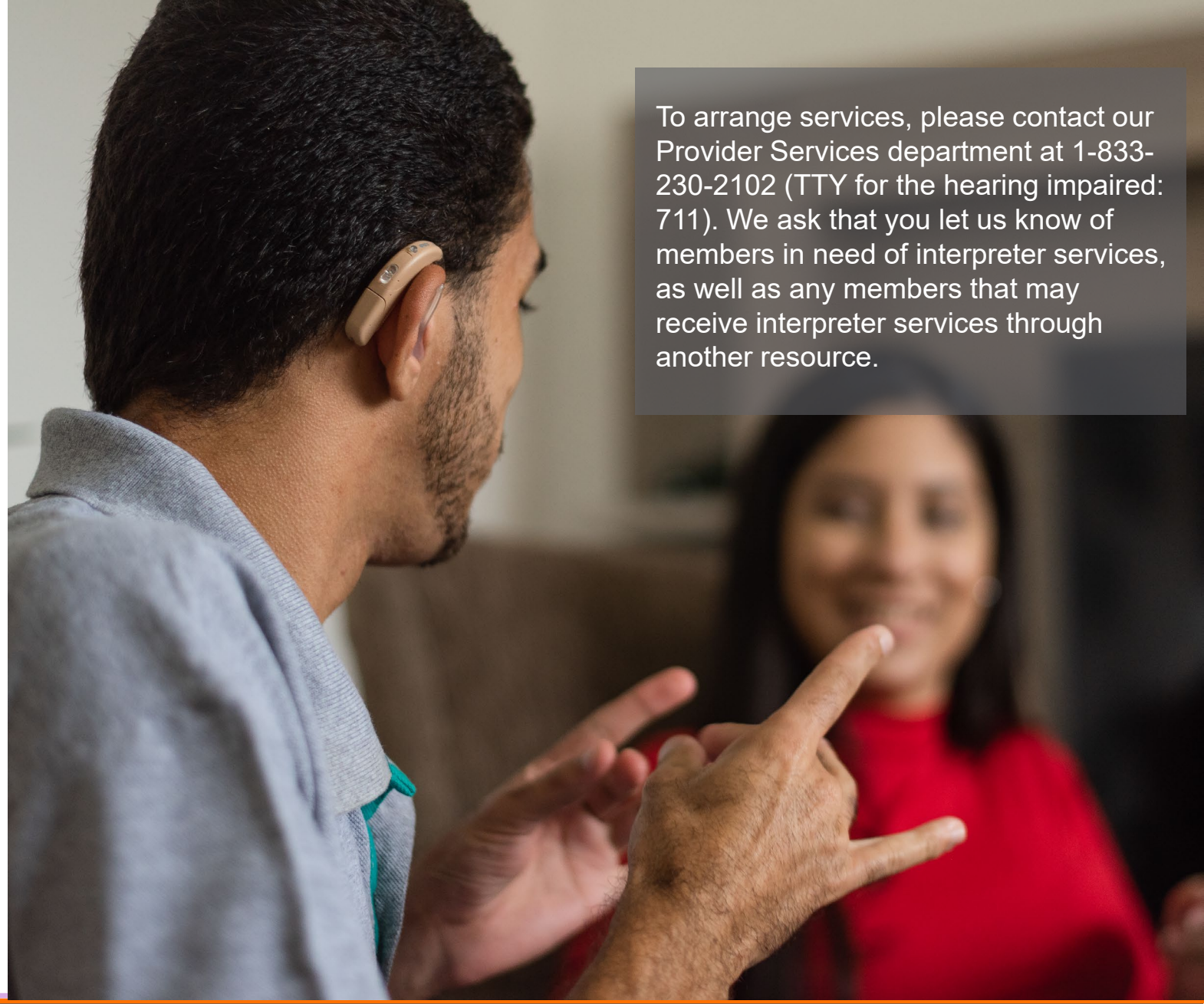
1-833-230-2102

- 8:00 a.m. to 6:00 p.m., ET
- 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!

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.



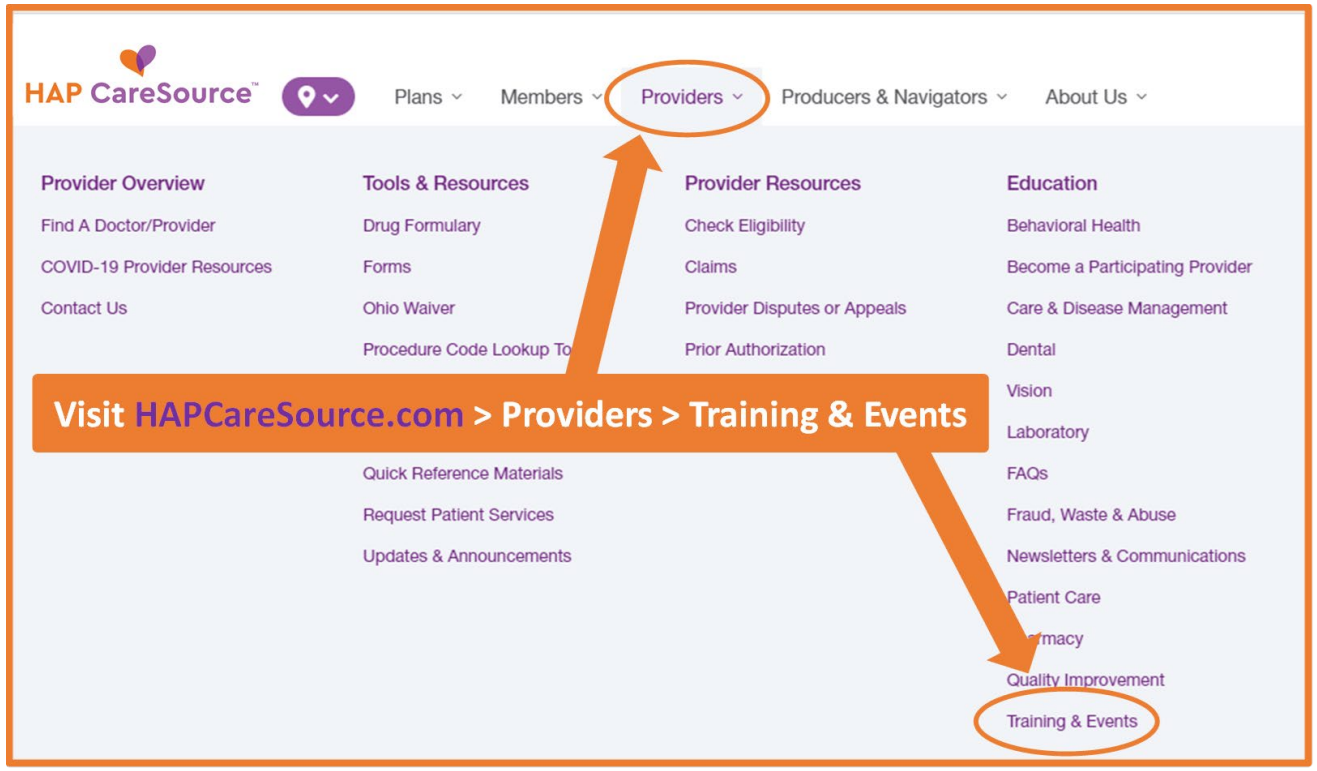
To arrange services, please contact our Provider Services department at 1-833-230-2102 (TTY for the hearing impaired: 711). We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Provider Education Series

The Provider Education Series is available on **HAPCareSource.com** by selecting Providers then 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.

If there is a topic you would like to see added to our series, let us know!



HAP CareSource ***Contacts***

	HAP CareSource
Provider Services	**1-833-230-2102**
Utilization Management Fax	Toll Free: 1-844-432-8931/Local 937-396-3539 NICU UM Fax: 937-396-3499
Provider Portal	HAPCareSource.com/Providers/Provider-Portal
Electronic Funds Transfer	ECHO® Health, Inc. Enrollment: 888-834-3511 Customer Service: 833-629-9725 Fax: **440-835-5656**
Electronic Claims Submission	Use Availity clearinghouse CS Payer ID: **MIMCDCS1**
Claim Address	HAP CareSource Attn: Claims Department P.O. Box 1186 Dayton, OH 45401
Timely Filing	180 days from date of service or discharge

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

MI-MED-P-2383750