Michigan Complete Health
(Medicare-Medicaid Plan)

2020
Provider Manual

mmp.michigancompletehealth.com

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INTRODUCTION

Welcome to Michigan Complete Health's (Medicare-Medicaid Plan). Thank you for participating in our network of physicians, hospitals and other healthcare professionals. This Provider Manual is a reference guide for Providers and their staff delivering services to members who participate in our Michigan Complete Health program. In addition to the Provider Manual, Michigan Complete Health provides additional reference materials and policy updates on its website: http://mmp.michigancompletehealth.com.

Overview

Michigan Complete Health is a subsidiary of Centene Corporation, a leader in the healthcare services field with over 30 years of experience in the government sponsored healthcare sector, with health plans across the country and a robust portfolio of innovative healthcare solutions.

Michigan Complete Health (Medicare-Medicaid Plan) is a product that provides coverage to members eligible under the MI Health Link Dual Demonstration project. Michigan Complete Health is an Integrated Care Organization (ICO) that encompasses the delivery of comprehensive and seamless care to members. Michigan Complete Health contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members.

This plan is available to persons age 21 or older who enrolled in Medicare and Medicaid. Services would include all Medicare benefits, including parts A, B, and D; and Medicaid benefits, including wrap-around services and long-term services and support (LTSS). The Michigan Complete Health service area includes Wayne and Macomb counties.

Our Purpose

Michigan Complete Health is committed to transforming the health of the community one person at a time.

Our Mission and Care Beliefs

The Mission of Michigan Complete Health is better health outcomes at lower costs. We achieve this through our unique set of care beliefs:

- We believe in treating the whole person not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enable meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities.

Our Model of Care

The Michigan Complete Health Model of Care (MOC) uses a Patient Centric Model with an integrated care team approach that offers beneficiaries a dedicated Care Coordinator to facilitate optimal improvement in individual health outcomes and quality of life. The Care Coordinator works with the member in the care

planning process and orchestrates interdisciplinary care integration with and on behalf of the member/family and providers. The Care Coordinator is an anchor for the member ensuring that all services and benefits are coordinated to maintain quality of life and independence in a community setting.

Key Contacts

Michigan Complete Health
800 Tower Drive
Suite 200
Troy, MI 48098

When calling Michigan Complete Health please have the following information available:

- National Provider Identifier (NPI) number
- Tax ID Number (TIN) number
- Member ID number or Medicaid ID number

Phone and Faxes

Department	Phone	Fax
Provider Relations (Mon-Fri 8am-8pm)	1-844-239-7387	1-844-276-9874
Member Services (Mon Fri 8am-8pm)	1-844-239-7387 (TDD/TTY) 711	1-844-867-5265
Behavioral Health Crisis (24 hour availability)	1-800-241-4949 – Wayne 1-855-996-2264 – Macomb	
Care Coordination, Authorizations, scheduling and notifications	1-844-239-7387	1-833-783-3178
MI HealthLink	1-800-975-7630	
Nurse Advice Line (Nursewise) available 24/7/365	1-844-239-7387	

Addresses

Department	Address
First submission of medical claims, corrected claims, and request for reconsideration	Michigan Complete Health Attn: Claims PO Box 3060 Farmington, MO 63640
Medical Claims Appeals (Non-Participating Providers)	Michigan Complete Health Attn: Appeals PO Box 3060 Farmington, MO 63640

Medical Claims Disputes (Participating Providers)	Michigan Complete Health Attn: Disputes PO Box 3060 Farmington, MO 63640-3060
Behavioral Health Claims	Macomb County Community Mental Health Services 22550 Hall Road Clinton Twp., MI 48036 Detroit Wayne Mental Health Authority 640 Temple Street Detroit, MI 48201
Pharmacy Claims	Michigan Complete Health ATTN: Pharmacy Claims PO Box 419069 Rancho Cordova, CA 95741-9069
Preservice Appeals	Centene Corporation ATTN: Appeals and Grievances Medicare Operations 7700 Forsyth Blvd St Louis, MO 63105 FAX: 1-844-273-2671

Vendor Services

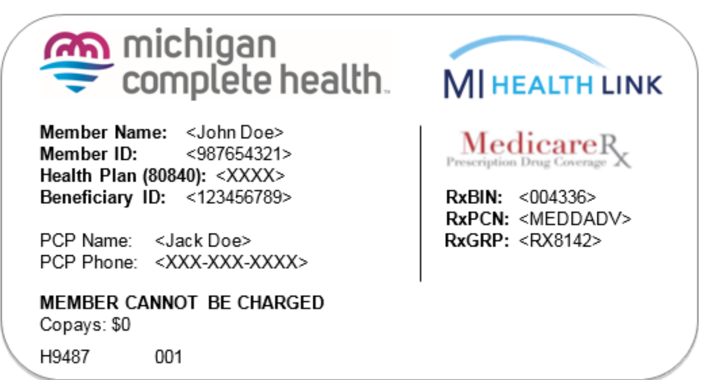
Vendor	Service	Phone
Envolve	Pharmacy	Customer Service: 1-844-239-7387 Prior Authorization: 1-844-202-6824
Envolve Dental	Dental	1-833-737-6655
LogistiCare	Transportation	1-877-564-5905
National Vision Administrators (NVA)	Vision Administrator	1-888-682-2020 www.e-nva.com provider@e-nva.com
PaySpan	EFT/ERA Transactions	1-877-331-7154 www.payspanhealth.com
Prepaid Inpatient Health Plans (PIHP)	Behavioral Health	1-800-241-4949 – Wayne 1-855-996-2264 – Macomb (24 hour availability)
Area Agency on Aging 1-B	Senior Support Services	1-800-852-7795
Detroit Area Agency on Aging	Senior Support Services	1-313-832-6300
The Senior Alliance	Senior Support Services	1-734-722-2830

VERIFYING ELIGIBILITY

All Michigan Complete Health Members will receive a Member ID card. Members should present their ID at the time of service, but an ID card in and of itself is not a guarantee of eligibility; therefore, providers must verify a Member's eligibility on each date of service. Information such as Member ID number, effective date, 24-hour phone number for health plan, and PCP information is included on the card. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card. If you are not familiar with the person seeking care, please ask to see photo identification. If you suspect fraud, please contact Provider Relations at 1-844-239-7387 immediately.

Sample Card

Front of Model Member ID Card



Back of Model Member ID Card

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your Care Coordinator within 48 hours or as soon as possible.

Member Services: <1-844-239-7387 (TTY: 711)>
24 Hour Nurse Advice Line: <1-844-239-7387 (TTY: 711)>
Pharmacy Help Desk: <1-888-865-6567>
Pharmacy Prior Auth: <1-800-867-6564>
Website: <https://mmp.michigancompletehealth.com>
Behavioral Health Services: <Wayne County: 1-800-241-4949 ***or*** Macomb County: 1-855-996-2264 (TTY: 711)>
24 Hr Behavioral Health Crisis Line: <Wayne County: 1-800-241-4949 ***or*** Macomb County: 1-855-927-4747 (TTY: 711)>

Send Claims To:
<Medical Claims:
Michigan Complete Health
PO Box 3060
Farmington, MO 63640-3822
Payer ID: 68069

Pharmacy Claims:
Michigan Complete Health
PO Box 419069
Rancho Cordova, CA 95741>

Claim Inquiry: <1-844-239-7387 (TTY: 711)>

To verify Member eligibility, please use one of the following methods:

- Log on to the secure provider portal at http://mmp.michigancompletehealth.com. Using our secure provider website, you can check Member eligibility. You can search by date of service plus any one of the following: Member name and date of birth, Medicaid ID number, or Michigan Complete Health (MMP) Member ID number. You can submit multiple Member ID numbers in a single request.

- Call Michigan Complete Health Provider Relations. If you cannot confirm a member's eligibility using the method above, call our toll-free number at 1-844-239-7387. Follow the menu prompts to speak to a Provider Relations representative to verify eligibility before rendering services. Provider Relations will need the Member name or Member ID number and the Member date of birth to verify eligibility. Provider Relations can be reached Monday-Friday 8am-5:30pm.

Through the Michigan Complete Health secure provider web portal, Primary Care Providers (PCP) are able to access their panel lists (a list of eligible Members who have selected the PCP or have been assigned to the PCP for services (Panel). The list is posted as of the first day of the month. The list also provides other

important information including date of birth and indicators for patients who are due for preventive services. Since eligibility changes can occur throughout the month and the Member list does not prove eligibility for benefits or guarantee coverage, please use one of the methods described above to verify Member eligibility on the date of service.

PHYSICIAN RESPONSIBILITIES

Primary Care Providers

Primary Care Providers (PCPs) are defined as Family Providers, General Practice Physicians, Geriatricians, Internal Medicine Physicians and their associated Nurse Practitioners and Physician Assistants. Their responsibilities include the following:

- Provide access to medical services 7 days a week/24 hours a day either directly or through call coverage.
- The management of medical care provided to Members who have chosen or been assigned to the physician and team as their PCP. A PCP is expected to provide all necessary care required by a Member that is within the scope of his or her practice and expertise. The PCP should refer a Member to a specialist or other provider when he or she is not able to provide the specialty care.
- Coordinate the services a Member may need, participate in care planning and team meetings.
- Obtain a referral or prior authorization from the Michigan Complete Health Medical Management team when appropriate.
- Coordinate a Member's care needed from specialty physicians or other healthcare providers by referring to the Michigan Complete Health network of providers. Preauthorization is not required for emergent or urgent situations and for renal dialysis services for those Members temporarily out of the service area. For other services which are not available within the Michigan Complete Health network, the Primary Care Provider must contact the Michigan Complete Health Medical Management team to obtain prior authorization to refer a Member to a non-participating provider ***before*** the care is rendered.
- Provide direction and follow-up care for those Members who have received emergency services.
- Primary Care Providers and their care team are responsible for the care of all Members who select them, including Members whom the PCP has not yet seen.
- Provider care in culturally sensitive manner.

Panel Closure

Occasionally PCPs will request closure of their panel to new Michigan Complete Health Members. Michigan Complete Health requires a 90-day written notice to the Provider Relations department prior to the proposed effective date of such closure. This panel closure must be in writing.

During the 90-day period between notification of closure and revision of the provider directories to reflect such closure, PCPs must continue to accept Members who select them. Michigan Complete Health will continue to list closed PCPs in the Michigan Complete Health Provider directories with a notation designating them as “Not accepting new Members.”

Reopening of Panel

The Michigan Complete Health Provider Relations department will continuously monitor the membership of all PCPs who have “closed” their panel to new Members. When a PCP requests to re-open their panel to new Members, the PCP will need to send a written notice to the Provider Relations department requesting re-opening of their panel and the effective date of the re-opening.

Specialist Providers

The role of a Michigan Complete Health participating specialist is to provide consulting expertise, as well as specialty diagnostic, surgical, and other medical care for Michigan Complete Health Members. Michigan Complete Health expects a participating specialist to support the PCP whose role is to coordinate and manage a Member's health care by providing only those specific services for which a referral has been issued and promptly returning the Member to the PCP as soon as medically appropriate. Open and prompt communication with the PCP concerning follow-up instructions, circumstances of further visit requirements, medications, lab work, x-rays, etc. is essential to the coordination of care.

Michigan Complete Health Specialist Responsibilities

Specialists must provide access to medical services 7 days a week/24 hours a day either directly or through call coverage. Specialists should order all laboratory testing, radiology studies or other diagnostic testing through a contracted, in-plan provider unless an emergency clearly indicates emergency lab or radiology services are needed. Michigan Complete Health has specific, contracted laboratory and radiology service providers in all regions. Refer to the “Prior Authorization Requirements for Michigan Complete Health” located in this manual. If you have any questions, please contact Provider Relations.

Access to Care

Prompt access to providers is vital to provide high quality care to members. Michigan Complete Health ensures that its providers are able to communicate with members in a manner that meets their individual needs, including those members with cognitive limitations. Michigan Complete Health makes resources available to members for medical, behavioral, community-based/ facility-based long-term service/ supports (LTSS) and pharmacy providers who work with members that require culturally, linguistically or disability care. Members and providers may access interpreters, translators and translation services in prevalent languages, as well as American Sign Language. Services and assistance appropriate to needs of members who are cognitively impaired (such as large print media and alternative, cognitively accessible formats) are also available. To inquire or schedule interpreter services, please call Provider Relations at 1- 844-239-7387. In addition, providers must comply with the Americans with Disabilities Act (ADA) and ensuring that all access standards are met.

Michigan Complete Health believes that its members are entitled to care that is delivered in the appropriate setting, appropriate timeframe and appropriate manner.

Michigan Complete Health requires health care providers to provide access to health care services without excessive scheduling delays. Providers will have policies and procedures in place to properly identify emergency conditions and appropriately triage such cases.

Medical Appointments

The maximum time period between a request for an appointment and the date offered will be:

- Life threatening, emergent problem: **Immediate access**
- Urgent care: **Same day**

Defined as services provided for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion and breathing difficulties, other than those of sudden onset and persistent severity.

- Preventive Care: **30 days**

Defined as a preventive health evaluation without medical symptoms for existing member, i.e. routine exam, annual physical.

- Routine Care: **7-14 days** (or earlier based on the membership)

Defined as non-urgent symptomatic condition that is medically stable.

If a provider's schedule cannot accommodate the member requesting an urgent care or routine care appointment within these time intervals, an appointment will be offered with an alternative provider, nurse provider, or physician assistant at the same location, or if none are available, at another location. Immediate care service may also be offered as an alternative to an urgent care appointment or a routine care appointment request which cannot be scheduled within the appropriate timeframe. The member may choose to decline alternatives and accept a delayed appointment with the provider.

Behavioral Health Appointments

The maximum time period between a request for an appointment and the date offered will be**:**

- Emergent and Life Threatening: **Immediate access**
- Emergent and Non-Life Threatening: **6 hours**
- Urgent Care: **48 hours**
- Routine Care: **10 working days**

If a provider's schedule cannot accommodate the member requesting an appointment within these time intervals, an appointment will be offered with an alternative provider at the same location, or if none available,

at another location. The member may choose to decline alternatives and accept a delayed appointment with the provider.

Office Hours/Office Wait Time

Michigan Complete Health requires health care providers to have established hours that accommodate the needs of Michigan Complete Health Members. These hours should be clearly posted and communicated to Members, authorized representatives and nursing staff at each facility. Wait time standards require Members to be seen within 30 minutes of the scheduled appointment.

MEMBER BENEFITS & PROVISION OF SERVICES

Covered services will be medically necessary services set forth between Michigan Complete Health, the State of Michigan and CMS and will be contained in the Member Handbook, which will be posted on the Michigan Complete Health website at: http://mmp.michigancompletehealth.com

MI Health Link Hospice Services

Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose. See bulletin MSA16-35 (http://www.michigan.gov/documents/mdhhs/MSA_16-35_539923_7.pdf) for information on Hospice services for individual's enrolled in MI Health Link.

The hospice provider will coordinate health care with the individual's Care Coordinator and will bill Medicare directly for services. The Health Link health plan will pay for Medicare Part D and Medicaid services not related to the member's terminal illness. See MI Health Link and Hospice Questions (http://www.michigan.gov/documents/mdch/MI_Health_Link_Hospice_Questions_481903_7.pdf).

For information on billing and payment for hospice services, see the Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf).

For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment unrelated to the terminal illness or related conditions. To accommodate situations where drugs used by hospice enrollee was unrelated to the beneficiary's terminal illness or related conditions, CMS circulated a form (Hospice Information for Medicare Part D Plans; OMB 0938-1269; https://mmp.michigancompletehealth.com/content/dam/centene/fidelis/pdfs/MMP_MI_hospice_508.pdf) to be used to facilitate coordination between Part D sponsors (i.e., Michigan Complete Health), hospices, and prescribers. For more information see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Part-D-Payment-Hospice-Final-2014-Guidance.pdf.

Medical Necessity Determinations

Medically necessary services will be defined as services:

- Medicare that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.

- Michigan Medicaid that are medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, the most cost-effective option in the least restrictive environment, and consistent with clinical standards of care. Medical necessity includes those services and supports designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.

- Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract between Michigan Complete Health, the state of Michigan and the Center for Medicare & Medicaid Services. The benefits will maintain coverage at least to the extent provided by Medicare and Michigan Medicaid as outlined in both state and federal rules. Integrated Care Organizations (ICOs) will be required to abide by the more generous of the applicable, Medicare and Michigan Medicaid standards.

Delivery of Care

All care will be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision. Amount, scope and duration of benefits will be determined through the assessment process.
All medical, and community-based and facility-based long-term service and support (LTSS) network providers, and all Prepaid Inpatient Health Plans (PIHP) behavioral health network providers, receive training in physical accessibility, which is defined in accordance with U.S. Department of Justice ADA guidance for providers, in the following areas:

- Utilizing waiting room and exam room furniture that meet needs of all Members, including those with physical and non-physical disabilities.

- Accessibility along public transportation routes and/or enough parking.

- Utilizing clear signage and way finding (e.g. color and symbol signage) throughout facilities.

AUTHORIZATION PROCESS

Authorization Requirements

The Michigan Complete Health Utilization Management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program's goals are to provide covered services that are medically necessary, appropriate to the Member's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Prior authorization is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Failure to obtain the required authorization may result in a denied claim or reduction in payment. Providers may NOT bill members for services when the Provider fails to obtain authorization and the claim is denied or reduced by Michigan Complete Health.

Services denied for lack of authorization will be reconsidered for payment only when submitted through the Claims Dispute process described within the manual.

A list of services requiring prior authorization can be found at http://mmp.michigancompletehealth.com. You can also visit the Michigan Complete Health website to access the Pre-Screen Tool to enter procedure codes to determine if authorization is required. Note: **All out of network services require prior authorization excluding emergency room services.**

Methods of submitting prior authorization requests are as follows:

- Through our portal at https://provider.michigancompletehealth.com (preferred). Please use the pre-auth check took on our webiste to determine if authorization should be submitted through Medicare or Medicaid record.
- Fax 1-833-783-3178
- Fax prior authorization requests utilizing the Prior Authorization fax forms posted on our website. Please note: faxes will not be monitored after hours and will be collected on the next business day.

Timeframes for Prior Authorization Request Notifications

Standard Authorization Request	Fourteen (14) days
Expedited Authorization Request	Seventy-two (72) hours

Prior authorization is not required for:

- Emergency care
- Urgent care
- Crisis stabilization, including mental health
- Family planning services
- Preventive services; health evaluation without medical symptoms for existing member, i.e. routine exam, annual physical
- Communicable disease services, including STI and HIV testing
- Out of area renal dialysis services

For Service Requiring Authorization:

Michigan Complete Health has physicians available and requires the Prepaid Inpatient Health Plans (PIHP) to have behavioral health providers available 24 hours a day for timely authorization of medically necessary items and services and coordinate transfer of stabilized members in the emergency department, if necessary.

Securing prior authorization is the responsibility of the requesting provider through an "Authorization/Pre-Certification Form". The requesting provider needs to complete and indicate the following on the form:

- Diagnosis
- Date and time of visit/service, number of visits and/or length of time anticipated as applicable.
- Provider requesting service
- Previous test results/consults if follow up appointment, if applicable.
- If service requested is for continuing care, the provider needs to send ongoing clinical information which documents medical necessity. Services for ongoing care would include, inpatient and outpatient care services.

For Retrospective Review:

Retrospective requests are requests for authorization of services or supplies that have already been provided to a member. This includes acute hospital stays when initial notification is received after the member has been discharged.
The requestor must submit a claim for payment. If the claim is denied, the provider and/or member will have the ability to file an appeal. Michigan Complete Health will complete a medical necessity review when authorization or timely notification to Michigan Complete Health was not obtained due to extenuating circumstances (i.e. unable to know situations- member was unconscious at presentation, member did not have their Michigan Complete Health ID card or otherwise indicated other coverage, services authorized by another Payer who subsequently determined member was not eligible at the time of service or Not Enough Time Situations - the member requires immediate medical services and prior authorization cannot be completed prior to service delivery). A decision will be made within 30 calendar days following receipt of all necessary information.

Expedited Organization Determinations

Expedited organization determinations are made when the member or his or her physician believes that waiting for a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the member's or physician's request. An extension may be granted for 14 additional calendar days if the member requests an extension, or if we justify a need for additional information and documents how the delay is in the best interest of the member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited requests must be called into our Utilization Management Department at 1-877-372-6121.

UTILIZATION MANAGEMENT AFFIRMATIVE STATEMENT REGARDING INCENTIVES

This statement is intended to comply with the Code of Federal Regulations 42 (C.F.R.) regarding Utilization Management Affirmative Statement Regarding Incentives. Any physician incentive plan operated by Michigan Complete Health meets the following requirements:

Michigan Complete Health makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular Member.
If the physician incentive plan places a physician or physician group at substantial financial risk (defined by 42 C.F.R. 422.208 (f)) for services that the physician or physician group does not furnish itself, Michigan Complete Health requires the physicians and physician groups to have either aggregate or per-patient stop-loss protection in accordance with regulatory requirements.
Michigan Complete Health does not reward providers, employees, or other individuals for issuing denials of coverage, service, or care. Denials for medical service requests are reviewed by Medical Directors and are based strictly upon review of the available clinical information, clinical judgment and plan benefits.

INTEGRATED CARE STRUCTURE

Care Coordination

The Michigan Complete Health care coordination process addresses ongoing individual needs in a comprehensive manner, occurring across a continuum of care, rather than a single episode at a time. Care coordination is a key element of the Michigan Health Link Program, ensuring that services are integrated and meet Member's goals and needs. The Michigan Complete Health care coordination team is comprised of specially qualified registered nurses, nurse practitioners, physician's assistants, and social workers who assess the member's risk factors; develop person centered and self-determined treatment goals; monitor outcomes; and evaluate outcomes for possible revisions of the treatment plan. Care coordination services establish a person-centered, outcome-approach, consistent with the CMS Model of Care (MOC) and Medicare and Medicaid requirements and guidance.

The goal of the Michigan Complete Health Care Coordination process is to provide one seamless integrated program. This begins at the time of enrollment when Michigan Complete Health assigns all Members a Care Coordinator. Care Coordinators work collaboratively with PCPs and other members of the Integrated Care Team, to develop a treatment plan, provide services and supports to members, coordinate care and expedite access to needed services. The Michigan Complete Health care coordination team also assists in actively linking members to providers, medical services, residential, social and other support services as needed.

Integrated Care Team (ICT)

The role of an ICT is to ensure the development of a comprehensive Individual Integrated Care and Supports Plan (IISCP) and to work collaboratively with the member and other team members to ensure the IISCP is fulfilled according to the person-centered planning process and the member's stated goals. ICT members will:

- Participate in the person-centered planning process at the member's discretion.
- Collaborate with other ICT members to ensure the person- centered planning process is maintained.
- Assist the member in meeting his or her goals
- Monitor and ensure that their part of the IISCP is implemented in order to meet the member's goals.
- Update the Integrated Care Bridge Record (ICBR) as needed and relevant to the team member's role in the ICT.
- Review assessments, test results and other pertinent information in the ICBR.

- Address transitions of care when a change between care settings occurs.
- Ensure continuity of care.
- Monitor for issues related to quality of care and quality of life.

The Care Coordinator offers the use of an ICT and honors the member's choice about his or her level of participation. The Care Coordinator revisits this choice periodically, as it may change.

The Care Coordinator leads the ICT. Membership in the ICT also includes the member, the member's chosen allies, PCP, and LTSS Coordinator and/or PIHP Supports Coordinator, as applicable. The team may also include the following persons as needed and available:

- Family caregivers and natural supports
- Primary care nurse care manager
- Specialty providers
- Paid long term services and supports personnel
- Nursing facility representative
- Others as appropriate

The operations of ICTs will vary depending on the needs and preferences of the member. A member with extensive service needs may warrant periodic meetings with all team members. A member with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the Care Coordinator and other direct communication with Members.

The ICT will adhere to a member's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for patients in substance use disorder treatment, C.F.R. 42, Part 2.

Individual Integrated Care and Supports Plan (IICSP)

In consultation with the Member and the ICT, the Care Coordinator will develop an Individual Integrated Care and Supports Plan (IICSP). This plan must focus on supporting the member to achieve personally defined goals in the most integrated setting.
The IICSP will be developed through the person-centered planning process and will include the following essential elements:

- The member's preferences for care, services, and supports.
- The member's prioritized list of concerns, goals and objectives, and strengths.
- Specific providers, services and supports including amount, scope, and duration.

- Results of the Initial Screening, Level I Assessment, and Level II Assessment (if performed).
- Summary of the member's health status.
- The plan for addressing concerns or goals and measures for achieving the goals.
- The person(s) responsible for specific interventions, monitoring, and reassessment.
- The due date for the interventions and reassessment; at least annually.

The IICSP will be updated upon a transition of care or significant change in member's health condition or upon request.

The IICSP will be completed for all members within 90 calendar days of enrollment. Existing person-centered service plans or plans of care can be incorporated into the IICSP.

PHARMACY

Covered pharmacy services for Michigan Complete Health Members include Medicare and Medicaid drugs when obtained from a network retail or mail order pharmacy. Information regarding the member's pharmacy coverage can be best found via our secure Provider Portal. Additional resources available on the website include the Michigan Complete Health Formulary, Envolve (Pharmacy Benefit Manager) Provider Manual and the Coverage Determination/Exception Request form.

Pharmacy Benefit Manager – Envolve

The Michigan Complete Health Formulary is designed to assist healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions and limitations
- The Utilization Management Program requirements and procedures
- An explanation of limits and quotas
- How prescribing providers can make an exception request

The Michigan Complete Health Formulary does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the professional judgment of the physician or pharmacist
- Relieve the physician or pharmacist of any obligation to the member.

The Michigan Complete Health Formulary is reviewed and approved by a Committee of doctors and pharmacists. Once established, the formulary will be maintained by the Committee, using at least quarterly meetings, to ensure that Michigan Complete Health Members receive the most appropriate medications in accordance with Medicare and State Medicaid guidelines. The Michigan Complete Health Formulary contains those medications that the Committee has chosen based on their safety and effectiveness. Copies of the formulary are available on our website: http://mmp.michigancompletehealth.com. Providers may also call Provider Relations for a hard copy of the formulary. The majority of prescriptions will be covered based on the Medicare formulary. In addition, Michigan Complete Health will assist with the following:

- Transitions of prescription drugs
- Out of Network Coverage
- Quality Assurance
- Utilization Management (Prior Authorization Requirements)
- Exceptions and Appeals
- Locate a network pharmacy
- Information about any formulary changes

Transition Policy

Under certain circumstances Michigan Complete Health offers a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. Coverage is for a temporary 30-day supply of the drug during the first 90 days they are a Member of Michigan Complete Health for Part D drugs and the first 180 days for Medicaid drugs. This allows time for the Member to talk to the Provider about alternatives. We will cover a 30-day supply of the drug if:

- It is not on our Formulary
- Health plan rules do not allow the Member to get the amount ordered
- The drug requires prior approval by Michigan Complete Health
- The drug is part of a step therapy restriction

Members who live in a nursing home or other long-term care facility can refill their prescription multiple times during the 90 days to allow as much as a 91 to 98 day supply. Throughout the plan year, there may be changes in the Member’s treatment setting based on the level of care required. Such transitions may include, but are not limited to:

- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting

- Members who transfer from one skilled-nursing facility to another and are served by a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up hospice status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimes

For those who experience changes in treatment settings, Michigan Complete Health will cover as much as a 31-days temporary supply of a Part D-covered drug when filled at a network pharmacy. If the member changes treatment settings multiple times within the same month, an exception or prior authorization request and approval for continued coverage may be needed. To request an exception or prior authorization, call Envolve at 1-844-202-6824.

Prior Authorization Requirements

Michigan Complete Health has a team of providers and pharmacists to create tools to help provide quality coverage to Michigan Complete Health Members. The tools include, but are not limited to: prior authorization criteria, clinical edits and quantity limits. Some examples include:

Age Limits: Some drugs require a prior authorization if the Member's age does not meet the manufacturer, Food and Drug Administration (FDA), or clinical recommendations.

Quantity Limits: For certain drugs, Michigan Complete Health limits the amount of the drug we will cover per prescription or for a defined period of time.

Prior Authorization: Michigan Complete Health requires prior authorization for certain drugs. (Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary through our exceptions process.) This means that approval will be required before the prescription can be filled. If approval is not obtained, Michigan Complete Health may not cover the drug.

Step Therapy: For certain drugs, Michigan Complete Health first requires a trial of a lower cost alternative.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand name drug was requested.
Prior Authorization may be requested by calling Envolve at 1-844-202-6824 or completing the prior authorization form found on our website at http://mmp.michigancompletehealth.com/prescription-drug-part- d-list-of-drugs/coverage-determinations-and-exceptions/.

Formulary Change Suggestions

Providers can offer Formulary Change suggestions by email at: MCHFormularyChange@centene.com.

BILLING INSTRUCTIONS

Michigan Complete Health follows CMS rules and regulations for billing and reimbursement. Please visit Centers for Medicare and Medicaid website: https://www.cms.gov/ for more information.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Michigan Complete Health for payment of covered services.

It is important that providers ensure Michigan Complete Health has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address.

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

Timely Filing

Participating Providers must submit all claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by Michigan Complete Health up to a maximum of 180 days. When Michigan Complete Health is the secondary payer, claims must be received within 180 calendar days of the final determination of the primary payer.

All claim requests for corrected claims or claim disputes from participating Providers must be received within 60 calendar days from the date of notification of payment or denial is issued.

Billing Guidelines for Atypical Providers

Through the Michigan Complete Health waiver services program, a variety of atypical providers contract directly with Michigan Complete Health for payment of covered services. Atypical providers include adult day service, home/car adaptations, home health agencies, day habilitation, homemaker services, home delivered meals, personal emergency response systems, respite, specialized medical equipment and supplies and supportive living facilities (SLFs).

It is important that providers ensure Michigan Complete Health has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify Michigan Complete Health 30 days in advance of changes pertaining to billing information. A provider change form is available on our website: https://mmp.michigancompletehealth.com/content/dam/centene/michigan-complete-health/pdfs/MCH-Provider-Change-Form-updated-072718.pdf. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member's contract on the date of service and prior authorization processes were followed
- Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual

Claims for Waiver Services and Supportive Living Facilities

Atypical Providers and supportive living facilities will be required to submit claims to Michigan Complete Health on a CMS 1500 form. This can be done through our secure provider portal or via submission of paper claims.

Billing guides and instructions for our online secure provider portal are available on our website at http://mmp.michigancompletehealth.com.

Basic Guidelines for Completing the CMS-1500 Claim Form:

- Use one claim form for each patient
- Enter one procedure code and date of service per claim line
- Enter information with a typewriter or a computer using black type

- Enter information within the allotted spaces
- Make sure whiteout is not used on the claim form
- Complete the form using the specific procedure or billing code for the service
- Use the same claim form for all services provided for the same recipient, provider and date of service
- If dates of service encompass more than one month, a separate billing form must be used for each month

Claims for Long-Term Care Facilities

Long-term care (LTC) facilities are required to bill on a UB-04 claim form. Both short term acute stays and custodial care are covered benefits. When submitting claims for short term sub-acute stays, facilities must ensure they are utilizing the appropriate revenue codes reflecting the short term stay.

Patient Credit File

In order for long-term care (LTC) facility claims to be processed, the Member that the facility is billing for must be on the Patient Credit File. This file is provided by the Michigan Department of Health and Human Services and shows the amount the Member needs to pay for residing in the facility. In certain instances, there can be a delay in the Member appearing on the Patient Credit File. As a result, some LTC facility claims may be denied. A specific code, call an Explanation Code or an EX code will display on the denied claim that reads “DENY: Mbr not currently on PT Credit File – will reconsider once on file.”

Michigan Complete Health has put a process in place to ease the administrative burden of long-term care facilities in these instances. Each month when the Patient Credit File is received, Michigan Complete Health will check each member on the file against any previously denied claims. If there are claims that have been denied as a result of the member not appearing on the Patient Credit File, and all other necessary information is included in the claim, Michigan Complete Health will process and pay the previously denied claim. It is important to note, that LTC providers must still submit claims within 180 days.

Electronic Claims Submission

Network providers are encouraged to participate in Michigan Complete Health electronic claims/encounter filing program. Michigan Complete Health can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims.

In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

The Michigan Complete Health (MMP) Payor ID is **68069, Centene Corporation**.

Our clearinghouse vendors include Emdeon, Emvoy, WebMD, Gateway EDI, Change Healthcare, Capario, MedAvant, ProxyMed, TriZetto Provider Solutions, Zirmed, MedAssets, Xactimed, SSI, All Scripts, Payerpath, SDS – Smart Data Solutions, Practice Insight, NEHEN, Netwerkes/Optum.

For questions or more information on electronic filing please contact:

Michigan Complete Health
Centene EDI Department
1-800-225-2573 Ext.6075525
E-mail at: EDIBA@centene.com

Paper Claims Submission

For Michigan Complete Health Members, all claims and encounters should be submitted to:

Michigan Complete Health
Attn: Claims Department
PO Box 3060
Farmington, MO 63640-3060

Claim Submission Requirements

Michigan Complete Health uses an imaging process for paper claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's:

- Do use the correct PO Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do attach the EOP from the primary insurance carrier when applicable
- Do submit on a proper original red and white form: CMS-1500 or UB-04

Note: Michigan Complete Health is able to receive primary insurance carrier EOP electronically

Dont's:

- Don't submit handwritten claim forms

- Don’t use red ink on claim forms
- Don’t circle any data on claim forms
- Don’t add extraneous information to any claim form field
- Don’t use highlighter on any claim form field
- Don’t submit photocopied claim forms (no black and white claim forms)
- Don’t submit carbon copied claim forms
- Don’t submit claim forms via fax

Clean Claim Definition

A clean claim means a claim received by Michigan Complete Health for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Michigan Complete Health.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Common Causes of Upfront Rejections

- Unreadable information
- Missing member date of birth
- Missing member name or identification number
- Missing provider name, tax ID, or NPI number
- The date of service on the claim is not prior to receipt date of the claim
- Dates are missing from required fields
- Invalid or missing type of bill
- Missing, invalid or incomplete diagnosis code

- Missing service line detail
- Member not effective on the date of service
- Admission type is missing
- Missing patient status
- Missing or invalid occurrence code or date
- Missing or invalid revenue code
- Missing or invalid CPT/procedure code
- Incorrect form type

Michigan Complete Health will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

Common Causes of Claim Processing Delays and Denials

- Incorrect form type
- Diagnosis code missing digits
- Missing or invalid procedure or modifier codes
- Missing or invalid DRG code
- Explanation of benefits from the primary carrier is missing or incomplete
- Invalid member ID
- Invalid place of service code
- Provider Tax ID and NPI do not match
- Invalid revenue code
- Dates of service span do not match listed days/units
- Missing physician signature
- Invalid Tax ID
- Missing or incomplete third party liability information

Michigan Complete Health will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Michigan Complete Health provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. **As a Provider, you can gain the following benefits from using EFT and ERA:**

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep total control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please contact our Provider Relations department at 1-844-239-7387.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 30 business days of the receipt
- 99% within 90 business days of the receipt

Claim Corrections, Requests for Reconsiderations, and Disputes

All corrected claims, requests for reconsiderations, or claim disputes must be received within 60 calendar days from the date of the Explanation of Payment (EOP) or denial. All non-contracted providers should refer to the Medicare Appeals section of this manual. Any photocopied, black & white, or handwritten claim forms, regardless of the submission type (first time, corrected claim, Request for Reconsideration, or Claim Dispute) will cause an upfront rejection. Prior processing will be upheld for corrected claims, requests for reconsideration or disputes received outside of the 60 day time requirement unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with the normal business operations of the Provider, or damage or destruction of the Provider's business office or records by a natural disaster or mechanical issue

- Delays or errors by Michigan Complete Health or the federal and/or state regulatory body

- The member was eligible; however the provider was unaware that the member was eligible for services at the time services were rendered because the member refused or was physically unable to provider his or her ID Card or information and this is documented in the provider's record.

Below are relevant definitions:

- Adjusted or corrected claim – A provider is CHANGING the original claim

- Request for Reconsideration – provider disagrees with the original claim outcome (payment amount, denial reason, etc.

- Claim Dispute – Provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the secure Provider Portal. Follow the instructions on the secure provider portal for submitting a correction.

- Submit a corrected claim electronically via a Clearinghouse referencing the original claim.

Submit a corrected paper claim to:

Michigan Complete Health
Attn: Corrected Claims
PO Box 3060
Farmington, MO 63640-3060

When submitting via paper claim include the original Explanation of Payment (EOP). Failure to submit the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing or denial for exceeding the timely filing limit.

How to submit a corrected claim EDI:

Both items listed below must be completed for an ANSI-837 professional claim to be considered a corrected claim.
In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:

- "7" – REPLACEMENT (Replacement of Prior Claim)

- "8" – VOID (Void/Cancel of Prior Claim)

In the 2300 Loop, the REF segment F8 qualifier (Claim Information), REG02 (Reference Identification ICN/DCN) must include the original claim number issued to the claim being corrected. The original claim

number can be found on your electronic claims receipt confirmation reports. Typically from the denial on an EOP.

Reconsiderations

- A request for reconsideration is a written communication (i.e. a letter) from a Provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected. Attach medical records for code audits, code edits or authorization denials. **Do not attach original claim form**.

- The documentation must also include a description of the reason for the request. The request must also include sufficient identifying information which includes, at minimum, the member name, member ID number, date of service, total charges and provider name.

A **"Request for Reconsideration"** should be sent to:

Michigan Complete Health
Attn: Reconsideration
PO Box 3060
Farmington, MO 63640-3060

Claim Dispute

- A claim dispute should be used only when a Provider has received an unsatisfactory response to a request for reconsideration.

- Providers wishing to dispute a claim must complete the Claim Dispute Form located at http://mmp.michigancompletehealth.com

- To expedite processing of the dispute, please include the original request for reconsideration letter and the response. Do not attach original claim form.

The Claim Dispute form and supporting documentation should be sent to:

Michigan Complete Health
Attn: Dispute
PO Box 3060
Farmington, MO 63640-3060

If the claim dispute results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a letter detailing the decision and steps for escalated reconsideration. Michigan Complete Health shall process, and finalize all adjusted claims, and disputed claims to a paid or denied status within 45 business days of receipt of the corrected claim or claim dispute.

Provider Refunds

When a Provider sends a refund for claims processed, the refund must be sent to the following address:

Michigan Complete Health

PO Box 959329
St. Louis, MO 63195

Billing Forms

Submit claims for professional services and durable medical equipment on a CMS-1500.

Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB-04 form.

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.
Michigan Complete Health, like all Medicaid programs, is always the payer of last resort. Michigan Complete Health providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Michigan Complete Health Members. If the provider is unsuccessful in obtaining necessary cooperation from a Member to identify potential third party resources, the provider shall inform Michigan Complete Health that efforts have been unsuccessful. Michigan Complete Health will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Michigan Complete Health will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Billing the Member

Michigan Complete Health reimburses only services that are medically necessary and covered through the Michigan Complete Health program. Providers are not allowed to **"balance bill"** for covered services if the provider's usually and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or Michigan Complete Health.

In order for a provider to bill a Member for services not covered under the Michigan Complete Health program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment following this language:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that Michigan Complete Health (MMP) through its contract with the Michigan Department of Health and Human Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

ENCOUNTERS

What Is An Encounter Versus A Claim?

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our Members. For example; if you are the PCP for a Michigan Complete Health Member and receive a monthly capitation amount for services, you must file an encounter (also referred to as an "“proxy claim”) on a CMS-1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data. Michigan Complete Health utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by Michigan Department of Health and Human Services and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS-1500 or UB-04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim.

You are required to submit either an encounter or a claim for each service that you render to a member.

CREDENTIALING

Credentialing Program

Michigan Complete Health has a comprehensive written credentialing program that has been established in accordance with the standards of the National Committee for Quality Assurance (NCQA) and applicable state and federal regulatory requirements. The program is reviewed and revised at least annually.

All providers who fall under the scope of Michigan Complete Health Credentialing Program must meet the minimum credentials, qualifications and criteria established by the Plan. Michigan Complete Health makes all decisions regarding provider participation in the Michigan Complete Health network in accordance with Michigan Complete Health credentialing criteria.

Getting Credentialed with Michigan Complete Health

Once you have completed the Michigan Complete Health Provider Information Form and executed the Network Provider Collaboration Agreement, you may become credentialed with Michigan Complete Health in one of two ways:

- **Council for Affordable Quality Health (CAQH):** Michigan Complete Health utilizes CAQH, a national credentialing clearinghouse. Once registered, CAQH will assign you a CAQH provider ID. A benefit of registering with CAQH is that your credentialing information may be made available to other payors/networks with which you wish to become affiliated. Simply provide us your CAQH provider ID number and we will access your application and begin our credentialing process.

- If you prefer not to sign up with CAQH, then you must complete the credentialing documents identified on the Provider Resources page at: http://mmp.michigancompletehealth.com. Documentation must be received and the credentialing process complete prior to full contract execution and the start of

participation status.

Who requires credentialing?

Credentialing is required for:

- Unless otherwise not required, all physicians who provide services to Michigan Complete Health members, including members of physician groups
- All other types of health care professionals who provide services to Michigan Complete Health members, and who are permitted to practice independently under state law.

Health care professionals included in the credentialing process include:

- Physicians who provide services to members and practice independently under state law are defined as below:
- Doctor of Medicine (MD); Doctor of Osteopathic Medicine (DO) Doctor of Dental Science (D.D.S.) who provide care under the medical benefit program; Doctor of Podiatric Medicine (DPM); Doctor of Chiropractic (DC); and Doctor of Optometry (OD).
- Behavioral Health Care providers to include Psychiatrists and Physicians who are certified in Addiction Medicine; doctoral and/or master's level Psychologists (PhD, PsyD) who are state certified or state licensed master's level
- Clinical Social Workers who are state certified or state licensed; master's level Clinical Nurse specialists or Psychiatric Nurse providers who are nationally or state certified or state licensed; and other Behavioral Health Care specialists who are licensed, certified, or registered by the state to practice independently
- Nurse providers, Nurse Midwives, and Physician Assistants who work in primary care and obstetrics/gynecology settings and who provide direct patient care, make referrals to specialists or have prescriptive duties
- Urgent care physicians and anesthesiologists who work outside the hospital setting

Credentialing is not required for:

- Health care professionals who are permitted to furnish services only under the direct supervision of another provider
- Hospital-based health care professionals and hospitalists who provide services to members incident to hospital services, unless those health care professionals are separately identified in member literature as available to members

- Students or fellows

Health care professionals who may be excluded from the credentialing process include:

- Pathologists, Radiologists, Anesthesiologists (excluding those that provide Pain Management services in an outpatient setting), Emergency Room Physicians, physicians practicing in free- standing facilities (i.e. surgical centers) and physicians who provide care for Michigan Complete Health enrollees only as a result of members being directed to the hospital/facility do not need to be credentialed by Michigan Complete Health unless otherwise noted.

Credentialing Criteria

Michigan Complete Health has adopted the following credentialing criteria and requirements for participating providers:

- Submission of a signed completed application, including the consent and other necessary releases
- Possess a current, valid license to practice in the state(s) in which he/she provides professional services as a contracted provider with Michigan Complete Health
- Possess and maintain certification by a medical specialty board recognized by the American Board of Medical Specialties or AOA; or have completed a residency-training program approved by the ACGME or AOA in the contracted specialty
- Possess current professional liability insurance coverage
- Possess verified, current state drug license and federal Drug Enforcement Agency certificates (DEA numbers), dependent on state requirements
- All contracted laboratory sites must maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification

What organizations require credentialing?

Health delivery organizations are required to be credentialed prior to seeing Members to ensure organizational providers are meeting minimally acceptable standards of patient care.

Health delivery organizations are defined as:

- Hospitals
- Home Health Agencies (HHA)
- Hospices
- Clinical laboratories

- Skilled Nursing Facilities (SNF)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Outpatient physical therapy and speech pathology providers
- Ambulatory Surgery Centers (ASC)
- Providers of end-stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable x-ray suppliers
- Durable Medical Equipment

Credentialing Criteria

Michigan Complete Health has adopted the following credentialing criteria and requirements for participating organizational providers:

- Submission of a signed completed application, including the consent and other necessary releases
- Possess a current, valid licensure in the state(s) in which services are provided as a contracted provider with Michigan Complete Health .
- Be reviewed and approved by an appropriate accrediting body. Accrediting bodies may include The Joint Commission (TJC, aka JCAHO), the Accreditation Association for Ambulatory Health Care, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Community Health Accreditation Program (CHAP), and the Continuing Care Accreditation Commission. In lieu of accreditation status, the organization may substitute a CMS or state review results not greater than three years old at the time of verification.
- Possess current professional liability insurance coverage with a minimum of $100,000 per occurrence and $300,000 aggregate. All contracted laboratory sites must maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.

Provider Rights

As a network provider, you have the right to:

- Review information submitted to your credentialing application.
- Correct erroneous information collected during the credentialing process.
- Be informed of the status of your credentialing or re-credentialing application.

- Be notified of these rights.

Requests for Additional Information

If Michigan Complete Health receives information from an outside source that differs substantially from information you have provided us, we will contact you directly as soon as the discrepancy is noted and request your clarification in writing within 10 business days.

Secure Web Portal

Michigan Complete Health offers a robust Secure Web Portal with functionality that will be beneficial to servicing Members and to ease Administration for our Providers. Each participating Provider's assigned Provider Network Specialist will be able to assist and provide education regarding the Web Portal functionality. The Portal can be accessed at www.Michigan Complete Health sc.com.

Functionality
All users of the Secure Web Portal must complete a registration process.
Once registered Providers may:

- Check eligibility
- View the status of recent claims that have been submitted
- View Providers associated with the Tax Identification Number ("TIN") that was utilized during the registration process
- Update demographic information (address, office hours, etc.)
- View and print patient lists (Primary Care Providers). This patient list will indicate the Member's name, Member ID number, and date of birth
- Review Member Health Risk Assessments completed within 45 days of Member's initial eligibility and annually thereafter
- Submit individual claims, batch claims or batch claims via an 837 file
- View a member's health record including visits (physician, outpatient hospital, therapy, etc.);medications and immunizations
- Review Member care plan completed within 90 days of Member's eligibilty and updated as changes occur
- View gaps in care specific to a Member including preventive care or services needed for chronic conditions

- Send secure messages to Michigan Complete Health staff

Appeals Process for Providers Terminated from the Michigan Complete Health Provider Network

A provider has the right to appeal a Quality and Peer Review Committee decision that has negatively impacted the provider. Michigan Complete Health complies with all state and federal mandates with respect to appeals for providers terminated from the Michigan Complete Health provider network. Michigan Complete Health notifies the provider in writing of the reason for the denial, suspension and termination. Terminated providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by Michigan Complete Health. In addition, the request for appeal must be received by Michigan Complete Health within thirty (30) days of the date of the rejection/termination letter. Upon receipt of the letter by Michigan Complete Health, the appeal is forwarded to the Michigan Complete Health Appeals Committee for review and further processing Michigan Complete Health will ensure that the majority of the hearing panel members are peers of the affected physician.

National Practitioner Data Bank (NPDB)

As a requirement of the participation agreement between Michigan Complete Health and the National Practitioner Data Bank pursuant to the Health Care Quality Improvement Act of 1986, as amended and other authorities per state and federal regulations, Michigan Complete Health is obligated to report the termination of a provider if the termination resulted from a quality of care issue resulting in harm to an Member's health and/or welfare. Any provider subject to this reporting requirement is notified via a letter of termination from Michigan Complete Health.

Confidentiality

Michigan Complete Health maintains the confidentiality of all information obtained about providers in the credentialing and re-credentialing process as required by law. Providers will have access to such information. Michigan Complete Health will not disclose confidential provider credentialing and re-credentialing information to any person or entity except with the written permission of the provider or as otherwise permitted or required by law.

Non-Discrimination

Michigan Complete Health will not discriminate against providers based on race, age, religion, creed, color, national origin, ancestry, sex, sexual orientation, gender identity, physical or mental handicap or serious medical condition, spousal affiliation, the types of procedures performed, or the Members in which the provider specializes in determining a provider's qualifications to provide health care services to Michigan Complete Health Members. Selection of participating providers will be primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.
Michigan Complete Health is committed to treating all Members in a non-discriminatory manner. Providers are prohibited from discriminating against any Member in the provision of covered services whether on the basis of the Member's coverage under the plan, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, language preference, disability, handicap, health status, source of payment, utilization of medical or mental health services or supplies, health insurance coverage, or other unlawful basis including, without limitation, the filing by such Member of any complaint, grievance or legal action against the provider.

Network Provider Demographic/Information Updates

Network Providers should advise Michigan Complete Health with as much advance notice as possible for demographic/information updates. Address information is essential to member selection of provider as well as plan assignment of new members to providers. Network Provider information such as physical and billing address, phone and office hours, spoken languages, cultural competency and Disability, Hospital Affiliation, Board Certification, Acceptance of new Members, and Accessibility to Public Transportation are used in our Provider Directory, and having the most current information accurately reflects our Michigan provider network.

Training

All providers must be trained on:

- Compliance, /Fraud, Waste and Abuse Laws and regulations related to Medicare Advantage and Part D fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.)
- Cultural Competency & Disability, including accessibility requirements such as: physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible
- Person-Centered Planning;
- Self-Direction
- Prohibition against Balance Billing
- Member Rights and Protections
- Michigan Complete Health ' Model of Care
- Evidence-Based Best Practices
- Critical Incidents & Abuse Reporting

APPEALS AND GRIEVANCES

Michigan Complete Health's Grievance System includes an informal complaints process and a formally structured grievance and appeals process. Michigan Complete Health's Grievance system is consistent with 42 C.F.R. § 431 Subpart E and 42 C.F.R. § 438 Subpart F in place for addressing member grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

Grievances

A member grievance is defined as any expression of dissatisfaction by a member about any matter other than an Action. The grievance process allows the member, or the member's appointed representative (guardian,

caretaker, relative, PCP or other treating physician) acting on behalf of the Member, to file a grievance either verbally or in writing.

A member, or an authorized representative, may file a grievance at any time with Michigan Complete Health or its providers by calling or writing to Michigan Complete Health or the provider. If the grievance is filed with a provider, the provider is required to forward it to Michigan Complete Health. If remedial action is requested regarding a Medicare issue, the member must file the grievance with Michigan Complete Health or provider no later than ninety (90) calendar days after the event or incident triggering the grievance.

Each member grievance will be responded to within a reasonable time, but no later than thirty (30) calendar days.

Expedited grievances will be responded to within twenty-four (24) hours. Grievances can only be expedited if Michigan Complete Health extends the appeals timeframe or refuses to grant a request for an expedited appeal. Members will be notified of their right to file an expedited grievance in these circumstances.

As Michigan Complete Health has strict timeframes under which we are required to resolve grievances, any grievances received directly by the provider/provider's office should be forwarded upon receipt (no later than 24 hours) to:

Centene Corporation
ATTN: Appeals and Grievances Medicare Operations
7700 Forsyth Blvd
Saint Louis, MO 63105
FAX: 1-844-273-2671

If Michigan Complete Health receives a grievance concerning a provider, the provider will be contacted and expected to provide any information and assistance for Michigan Complete Health to effectively resolve the grievance and respond to the Member within the required timeframes. In no circumstance is the provider to hold the fact the Member has filed a grievance against the Member and/or allow any impact to the future treatment or communication with the Member.

MEDICARE RECONSIDERATIONS/APPEALS

Preservice (Prior Authorization) Appeals:

- A Member, a Member's representative, or physicians (regardless of whether the physician is affiliated with Michigan Complete Health) are the only parties who may request or expedite a Medicare reconsideration/appeal

- For standard pre-service reconsiderations, a physician who is providing treatment to a Member may, upon providing notice to the Member, request a standard Medicare reconsideration/appeal on the Member's behalf without submitting a representative form

- A Member, a provider or an authorized representative acting on behalf of a Member and with the Member's written consent may appeal the entity's decision to deny, terminate, suspend or reduce services

- In accordance with 42 C.F.R §§ 438.402 and 422.574, a Member, provider or authorized representative acting on behalf of a Member and with the Member's consent may also appeal the entity's delay in providing or arranging for a covered service

- Appeals will be resolved as expeditiously as the Member's condition requires, but always within thirty (30) calendar days of request for standard Appeals and within seventy-two (72) hours of request for expedited appeals

    - This time frame may be extended up to fourteen (14) calendar days if the Member, the authorized representative, the provider or Michigan Complete Health can show that there is a need for additional information and can demonstrate that the delay is in the Member's best interest.

Preservice Appeals should be submitted to:

Centene Corporation
ATTN: Appeals and Grievances Medicare Operations
7700 Forsyth Blvd
Saint Louis, MO 63105

Post Service (Claims) Appeals:

- Contracted providers do not have formal Medicare appeal rights, but may dispute and/or resubmit claims as appropriate for review. (See Claim Corrections, Requests for Reconsiderations and Disputes section of this manual)

- A Member, a provider or an authorized representative acting on behalf of a Member and with the Member's written consent may appeal the entity's decision to deny, terminate, suspend or reduce services

- Non-contracted providers have the right to request an Appeal in accordance with the Medicare managed care regulations

- Non-contracted providers have 60 calendar days from the retreival of EOP or correspondence date to file the appeal

- Non-contracted providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal

- Non-contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement

Member and non-contracted provider Appeals for denied claims should be submitted to:

Michigan Complete Health
Attn: Denied Claim Appeals

PO Box 3060 Farmington, MO 63640

Member Rights and Responsibilities

Providers are responsible for observing all Member rights.

Michigan Complete Health Members have the following rights:

The right to respect, fairness and dignity. This includes:

- The right to get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
- The right to request information in other formats (e.g. audio, CD-ROM, large print, Braille);
- The right to be free from any form of restraint or seclusion
- The right not to be billed by providers

The right to get health care information. This includes information on treatment and treatment options. This information should be a format the Member can understand. These rights include getting information on:

- Description of the services we cover
- How to get services
- How much services will cost the Member
- Names of the health care providers and Care Coordinators

The right to make decisions about care, including refusing treatment. This includes the right:

- To choose a Primary Care Provider (PCP) (including a specialist to act as a PCP) and to change PCP at any time
- To see a women's health care provider without a referral
- To get covered services and drugs quickly
- To know about all treatment options, no matter what they cost or whether they are covered;
- To refuse treatment, even if this is against the Member's doctor advice
- To stop taking medicine
- To ask for a second opinion, Michigan Complete Health will pay for the cost of a second

opinion visit

The right to timely access to care that does not have any communication or physical access barriers. This includes the right to:

- Get medical care timely
- Get in and out of a health care provider's office. This means barrier free access for people with disabilities, in accordance with the Americans with Disabilities Act. This includes the ability to transfer easily to the exam table and use the bathroom
- Have interpreters to help with communication with doctors and the health plan

The right to seek emergency and urgent care when needed. This means:

- Members have the right to get emergency services without prior approval in an emergency;
- Members have the right to see an out of network urgent or emergency care provider, when necessary

The right to confidentiality and privacy. This includes:

- The right to ask for and get a copy of the Member's medical records in a way that the Member can understand and to ask for his or her records to be changed or corrected
- The right to have personal health information kept private.

The right to make complaints about covered services or care. This includes the right to:

- File a complaint or grievance against Michigan Complete Health or providers;
- Ask for a state fair hearing;
- Get a detailed reason for why services were denied.

The right not to be balance billed for any covered service. This includes:

- The cost of any covered service, including any coinsurance, deductibles, financial penalties, or any other amount in full or in part.

Michigan Complete Health Members also have the following responsibilities:

- To ask questions if they don't understand their rights
- To select a Primary Care Provider (PCP) from the Michigan Complete Health provider directory
- To change their health plan and/or PCP in agreement with the rules of Michigan Complete Health. To

keep their scheduled appointment

- To have their ID cards with them
- To notify their PCP of emergency room treatment
- To cancel appointments in advance when they can't keep them
- If Michigan Complete Health is providing transportation to a medical appointment, to provide a car seat for any child riding with you if the child is 4 years of age or younger, or if the child weighs less than 40 pounds;
- To contact their PCP first for their non-emergency medical records
- To only go to the emergency room when they think it is an emergency
- Be sure they have approval from their PCP before going to a specialist except for self-referrals
- To share information relating to their health status with their PCP and become fully informed about services and treatment options. That includes the responsibility to:
  - Tell their PCP about their health
  - Talk to their providers about their healthcare needs and ask questions about different ways their healthcare problems can be treated
  - Help your providers get your medical records
- Actively participate in decisions relating to safe services and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their provider in deciding what healthcare is best for them;
  - Do the best they can to stay healthy
  - Treat providers and staff with respect

Michigan Complete Health provides services to our enrollees because of a contract Michigan Complete Health has with MI Health Link and with the Center for Medicare & Medicaid Services (CMS).

- Members can contact Michigan Complete Health to get any other information they want, including the structure and operation of Michigan Complete Health and how we pay our providers
- To tell us about things we should change, please call the Member Services Department at 1-844-239-7387

- Members have the right to make recommendations about Michigan Complete Health per its Rights and Responsibilities policies

- Members have the right to ask Michigan Complete Health about our reasons for the decisions we make about their healthcare.

At Michigan Complete Health, privacy is important to us. We will do all we can to protect our members' health records. By law, we must protect member health records and send a Privacy Notice, which we send to all members in a new member packet. The Privacy Notice tells members how we use their health records. It describes when we can share their records with others. It explains their rights about the use of their health records. It also tells members how to use those rights and who can see their health records. The notice does not apply to information that does not identify our members. When we talk about health records in the notice, it includes any information about members' past, present or future physical or mental health while they are a Member of Michigan Complete Health. This includes providing health care while they are our member. If you would like a copy of this Privacy Notice, please call Provider Relations.

Member Reconsiderations/Appeals

The Member Handbook contains information on how Members may file an appeal or grievance.

Members shall be entitled to file internal grievances directly with Michigan Complete Health. Michigan Complete Health tracks and resolves its grievances according to applicable Medicare and Medicaid rules or, if appropriate, re-routes grievances to the coverage decision or appeals processes.

Michigan Complete Health will use the unified set of requirements developed by CMS and the State of Michigan for grievances and internal appeals processes that incorporate relevant Medicare and Medicaid managed care requirements, to create a more Member-friendly and easily navigable system. Michigan Complete Health will manage Medicare Part D appeals and grievances and Medicaid non-Part D pharmacy appeals will continue in accordance with existing rules.

Members will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS.
Michigan Complete Health will provide assistance, information, forms and referrals to the Members on the appeals process as requested and in accordance with all federal and State laws and regulations.
Appeal time frames:

Time frames for filing appeals related to benefits will be unified.

- Individuals, their authorized representatives and providers for Medicare service appeals will have 90 days to file an appeal related to denial or reduction or termination of authorized **Medicare** benefit coverage.

    - Michigan Complete Health will apply applicable time frames for Medicare service appeals that have been inappropriately made to the State instead of the plan. Such appeals will be forwarded by the State to Michigan Complete Health for a determination.

- Individuals or their authorized representatives will have 90 days to file an appeal related to denial, or

reduction or termination of authorized **Medicaid** benefits covered by the Michigan Complete Health plan.

- Appeals will be expedited if Michigan Complete Health determines (based on the member request) or the Provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.
- Members will continue to have full access to the Medicare and Medicaid appeals frameworks for benefit appeals.
- Initial appeals (Reconsiderations) for Medicare services will be decided by Michigan Complete Health , with rights to subsequent appeals to an Independent Review Entity (IRE), (an independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations), and thereafter to an Administrative Law Judge.
- Initial appeals will be resolved as expeditiously as the patient's condition requires, but always within 30 calendar days of request for standard appeals, and within 72 hours of request for expedited appeals. Michigan Complete Health will continue to provide all non-part D benefits pending internal appeals, provided the appeal is requested within the latter of applicable timeframes for making such request or the effective date of the proposed action.
- Members will have rights to appeal through the State's Fair Hearing process.

REGULATORY AND CONTRACTUAL RESPONSIBILITIES

Compliance with the Contract, Regulations, and this Manual

Michigan Complete Health is subject to certain requirements as set forth by the Centers for Medicare and Medicaid Services (CMS) and the State of Michigan. Michigan Complete Health will disclose to CMS and the State all information necessary to administer and evaluate the program, and establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare and Medicaid services. The Michigan Complete Health provider contract requires compliance with the contract federal and state regulations governing health plans, and with the plan's policies and procedures. Providers must comply with all applicable federal and state laws and regulations, including but not limited to: federal laws and regulations designed to prevent or ameliorate waste, abuse and fraud such as applicable provisions of federal criminal law, the False claims Act, the anti-kickback statute of the Social Security Act and HIPAA administrative simplification rules. Those requirements are set forth in the Michigan Complete Health provider contract, this manual and from time to time in provider newsletters and other communications and notices sent by Michigan Complete Health.

All Providers agree that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

General Federal and Medicare Regulations

Through written agreement, we may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, credentialing and re- credentialing, network management, and provider training. We oversee and are accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. We will ensure written agreements which specify these responsibilities by us and the delegated entity are clear and concise. Agreements will be kept on file for reference.

If a Michigan Complete Health provider files an affidavit with CMS stating that they will furnish Medicare covered services to Medicare beneficiaries only through private (direct) contracts with the beneficiaries under Section 1802(b) of the Social Security Act (i.e. they will not accept payment from Medicare), then their contract with Michigan Complete Health will terminate concurrently. A Michigan Complete Health provider must provide notice to Michigan Complete Health within five (5) days of providing any notice with CMS.

Michigan Complete Health providers must provide covered services to all Members, including those with ethnic backgrounds, physical or mental disabilities, and limited English proficiency, in a culturally competent manner. Michigan Complete Health providers must provide disabled covered persons with the assistance necessary to effectively access services and communicate with the participating provider and their staff, as required by the Americans with Disabilities Act.

Michigan Complete Health monitors and reports on quality and performance including but not limited to: Member satisfaction, disenrollment, HEDIS measures and health outcomes.

Providers will comply with the requirements of 42 C.F.R. 422.504(g)(I)(iii) and agrees that dual eligible Members will not be responsible for any plan cost sharing for Medicare A and B services when the state is responsible for paying those amounts. Providers shall either:(1) accept amounts received from Michigan Complete Health as payment in full, or (2) bill the state Medicaid program for applicable co-payments, deductibles, and co- insurance for dual eligible Members.

Subcontracting with Other Providers

The agreement with Michigan Complete Health contains numerous important provisions that are synopsized below. In some situations, a Michigan Complete Health contracted provider may subcontract with another provider to provide services to a Michigan Complete Health Member. **In all cases, any such subcontracts must include the following provisions:**

- Providers understand that Michigan Complete Health is responsible for overall administration of the health plan including all final coverage determinations and monitoring of its contracted provider's compliance with state and federal regulations
- Michigan Complete Health is responsible for all marketing of the health plan and providers are not authorized to act as agents of Michigan Complete Health in marketing. Only Michigan Complete Health approved marketing materials may be provided to beneficiaries to explain the Michigan Complete Health program
- Providers will comply with Michigan Complete Health Utilization/Care Coordination Policies and Procedures

- Providers will comply with Michigan Complete Health Quality Improvement program. Michigan Complete Health requires that all providers participate in periodic audits and/or site surveys for evaluating compliance with Michigan Complete Health Quality Improvement standards and regulatory requirements

- Medical Records - Michigan Complete Health Providers must safeguard the privacy of any information that identifies a particular Member and must maintain Member records in an accurate and timely manner

- No Balance Billing of Members

Providing Access to Medical Records

Contracted providers must provide a Michigan Complete Health Medical Director or designee access to all Michigan Complete Health members' charts and medical records for the purpose of determining or resolving eligibility, liability or appropriate care issues. Provider, as prescribed by State and federal law under HIPAA regulations, will maintain confidentiality of this information. Michigan Complete Health is committed to protecting Member privacy and complying with the HIPAA privacy regulations. Generally, covered health plans and covered providers are not required to obtain individual Member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category.

All medical records must be maintained for up to ten (10) years.

Members may access their medical records at any time by contacting their provider directly. Members shall be given the opportunity to review their medical records in a timely fashion.

Access to Records and Audits by Michigan Complete Health

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Michigan Complete Health or its designated representative access to provider's records, at provider's place of business in this State during normal business hours, or remote access of such records, in order to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Michigan Complete Health or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Provider will grant Michigan Complete Health access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the Michigan Complete Health for this access.

Additional Contractual Requirements

- Contracted Providers agree to retain financial and medical records relating to Michigan Complete Health Members for a period of ten (10) years from the termination of the contract or such time as

may be required by applicable state or federal law, regulation or customary practice

- Michigan Complete Health Providers must give the U.S. Department of Health and Human Services, the U.S. Government Accounting Office and their designees the right to audit, evaluate, and inspect their books, contracts, medical records, member documentation and other relevant records. These rights will extend for ten (10) years beyond termination of the Michigan Complete Health agreement and until the conclusion of any governmental audit that may be initiated that pertain to such records.

- Michigan Complete Health Providers must not discriminate against members based on their health status. Further, providers must ensure that members are not unlawfully discriminated against based on race, color, creed, national origin, ancestry, language preference, religion, sex, marital status, age, physical or mental handicap, or in any other manner prohibited by state or federal law.

- Michigan Complete Health Providers must provide all covered benefits in a manner consistent with professionally recognized standards of health care.

- Michigan Complete Health Providers must participate as members of the Integrated Care Team in accordance with the Michigan Complete Health Care Coordination policies and procedures, as required by the MI Health Link program.

- Michigan Complete Health Providers must cooperate with the plan's grievance and appeals procedures that protect members and member rights.

- Michigan Complete Health Providers have specific continuity of care obligations in the event that the Michigan Complete Health agreement terminates for any reason, including a provider's de-participation or if Michigan Complete Health becomes insolvent. In the event of insolvency, Michigan Complete Health providers must continue to provide care to enrollees through the period in which their CMS payments have been made to Michigan Complete Health . Additionally, if the member is hospitalized, services must be provided until termination of CMS' agreement with Michigan Complete Health or, in the event of Michigan Complete Health insolvency, through the date of the Member's discharge.

- Michigan Complete Health Providers may not encourage members to disenroll.

- A Michigan Complete Health contracted Provider agrees not to impose any charges on any Michigan Complete Health Member for Covered Benefits beyond those shown in the Evidence of Coverage. Further, contracted Providers agree to accept the Michigan Complete Health payment as payment in full and agree not to seek compensation from a Michigan Complete Health member for services provided to that member, even in the event of non-payment by Michigan Complete Health. Provider further agrees that it will not attempt to collect co-payments or coinsurances from members who have Medicaid as a secondary insurance, or for members who have lost their Medicaid coverage while they are eligible to remain in the plan.

Review the Michigan Complete Health contract for any additional sections or provisions not discussed in this section. In addition, the description of the contract provisions listed in this section does not constitute the

complete disclosure of all requirements placed on providers contracted with Michigan Complete Health. Contracted providers should refer to their Michigan Complete Health contract for further information.

Independent Judgments and Communications

Participating providers are responsible for maintaining the provider-member relationship with each member. Nothing contained in the Michigan Complete Health agreement or this manual is intended to interfere with such provider-Member relationship, nor should any provision be interpreted to discourage or to prohibit a participating physician or other provider from discussing treatment options or providing other medical advice or treatment deemed appropriate by the participating provider. The participating physician shall have the sole responsibility for the medical care and treatment of members.

In the event that a Michigan Complete Health provider terminates their participation or relationship with the plan, Michigan Complete Health has the exclusive right and responsibility to communicate with its members regarding those changes; participating providers should not send independent notices to Michigan Complete Health Members.

The Health Insurance Portability & Accountability Act of 1996

Michigan Complete Health is concerned with protecting member privacy and is committed to complying with the HIPAA privacy and security regulations. Generally, covered health plans and covered providers are not required to obtain individual Member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities that fall into this category include care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement. If you have further concerns, please contact your Michigan Complete Health Provider Network Specialist.

Fraud, Waste and Abuse

Providers and Michigan Complete Health have an obligation to comply with all federal and state laws and Medicare requirements related to fraud, waste, and abuse.
Michigan Complete Health takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with federal and state laws. Michigan Complete Health is responsible for monitoring the activities of its providers, vendors, and other downstream contractors to ensure that claim submission / billing practices, utilization practices, and business practices meet federal, state and Medicare requirements. Michigan Complete Health, in conjunction with its parent company Centene, operates a waste, abuse and fraud unit that routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse and/or fraud. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies

- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify situation

Some of the most common WAF practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the Member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Michigan Complete Health will notify any provider or vendor that it suspects is not complying with these requirements and request a review of its records and/or activities. In certain cases, this could include suspension of payment until corrective action plans are in place.

Fraud Statutes

The **Anti-Kickback Statute** is a criminal statute that prohibits anyone (not only physicians) from knowingly and willfully offering, paying, soliciting, or accepting anything of value to induce or reward patient referrals or generate Medicare or Medicaid business. When contracting with physicians for services the following factors are required:

- There is a legitimate need for those services
- The services are provided as described in the contract
- Compensation is consistent with terms of provider agreement or contract and conducted in an arm’s length transaction
- The arrangement is completely decoupled from the volume or value of Medicare or Medicaid business generated.

Violations of Anti-Kickback rules require proof of intent. Penalties can include fines, jail time, and exclusion from federal healthcare programs.

The **Stark Law** is a strict liability statute that does not require proof of intent-meaning even inadvertent infringements are illegal. Quite simply, it is illegal for physicians to refer patients for Medicare-insured “designated health services”—clinical lab services, home health services, physical therapy, etc.—to an entity in which they (or a comprehensive list of related family members) have a financial stake. Penalties for Stark violations can include fines, jail time and exclusion from federal health care programs.

The **False Claims Act**—prohibits the submission of "knowing" false claims to obtain federal funds. The United States may sue violators for treble damages (three times the government's loss), plus $5,500 to $11,000 per false claim. The law is not limited to claims submitted with fraudulent intent. It also applies to "ostriches with their heads in the sand" who make false claims with "deliberate ignorance" or "reckless disregard" of truth or falsity, or "gross negligence." Everyone involved in a scheme can be prosecuted-even “downstream” providers or subcontractors who receive federal funds through third parties, such as government contractors and HMO’s.

For fraud concerns pertaining to our Medicare Part D product, you may also report to the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx or 1-877-772-3379.

Fraud & Abuse Reporting

Centene Corporation and Michigan Complete Health, is dedicated to conducting business in an ethical and legal manner. As a key partner, it is critical that you understand that we are committed to preventing, detecting and responding to fraud, wrongdoing or any type of misconduct. If you ever have any concerns, suspect wrongdoing, or are ever asked by anyone, including a Michigan Complete Health employee or member or provider, to engage in any behavior that you believe is wrong, unethical or illegal, please immediately contact Michigan Complete Health at any of the numbers below:

Centene’s Ethics & Compliance Helpline:
1-800-345-1642
www.mycompliancereport.com/brand/centene

Available 24 hours a day, seven days a week. Callers are not required to give their names and all calls will investigated and remain confidential.

Or

Michigan Complete Health Compliance Officer at: 248-729-8929 or email
michigancompletehealthcompliance@centene.com

Office of Health Services Inspector General PO Box 30479
Lansing, MI 48909
855-MI-FRAUD (643-7283)
www.michigan.gov/fraud

Our Ethics and Compliance department will promptly investigate allegations of wrongful, illegal or unethical business practices by any Centene Michigan Complete Health employee or any provider and when necessary report allegations of the Anti-Kickback Statute, Stark Law violations and the False Claims Act to government regulators.

Required General Compliance and Fraud, Waste and Abuse Training

CMS requires First-Tier, Downstream, and Related Entities (FDR)*, which includes contracted physicians, health care professionals, facilities and ancillary providers, contractors, and related parties, as well as delegated entities, to complete Compliance and Fraud, Waste and Abuse training via the Medicare Learning Network (MLN) website. The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively. The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter. Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan.

**Note: FDRs deemed to have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) Provider are exempt from the FWA training requirement only (General Compliance training remains a requirement).*

To complete Compliance and FWA training (if applicable) and access your certificate of completion:

- Visit the CMS MLN site:

To access training, use the following link and refer to the "Downloads" section of the webpage: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

(See: Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training)

- Access FWA training by visiting the Michigan Complete Health website: http://mmp.michigancompletehealth.com

Michigan Complete Health will notify any provider or vendor that it suspects is not complying with these requirements and request a review of its records and/or activities. In certain cases, this could include suspension of payment until corrective action plans are in place. If you suspect or witness a provider inappropriately billing or a Member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664.

QUALITY IMPROVEMENT PLAN

Overview

Michigan Complete Health culture, systems and processes are structured around its mission to improve the health of all enrolled Members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system incorporates a continuous cycle for assessing the level of care and service for Members through initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Michigan Complete Health requires all practitioners and providers to cooperate with all Quality Improvement (QI) activities, as well as to allow Michigan Complete Health to use practitioner and/or provider performance data to ensure the success of the QI program.

Michigan Complete Health will arrange for the delivery of appropriate care with the primary goal being to improve the health status of its Members. Where the Member's condition is not amenable to improvement, Michigan Complete Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Member. This will include the identification of Members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Michigan Complete Health QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its Members.

QAPI Program Structure

The Michigan Complete Health Board of Directors (BOD) has the ultimate oversight for the care and service provided to Members. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to:

- Enhance and improve quality of care
- Provide oversight and direction regarding policies, procedures, and protocols for Member care and services
- Offer guidelines based on recommendations for appropriateness of care and services

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve Member outcomes; and the education of Members, providers and staff regarding the Quality Improvement (QI), Utilization Management (UM), and Credentialing and Re-credentialing programs.

The following sub-committees report directly to the QIC:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Performance Improvement Team
- Advisory Council
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

- Pharmacy and Therapeutics

Practitioner Involvement

Michigan Complete Health recognizes the integral role that practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Michigan Complete Health promotes PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to Michigan Complete Health Members. The Michigan Complete Health QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.
The Michigan Complete Health primary QAPI Program goal is to improve Members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the care and services delivered.

Quality Improvement goals include but are not limited to the following:

- A high level of health status and quality of life will be experienced by Plan members
- Network quality of care and service will meet industry-accepted standards of performance
- Plan services will meet industry-accepted standards of performance
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Plan functional areas
- Member satisfaction will meet the Plan's established performance targets
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, congestive heart failure, coronary artery disease, diabetes and chronic obstructive pulmonary disease
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

To that end, the Michigan Complete Health QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with Member confidentiality laws and regulations

- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Member enrollment and disenrollment
- Member grievance system
- Member satisfaction
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider complaint system
- Provider network adequacy and capacity
- Provider satisfaction
- Selection and retention of providers (credentialing and re-credentialing) Utilization management, including under and over utilization.

Practice Guidelines

Michigan Complete Health whenever possible adopts preventive and Clinical Practice Guidelines (CPG) from recognized sources, for the provision of acute, chronic and behavioral health services relevant to the populations served. Guidelines will be presented to the Quality Improvement Committee (QIC) for appropriate physician review and adoption. Guidelines will be updated at least every two years or upon significant new scientific evidence or changes in national standards.

Michigan Complete Health adopts Clinical Practice Guidelines for at least two non-preventive acute or chronic medical conditions. Centene also adopts at least two behavioral health conditions (preventive or non-preventive) relevant to the population. At least two of the adopted CPGs directly correspond with two disease

management programs offered by the Michigan Complete Health plan. Guidelines will be based on health needs of population and/or opportunities for improvement as identified through the QAPI program.

Clinical Practice Guidelines (CPG) may include, but are not limited to:

- Guidelines for Diagnosis and Management of Asthma
- Practice Guidelines for General Diabetes Care

Michigan Complete Health also adopts applicable preventive health guidelines.

Preventive Health guidelines may include, but are not limited to:

- Adult Preventive Health Guidelines
- Immunization Guidelines

All guidelines are reviewed annually for updating and/or when new scientific evidence or national standards are published.

The Michigan Complete Health QAPI program assures that Practice Guidelines meet the following:

- Adopted guidelines are approved by Michigan Complete Health QIC. Michigan Complete Health reviews its guidelines against clinical evidence at least annually or more frequently if national guidelines change within the annual cycle
- Adopted guidelines are evidence-based and include preventive health services
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than bi-annually
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
    - Provider orientations and other group sessions
    - Provider e-newsletters
    - Online via the HEDIS Resource Page
    - Online via the Provider Portal
    - Targeted mailing

Guidelines are posted on the Michigan Complete Health website or paper copies are available upon request by contacting the Michigan Complete Health QI Department.

Patient Safety and Level of Care

Patient Safety is a key focus of the Michigan Complete Health QAPI program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care (QOC) issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Plan employees (including medical management staff, member services staff, provider relations, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the QI department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The Michigan Complete Health QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non- clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.
Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Michigan Complete Health to monitor improvement over time.

Annually, Michigan Complete Health develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Michigan Complete Health communicates activities and outcomes of its QAPI Program to both Members and providers through avenues such as the Member newsletter, provider newsletter and the Michigan Complete Health website at http://mmp.michigancompletehealth.com

At any time, Michigan Complete Health providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Michigan Complete Health progress in meeting the QAPI Program goals by contacting the Quality Improvement department.
Additionally, Michigan Complete Health develops and implements chronic care improvement programs and quality improvement projects required by CMS. Michigan Complete Health encourages all providers to participate in these initiatives.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. CMS utilizes HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its Members.

HEDIS Rate Calculations

HEDIS rates are calculated in two ways: administrative method or hybrid method. The administrative method consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative method include, but are not limited to Breast Cancer Screening (BCS), Colorectal Cancer screening, Antidepressant Medication Management (AMM), Adults' Access to Preventive/Ambulatory Health Services (AAP), Plan All Cause Readmissions (PCR) and, and Mental Health Utilization (MPT).

The hybrid method consists of both administrative data and a sample of medical record data. This method requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include but are not limited to Adult BMI Assessment (ABA), Comprehensive Diabetes Care (CDC) that includes HbA1c, and LDL lab results, eye exam and nephropathy, and Controlling High Blood Pressure (CBP).

Who conducts Medical Record Reviews (MRR) for HEDIS?

Michigan Complete Health may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Michigan Complete Health that allows them to collect PHI on our behalf.

How can Providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Michigan Complete Health claims and encounter data is the most efficient way to report HEDIS
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record

documentation of each member service and document conversation/services

- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes related services, eye exam, and blood pressure

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-844-239-7387.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members' expectations.

Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care which measures the member's perception of the physical and mental health. This standardized survey is administered yearly to a baseline population by a NCQA certified survey vendor. The survey is repeated in two years to the same baseline cohort of members surveyed to determine if the member's perception of mental and physical health has improved or decline as compared to baseline. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping Medicare beneficiaries make informed health care choices. Michigan Complete Health must participate in the Medicare Health Outcomes Survey.