

WORKING TOGETHER HEALTH PLAN OF MICHIGAN'S LATEST HEALTHCARE NEWS FOR PROVIDERS

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The Changing Face of Medicaid and Managed Care

It is important for providers to understand the Medicaid program in the national, state and local context. HPM has compiled the information in this article to illustrate current trends in Medicaid and managed care.

At the national level, Medicaid is now the largest health insurance program in the United States covering over 56 million people, and it is expected to increase by 24 percent to 72.8 million people by 2016. The Medicaid program covers four categories of individuals: children, adults, aged and disabled. Children under the age of 18 are the largest population covered by Medicaid, accounting for over half of all Medicaid enrollees, yet they only represent about 19% of overall Medicaid costs.

National Medicaid spending is increasing at a rate exceeding overall health spending across the country. It is estimated that total Medicaid spending for the U.S. will increase by 132 percent to \$690 billion by the year 2016. The largest category of spending is for nursing facilities, which represent 20 percent of all Medicaid costs at the national level.

At the State level, Michigan Medicaid enrollment has increased over the past year. According to data published by the Michigan Department of Community Health, there are over 1.6 million individuals enrolled in the Medicaid program. Of those, 972,000 are enrolled in one of thirteen managed care plans, while the rest are covered by fee for service or other programs. Enrollment in Medicaid health plans has increased by 5.6% from August 2006 to August 2007.

Spending on health services in Michigan represented 22% of overall State spending in 2006, second only to higher education. Michigan shows a similar trend as the rest of the nation in terms of costs by enrollee category. Although children make up 55% of the Medicaid population in Michigan, they account for only 21% of the costs. Meanwhile, the elderly make up only 24% of the Medicaid population but they account for 64% of the costs.

Health Plan of Michigan has seen a general upward trend in membership over the past year from 107,649 in August 2006 to 130,111 in August 2007. That represents an increase of nearly 21 percent. The following are some characteristics of HPM's membership:

- * 55% of HPM's members are female and 45% are male.
- * The majority of members are children. 69% of all members are under the age of 18, while 26% are between the ages of 18 and 44, and 6% are age 45 or older.
- * There have been over 1,800 newborn deliveries in 2007 to date.

Continued.....

Additional Information for practitioners found at our HPM website: www.hpmich.com

- Health Plan of Michigan Formulary
- Member Rights and Responsibilities
- Provider Manual
- Provider Directory
- Clinical Practice Guidelines
- QM Program

Information is updated on a routine basis, please check back periodically for updates on new features and benefits. Hard copies are available by calling 1-888-773-2647.



The Changing Face of Medicaid (Cont'd)

HPM recognizes that our State is experiencing financial challenges resulting in higher Medicaid enrollment which increases the burden on Medicaid providers. As you can see from the data, the Medicaid population represents a diverse group of individuals who are in need of accessible, high quality, compassionate care.

We would like to thank you for your ongoing efforts to serve our membership. If you have any questions or need assistance, please contact Provider Services at 1-888-773-2647.

** National statistics cited in this article are from the Centers for Medicare & Medicaid Services.*

Information & Announcements

HPM TO ENTER WAYNE COUNTY

Effective October 1, 2007 HPM will begin serving the Medicaid Members residing in Wayne County. With this latest approval for expansion, HPM's territory now includes 34 Counties across the lower peninsula.

We look forward to partnering with Wayne County Providers to coordinate care for our newest members. For more information please contact Network Development Specialists, Matthew Enders and Ben Schoen at 1-888-773-2647.

NATIONAL PRACTITIONER IDENTIFIER (NPI)

The NPI is part of the HIPAA mandate requiring a standard unique identifier for health care providers that went into effect on May 23, 2007. The State of Michigan granted an extension for providers to obtain and notify Health Plans of their NPI numbers. The deadline of October 1, 2007 is fast approaching. If you have not already submitted your NPI number to Health Plan of Michigan, please call the Provider Services department at 1-888-773-2647.

HEALTH PLAN OF MICHIGAN'S NEW WEBSITE

HPM is pleased to announce the new design of its website is complete. Please take a moment to view our new look and see for yourself all the features that are available to both Providers and Members.

www.hpmich.com

2007 PROVIDER MANUAL

The 2007 Provider Manual is available at HPM's website, www.hpmich.com. The manual is also available in a CD version. If you would like a copy, please call Provider Services at 1-888-773-2647.

TRANSPORTATION FOR HPM MEMBERS

HPM members have a non-emergency transportation benefit available to them when needing to access a healthcare provider for scheduled medical appointments. HPM's transportation provider is Access2Care. Members may call Access2Care's toll free number at 1-800-821-9369 to make arrangements for transportation once they have scheduled appointments with their healthcare provider. Members are requested to schedule their transportation at least five days in advance. They may also contact HPM's Member Services department at 1-888-437-0606 for assistance.

MANAGED CARE SYSTEM (MCS) UPDATE

The Progress Version 10 MCS update which began in June of 2007 is nearing completion. This new version replaces the Version 9 program and provides performance improvement on the MCS. The completion deadline is November 12, 2007. An IT representative from HPM, or your area representative, is available to come to your office to complete this upgrade. If your system requires this conversion, please call the Provider Services department at 1-888-773-2647.

MCS SERVICES

Just a reminder, PCPs can review a [PCP Summary](#) on each of their assigned members. This brief summary contains Claims, Pharmacy, Office Visit, ER, HEDIS, Outpatient, Disease/Case Management, and Inpatient information as well as Member Stated information if the member has completed an HRA. It can be printed for your office chart.

Refilling Prescriptions

A concern of many Primary Care Physicians is having your patients get and take prescriptions as ordered. Please remind your HPM members that a good rule of thumb is to refill their prescription five days before it runs out. Let the member know if they go any earlier, the pharmacy will not refill it and if they wait much longer they may run out.

It is also important when refilling prescriptions, members bring both the **Health Plan of Michigan** card and the **MiHealth** card provided by the State of Michigan. Not all prescriptions you order are covered by the health plan. Some, such as psychotropic, seizure and HIV medications, are exclusively covered by the State of Michigan.



“How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving and tolerant of the weak and strong. Because someday in life you will have been all of these.”

- George Washington Carver

ENROLLEE RIGHTS AND RESPONSIBILITIES

- A right to receive information about the organization, its services, its practitioners and providers and enrollees' rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's enrollees' rights and responsibilities policies.
- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed on with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- A responsibility to contribute towards their own health, including demonstrating appropriate behavior.

Health Plan of Michigan and contracted providers will comply with all requirements concerning enrollee rights. This document is available on the HPM website at www.hpmich.com.

Fraud and Abuse

Recent Audit Shows Inconsistencies in Provider Billing of Office Visits

In order to ensure appropriate billing and payment for services, Health Plan of Michigan periodically conducts audits of medical records. Recently an audit was conducted related to providers billing high level office visit codes, including the following codes:

CPT Code	Definition	Average Time Spent by Physician
99204	New Patient Office E/M Level IV	45 Minutes
99205	New Patient Office E/M Level V	60 Minutes
99214	Established Patient Office E/M Level IV	25 Minutes
99215	Established Patient Office E/M Level V	40 Minutes

HPM identified providers whose overall billing pattern demonstrated that they used the high level office visit codes at least 80% of the time or greater. Of those providers, HPM selected eight offices for the medical record audit. The audit was conducted by an external medical review group. They were given a copy of the record for each visit and were instructed to code the visit based on the documentation presented. All of the records had been billed by the provider as 99204/99205 or 99214/99215. The following is a summary of the results:

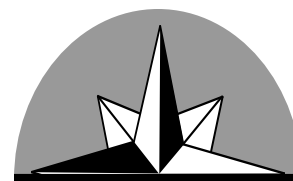
- * For new patient visits, of the 33 charts reviewed only 25% met the standard for 99204 and none met the standard for 99205. 45% should have been coded as 99202 and 30% should have been coded as 99203.
- * For established patient visits, of the 72 charts reviewed only 25% met the standard for 99214 and none met the standard for 99215. 44% should have been coded as 99212 and 31% should have been coded as 99213.

HPM works to educate its providers regarding appropriate billing practices. Providers should refer to the most recent CPT coding guidelines to ensure that they are billing the appropriate level of office visit, based on the time spent and the complexity of medical decision making. In instances where fraud and abuse is suspected, HPM is required to report the provider to the State of Michigan Program Investigations Section.

At Health Plan of Michigan, we are committed to implementing the necessary measures to prevent and detect fraud and abuse. Providers may report concerns directly to the Michigan Department of Community Health (DCH) at the following address:

Program Investigation Section
 Capitol Commons Center Building
 400 S. Pine Street - 6th Floor
 Lansing, MI 48909
 Toll Free: 1-866-428-0005

An on-line reporting form is available at <http://www.michigan.gov/mdch>. Reports can be submitted anonymously. If you have a question or concern regarding a potential fraud and abuse situation, you may contact HPM's Director of Provider Services at (888) 773-2647.



"Greatness is not in where we stand, but in what direction we are moving. We must sail sometimes with the wind and sometimes against it—but sail we must and not drift, nor lie at anchor."

**- Oliver Wendell
Holmes**

Utilization Management

If You Have a Question about Utilization Management Decisions

Health Plan of Michigan staff are available during normal business hours Monday through Friday 8:00am-5:30pm to receive and return your calls regarding Utilization Management issues including denials and clinical criteria used in decision making. We provide 24 hour emergency phone coverage, 7 days a week, through our after hours program. All calls you make to HPM are toll free at 1-888-322-8843. When we answer the phone we'll greet you by identifying ourselves by name, title and company. At Health Plan of Michigan we encourage you to call whenever you have a question about the Utilization Management process.

Adequate Action Notice, Notice of Denial

It is the policy of the Health Plan of Michigan that all notifications of an adverse decision include:

- The specific reason(s) for the denial, in easily understandable language;
- A reference to the benefit provision, guideline, protocol or other criterion on which the denial decision was made;
- Notification that the enrollee/practitioner can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based by contacting the UM Department;
- Information on how the practitioner can contact the reviewing physician or pharmacist to discuss the decision;
- Description of appeal rights;
- Explanation of the appeal process; and
- Description of the expedited appeal process for urgent pre-service and urgent concurrent denials.

Appealing Utilization Management Decisions on Behalf of the Enrollee

In accordance with the Department of Community Health (DCH) and the Office of Finance and Insurance Services (OFIS) the Health Plan of Michigan requires that an enrollee submit written permission to the health plan for an authorized representative, including a physician, family member or other representative, to appeal a denied service on their behalf.

Please note that written permission from the enrollee must be received by the health plan prior to an appeal being processed.

Authorization Decisions

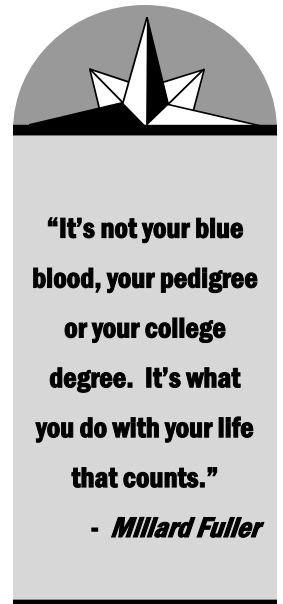
The references used in making authorization decisions are available upon written request. Our physician reviewer is also available to discuss clinical denial decisions with the requesting physician by calling 1-888-322-8843.

A Provider Statement About Incentives and Utilization Management

Health Plan of Michigan makes medical necessity (Utilization Management) decisions based only on the appropriateness of care and service and the existence of coverage. HPM does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Referral to Case Management

To refer a member to case management, select the "Notify HPM" button on the member screen in MCS. Enter a detailed description of the reason for the referral in the "Additional Comments" box, click on the "Case Management" button and hit "OK." A case manager will contact your office with a status on the referral of your patient. You may also call Member Services at 1-888-437-0606.



**"It's not your blue
blood, your pedigree
or your college
degree. It's what
you do with your life
that counts."**

- Millard Fuller

2006 Quality Improvement Program Evaluation

Health Plan of Michigan made excellent progress toward achieving its quality improvement goals. In 2006, we experienced double-digit growth in membership, with the average membership increasing by 19% from the prior year. HPM has remained focused on the goals of continuous quality improvement, maintaining the NCQA accreditation status of “Excellent” and pioneering innovative processes to enhance customer service and satisfaction for both members and providers.

Each year, HPM conducts separate member and provider satisfaction surveys. In 2006 the member satisfaction survey was re-designed to follow a similar format as the Consumer Assessment of Health Plans Survey (CAHPS). This was done to allow HPM to more directly compare its results to the CAHPS and determine areas for improvement. The results of this survey revealed that the ability to successfully engage in outreach activities with members is the key to increasing member satisfaction. In 2007, HPM is expanding these efforts.

HPM also conducts an annual review of provider satisfaction. The most notable improvement from the survey was the increase in the number of providers who feel that HPM is responsive to their pharmacy concerns. HPM’s pharmacy director has worked closely with RxAmerica to update HPM’s formulary and streamline the authorization process. We are pleased that providers are noticing these positive changes.

Although satisfaction increased in many areas, there was an overall decrease in satisfaction with the UM process. Based on feedback from providers, we have improved the process for notification related to UM denials and appeal rights. HPM continues to invest considerable effort and resources into technology intended to improve the authorization process and have it appear more seamless to the provider and the member. In addition, we have enhanced the clinical oversight in the department. In November 2006 the Medical Director assumed a supervisory role over the Quality and Care Management Departments and a Director of Care Management position was created.

Quality Management goals for 2006 were focused on ensuring a comprehensive program for HPM enrollees. HPM engaged in new and ongoing initiatives related to managing acute and chronic conditions, improving HEDIS and CAHPS scores and ensuring member safety. The Quality Management Department also worked on numerous collaborative efforts with the State of Michigan and other health plans designed to promote the quality of care and service for our members.

The Disease Management Program worked to improve the quality of life for members with chronic conditions through member and practitioner outreach and education. The Disease Management Program continued its focus on growth of the Diabetes and Asthma programs, and added new programs for Cardiovascular Disease (CVD) and Weight Management.

Lead screening for members ages 12 to 36 months remained one of the priority quality initiatives through 2006. Lead testing is a state mandated requirement. In 2006, HPM received a 100% compliance rating for all critical components of the Lead Performance Improvement Plan. HPM participated in over 15 community events including health fairs, provider office lead testing events and the state wide “Not in My Backyard” (NIMBY) project initiated by the Medicaid health plans in Michigan.

The responsibility for following up on Border Babies was transitioned to the Women and Children’s staff to provide continuity of care for babies born prematurely and/or needing significant medical intervention. Women and Children’s Services continued to see growth in the number of deliveries in 2006. Current efforts include encouraging mothers to take their children for the first well child visit and identifying mothers at high risk.

HPM was ranked 28th in the nation by *U.S. News & World Report* for quality of care and services to Medicaid members. HPM continues to make progress toward its goal of becoming one of the top three Medicaid health plans in the State of Michigan and maintaining NCQA Excellent Accreditation status. That journey brings with it significant responsibility and commitment of resources to support organizational, membership and network growth.

Continued.....

2006 Quality Improvement Program Evaluation (Cont'd)

HPM recognized early on that technology was key to achieving performance standards. The creation, implementation and ongoing enhancement of our proprietary MCS management information system demonstrate HPM's ongoing commitment to harnessing the power of technology to benefit the organization, its employees, members and providers. It is this system that will support and sustain the level of performance necessary to meet future goals and objectives and maintain HPM's Excellent NCQA accreditation status in the years to come.

If you have any questions about HPM's Quality Improvement Program, please contact Provider Services at 1-888-773-2647.

Weight Loss Program

HPM offers a comprehensive weight management program for our members. Our program offers benefits for two different weight loss programs. Members must complete the first program before being considered for the second program.

HPM's first step in the weight loss program is called Healthyroads. Healthyroads is a telephone based coaching program. This program offers tools and educational resources with diet, exercise, relaxation or stress management skills, and other solutions for weight management. HPM members must be referred by their PCP and meet the specific criteria. In addition to the PCP referral, the following item will need to be submitted with the referral:

- Member 30-day food and drink diary
- Signed member letter of commitment for the Healthyroads program

Members must participate in Healthyroads for a minimum of 6 months and up to a maximum of one year.

The second step in HPM's weight loss program is a referral to the Medical Weight Loss Clinics. This can be a covered benefit if the member meets specific criteria. It also requires a referral from the PCP and the following items need to be submitted:

- Documentation of successful completion of the Healthyroads program
- Signed member letter of commitment for the MWLC program

If the member is approved for MWLC, they will attend the clinic closest to their home. All supplements and nutrients may also be covered for approved members. Members must complete the program within a maximum of 6 months.

Members who have successfully completed these two programs, but need additional weight loss may be referred to the Detroit Medical Center, a certified Center of Excellence, for a Bariatric surgery evaluation.

If the PCP and/or HPM determine that the member does not meet the criteria for Healthyroads or MWLC but needs weight management, HPM will cover 2 visits for nutritional counseling as long as the member has the following conditions:

- Obesity (BMI equal or greater than 35)
- High Cholesterol
- High Blood Pressure
- Heart Failure
- Diabetes
- Chronic kidney/renal disease

Contact the Disease Management Department at 1-888-437-0606, ext 1395 for commitment letter forms or additional information.

Health Plan of Michigan
777 Woodward Avenue.
Suite 600

Provider Services Department:
Phone: 1-888-773-2647
Fax: 313-202-2008
www.hpnich.com

Mailing Address Line 1
Mailing Address Line 2
Mailing Address Line 3
Mailing Address Line 4
Mailing Address Line 5

Health Plan of Michigan's New Website Design is Now Complete!



HPM Receives Prestigious CIO 100 Award

Health Plan of Michigan is pleased to announce that we have been honored with a 2007 CIO 100 Award. The 20th annual award program recognizes organizations around the world that exemplify the highest level of operational and strategic excellence in information technology.

Health Plan of Michigan was recognized with the CIO 100 award for its innovative use of automated dialing technology to provide preventive health reminders to its members. Through this new initiative, HPM increased the number of households reached by over 240% within a one-year time period. The integration of the automated dialing system with HPM's proprietary MCS system allowed HPM to improve its overall preventive health screening rates by an average of 8.6% as measured by HEDIS.

In a highly competitive managed care market such as Michigan Medicaid, these improvements can give HPM the competitive edge that it needs to obtain increased membership, while ensuring the health of its existing membership.

"Health Plan of Michigan has made a significant investment in health information technology over the past several years through the development of our proprietary managed care system," said Tom Lauzon, Vice President and Chief Information Officer for Health Plan of Michigan. "We are honored that *CIO* magazine has recognized our company for its outstanding results."

The CIO 100 awards were presented on August 21, 2007 at the La Costa Resort & Spa in Carlsbad, California as part of the ninth annual CIO 100 Symposium® and Awards Ceremony.