Changes in Your Practice — General Requirements

In order to better serve both you and our members; HealthPlus must be promptly informed, in writing, of all changes to the following information related to your practice:

- Practice name
- Practice location, telephone number or fax number
- Practice billing address
- Tax identification number (must submit a copy of a W-9 form with the change)
- Physicians joining or leaving the practice
- Physician's hospital affiliation
- Physician's Board certification status
- Patient accepting status
- E-mail address

By providing HealthPlus with this information, you will ensure:

- Your practice is properly listed in the HealthPlus directories
- Payments made to you or your associate(s) are sent to the correct location
- Monies are properly reported to the IRS
- HealthPlus members are given the most current information regarding your practice
- Electronic communications are received

To inform HealthPlus of any changes, complete the "Provider Request Change Form" which can be found on our website at www.healthplus.org in the *Provider* section. Please make copies to keep in your files for future use.

Upon completion, fax or mail the form to HealthPlus according to the instructions on the form.

Adding a Physician to Your Practice

General Requirements

HealthPlus utilizes the CAQH Universal Credentialing DataSource (CAQH UCD) to process applications for participation. Please call a HealthPlus Provider Network Documentation Specialist to begin the process for a new physician/practitioner.

The following information is required to complete a CAQH Intake form:

- Physician/Provider's full name
- Credentials (MD/DO)
- Date of post-graduate training completion (in specialty practiced)
- Medical specialty
- Primary Physician Group (PPG) affiliation, if a primary care physician
- Other physicians in practice, if joining an existing group
- Board certification or board eligibility
- If certified, Board expiration date
- HealthPlus-affiliated hospital privileges

Note: If your affiliated Physician Hospital Organization (PHO) or Physician Organization (PO) administers the application process, please follow the appropriate guidelines set forth in the PHO/PO agreement.

The following criteria are taken into consideration before a CAQH Intake form for participation is extended:

- Network adequacy requirements
- Physician-to-member staffing ratios
- Board certifications
- Hospital privileges at an HealthPlus-affiliated hospital
- Malpractice insurance coverage

Upon receipt of a completed intake form and CAQH application, HealthPlus verifies the medical license, education and malpractice insurance, and queries the National Practitioner Data Bank, as well as other sources that supplement the credentialing investigation and verification process. The entire investigation and verification process takes approximately three to four weeks. Once verification is complete, the application is then taken to the HealthPlus physician/peer-represented Credentialing Committee for approval. In certain circumstances, the application is also taken to the Medical Affairs Committee and the HealthPlus Board of Directors.

Upon approval, you will receive a letter that will include the effective date and HealthPlus provider identification number for billing purposes.

Board Certification | General Requirements

The HealthPlus credentialing process requires that physicians be board certified by a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC), or be actively pursuing board certification. It is expected that board certification will be achieved within five years of completion of residency training; physicians who do not become board certified in this period of time may be subject to departicipation by the plan.

HealthPlus utilizes the CAQH Universal Provider DataSource® (UPD) to process applications for participation.

The UPD service is the industry standard for collecting provider data used in credentialing. By streamlining data collection electronically, UPD is reducing duplicative paperwork and administrative costs for many physicians and other health professionals. HealthPlus has accepted the UPD for credentialing and recredentialing since 2006. When practitioners review and re-attest to their information on the UPD regularly, the recredentialing process is virtually seamless.

HealthPlus will accept only the UPD for initial credentialing or recredentialing of HealthPlus practitioners. If you are not currently registered through the CAQH UPD, visit their website at www.caqh.org/ucd.php to get started. Be sure to designate HealthPlus of Michigan as a recipient of your information. If you have any questions about credentialing, please contact (810) 230-2058, or your HealthPlus Provider Network Educator.

The HealthPlus credentialing process evaluates the credentials of practitioners applying for affiliation.

This involves an intense peer review of:

- Education
- Training and relevant experience
- Current licensure status
- Liability coverage
- Hospital privileges
- Board certification
- Professional liability and sanctions history

HealthPlus evaluates all practitioners every three years to reassess their current clinical competence and ongoing ability to care for HealthPlus members. Items evaluated include:

- Current licensure status
- Liability coverage
- Hospital privileges
- Board certification status
- Professional liability and sanctions history (past 3 years)
- Data from utilization management records
- Quality reviews
- Member complaints

Practitioners have a right to be informed (upon request to the Credentialing Department) of the status of their credentialing or recredentialing application. They also have a right to review nonpeer-protected information obtained during the credentialing process that varies substantially from that submitted by the applicant, including actions on a license, professional liability history, and sanctions by Medicare/Medicaid, pending past actions involving hospital staff privileges or board certification decisions on information about professional training participation. The applicant has a right to correct a discrepancy.

All HealthPlus practitioners are expected to maintain compliance with HealthPlus Practitioner Office Site and Medical Record-keeping Standards (see Chapter 14). To ensure continued compliance with HealthPlus Medical Record Documentation Standards, a sampling methodology is used to conduct reviews of records maintained by primary care physicians. HealthPlus may also conduct office or medical record reviews in response to a member complaint. Practitioners who do not meet HealthPlus thresholds are educated and re-evaluated after a specific period of time to determine if the needed improvements have occurred.

HEDIS® (Healthcare Effectiveness Data and Information Set)	General Requirements

HEDIS is a set of health care performance measures that include approximately 76 measures across eight domains of care. HEDIS results are used to measure health plan performance on important dimensions of care and service.

The HEDIS measurement set is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of health care. HEDIS is one of the most widely used set of health care performance measures in the United States. HealthPlus utilizes the HEDIS data set for quality improvement activities including physician and provider group performance measurement and feedback.

Domains of Care

- Effectiveness of care
- Access/availability of care
- Satisfaction with the experience of care
- Use of services
- Cost of care
- Health plan descriptive information
- Health plan stability
- Informed health care choices

Some HEDIS measures are based on administrative data. It is important that you use appropriate, up-to-date diagnosis and procedure codes to assure that services provided are captured accurately. Other HEDIS measures are based on outpatient chart review. HealthPlus staff may visit your office to collect chart-based information.

When a Physician Leaves Your Practice or You Departicipate with HealthPlus	General Requirements

When a physician leaves your practice or decides to departicipate with HealthPlus, it is imperative to notify HealthPlus in writing as soon as possible. To ensure continuity of care for HealthPlus members, HealthPlus must notify members in a timely manner of the departure of a primary care or specialty physician from the network so that the members may select a new physician and have access to uninterrupted care. HealthPlus will provide timely notification to enrollees who have been under the ongoing care of a PCP or specialist physician prior to the effective date that a physician's employment or contract arrangement terminates or such physician otherwise becomes unavailable to care for enrollees. Unless extenuating circumstances exist, HealthPlus should be notified at least 90 days prior to the effective date of such termination or unavailability.

Please send a letter to the attention of the Provider Network Management Department in your region and include the following information:

- Physician's name
- Reason for leaving or departicipation
- Effective date of change
- New location, billing address, tax identification, if applicable
- Covering physician information

Note: If your affiliated Physician Hospital Organization (PHO) administers this process, please follow the appropriate guidelines set forth in your PHO agreement.

Enrollee Listing — General Requirements

Each month, HealthPlus will send the PCP an Enrollee Listing(s) by product line. The list(s) gives the name and address of the enrollee and benefit information, including office and pharmacy copays.

Every two weeks, HealthPlus will send a list that will contain any changes, additions and/or deletions to your patient roster. These are changes the enrollee made during the current month, *but with the effective dates the first of the next month.* The information will arrive in your office in advance of the change becoming effective so that you can update your full patient roster. After the first of the month, HealthPlus will send you another full patient roster that will include the previous changes.

Please refer to the "Effective Date" column on the Enrollee Listing for the most current information on all of your patients.

The Enrollee Listing(s) provide your office with the opportunity to make an initial contact with your new patients to encourage them to schedule a visit. In turn, the enrollee education materials also discuss the importance of the initial visit with the PCP and encourage the enrollee(s) to schedule an initial visit as soon as possible.

PHYSICIAN ENROLLEE LISTING Provider: 9999999 ANY DOCTOR CURRENT MEMBERS								
Member Name	**Member #**	**Eff Date**	**Term Date**	**DOB**	**Sex**	**Benefit**	**OV Copay***	**Phone #**
JIMBOB ANYNAME	777777777-01	08/01/98	XX/XX/XX	09/08/56	M	IN	$5.00	(810) 777-8888
JANE ANYNAME	777777777-02	08/01/98	XX/XX/XX	06/25/58	F	IN	$5.00	(810) 777-8888
JUSTIN ANYNAME	777777777-03	08/01/98	XX/XX/XX	04/21/88	M	IN	$5.00	(810) 777-8888
JEFFREY ANYNAME	777777777-04	08/01/98	XX/XX/XX	06/26/90	M	IN	$5.00	(810) 777-8888
JOHN DOE	111111111-01	10/01/96	XX/XX/XX	03/08/56	M	AD	$0	(810) 111-2222
JANE DOE	111111111-02	10/01/96	XX/XX/XX	08/18/66	F	AD	$0	(810) 111-2222
MYNAME JONES	888888888-01	12/01/97	XX/XX/XX	07/22/69	M	CA	$5.00	(810) 999-1111
ANY MEMBER	222222222-A0	07/01/95	XX/XX/XX	01/11/22	M	B5	$7.00	(248) 222-3333
MYNAME SMITH	333333333-01	07/01/95	XX/XX/XX	10/22/61	M	AG	**	(810) 444-7777
YOURNAME ZIGGY	999999999-01	07/01/95	XX/XX/XX	08/16/63	F	AD	$0	(810) 333-5555

Number of CURRENT MEMBERS 10

*Copay is the lesser of dollar amount shown or 50% of the allowed amount

**See Benefit Summary for copay details

PHYSICIAN ENROLLEE LISTING Provider: 9999999 ANY DOCTOR NEW ADDITIONS									
Member Name	**Member #**	**Eff Date**	**Term Date**	**DOB**	**Sex**	**Benefit**	**OV Copay***	**Phone #**	**Reason**
JOHN DOE	111111111-01	10/01/98	XX/XX/XX	09/08/56	M	AD	$0	(810) 111-2222	Changed PCP
JANE DOE	111111111-02	11/01/98	XX/XX/XX	06/25/58	F	AD	$0	(810) 111-2222	Changed PCP
ANY MEMBER	222222222-A0	10/01/98	XX/XX/XX	04/21/22	M	B5	$7.00	(248) 222-3333	
MYNAME SMITH	333333333-01	11/01/98	XX/XX/XX	06/26/90	M	AG	**	(810) 444-7777	Changed PCP
YOURNAME ZIGGY	999999999-01	10/01/96	XX/XX/XX	03/08/56	F	AD	$0	(810) 333-5555	Changed PCP

Number of CURRENT MEMBERS 5

*Copay is the lesser of dollar amount shown or 50% of the allowed amount

**See Benefit Summary for copay details

PHYSICIAN ENROLLEE LISTING Provider: 9999999 ANY DOCTOR DELETIONS			
Member Name	**Member #**	**Term Date**	**Reason**
ANOTHERNAME ADAMS	999999999-01	09/30/98	Changed PCP
WHATEVERNAME JONES	111112222-01	10/31/98	Changed PCP
MYCHILD1 JONES	111112222-03	09/30/98	Changed PCP
MYCHILD2 JONES	111112222-04	10/31/98	Changed PCP
YOURNAME SMITH	333332222-01	09/30/98	Changed PCP

Number of CURRENT MEMBERS 5

PHYSICIAN ENROLLEE LISTING Provider: 9999999 ANY DOCTOR BENEFIT CHANGES									
Member Name	**Member #**	**Eff Date**	**Term Date**	**DOB**	**Sex**	**Benefit**	**OV Copay***	**Rx Copay**	**Phone #**
JIMBOB ANYNAME	777777777-01	11/01/98	XX/XX/XX	09/08/56	M	IN	$5.00	$5.00	(810) 111-2222
JANE ANYNAME	777777777-02	11/01/98	XX/XX/XX	06/25/58	F	IN	$5.00	$5.00	(810) 111-2222

JUSTIN ANYNAME	777777777-03	11/01/98	XX/XX/XX	04/21/22	M	IN	$5.00	$5.00	(810) 111-2222
JEFFREY ANYNAME	777777777-04	11/01/98	XX/XX/XX	06/26/90	M	IN	$5.00	$5.00	(810) 111-2222
MYNAME JONES	888888888-01	11/01/98	XX/XX/XX	03/08/56	M	CA	$5.00	**	(810) 444-5555

Number of CURRENT MEMBERS 5

**See Benefit Summary for copay details

PCP Request to Discharge a Member

General Requirements

HealthPlus requires that PCPs accept and see patients according to the terms of their contractual agreements. Inasmuch as a member chooses his or her primary care physician, HealthPlus discourages the discharge of any patient without full discussion and an attempt to resolve issues. HealthPlus realizes, however, that there may be times when the physician/patient relationship cannot be preserved. HealthPlus requires patient discharge requests be nondiscriminatory and consistent with the physician's office policy for all of his or her patients.

To request to discharge a patient from his or her practice, the PCP must complete a HealthPlus Member Discharge/Termination Request Form which can be found on our website at www.healthplus.org in the Provider, Provider Resources section. Fax the completed form to your Provider Network Management Department:

(810) 230-2081 or (989) 799-8494.

It is the Physician Group Medical Director's role to review the physician's request and documentation to discharge a patient (if applicable). It is the role of the HealthPlus Medical Director to evaluate the reason for the physician's request to discharge a patient. Your request must be approved by the HealthPlus Medical Director prior to notification of your patient. Please do not communicate information to the patient until you have received formal notification from HealthPlus.

The HealthPlus Medical Director will review the patient discharge request and make a decision based on documented facts provided by the PCP. Each discharge must include detailed documentation regarding the facts surrounding the discharge. The following is a list of possible reasons for a member discharge, including, but not limited to:

- The member's age is inconsistent with the PCP's practice
- The member is unwilling to use affiliated providers for specialty care
- The member did not want to receive services through the PCP's affiliated hospital system
- The member has an unpaid financial debt with the PCP that is over 90 days outstanding and attempts have been made by the PCP to collect the outstanding debt
- The PCP was listed as not accepting new patients in the HealthPlus provider directory at the time of open enrollment
- The member is non-compliant with recommended treatment, resulting in excessive ED and AHC usage
- The member has missed numerous appointments without providing notification (3 no shows within a 12mo period)
- Member has permanently moved outside of the HealthPlus coverage area
- Breakdown in physician patient relationship, including but not limited to threatening behavior. Information must be clearly documented and submitted with the discharge request

Any other reason for the discharge of a member must be documented and will be reviewed by the HealthPlus Medical Director.

If the HealthPlus Medical Director approves the discharge, the HealthPlus Medical Director will notify the health system designee of the outcome of the patient discharge request, The PCP will provide written notification of the discharge to the member. HealthPlus Provider Network Management will forward the completed discharge form to the Customer Service Department at HealthPlus. The PCP must continue to provide emergency and urgent care services to the member for at least 30 days following the approval date of the discharge.

Member discharges approved by the HealthPlus Medical Director will be effective based on the following time frame:

- Approval prior to the 15th of the month, the effective date will be the first of the following month.
- After the 15th of the month the effective date, will be the first of the month following a 30-day waiting period. This period is necessary in order to have sufficient time to notify the PCP of discharge approval, patient notification by the PCP, new PCP selected by the member, and member records transferred.

It is imperative that patient discharge requests be given to the HealthPlus Medical Director by Provider Network Management within 7 business days ensure physician access for the member.

In order to maintain the best possible care for our members, HealthPlus has adopted a formal set of standards and procedures to ensure accessibility of health care services to our members.

Accessibility of Care

HealthPlus requires access to primary care and specialist practitioners for required medical care 24 hours a day, seven days a week, under applicable state and federal HMO laws. HealthPlus members are encouraged to contact their PCP for coordination of all medical care. In accordance with generally accepted medical standards:

- Urgent care will be provided the same day
- Routine symptomatic, non-urgent care will be provided within four calendar days
- Non-symptomatic and preventive care will be provided within 30 calendar days

For behavioral health, standards are as follows:

- Non life-threatening emergency services will be provided within six hours
- Urgent care will be provided within 48 hours
- Routine, non-urgent care will be provided within 10 working days

When the office is closed, the primary care physician (or designee) must be available to members, by telephone, 24 hours a day, 365 days per year. This availability can be provided through an answering service or on a recorded message indicating the telephone number of a covering physician or directions for emergency care.

Practitioners are monitored to ensure service levels are met. HealthPlus works directly with those practitioners who are non-compliant to develop a corrective action plan.

Medical Records — General Requirements

Practitioners must maintain a single medical record with complete and accurate information for each member. All medical records must be updated in a timely fashion. To the extent required by law, appropriate State and Federal agencies shall have the right, upon request, to inspect at all reasonable times, all accounting and administrative records maintained by the physician(s).

Access standards and procedures for maintaining medical records for HealthPlus members shall be in compliance with MDCH and HMO licensing and qualification requirements and HealthPlus standards.

Medical records shall be made accessible to members, any physician treating the members, applicable "approved committee" or HealthPlus, upon request, subject to, but not limited to:

- Record content and quality
- Peer review
- Grievance review

Confidentiality of Information

Physician(s) are responsible to maintain confidentiality and security of information contained in the medical records of a HealthPlus member, in compliance with federal and state requirements, including Health Insurance and Portability and Accountability Act Privacy – Security Standards.