ProviderPlus

HealthPlus
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A BI-MONTHLY NEWSLETTER PUBLISHED FOR HEALTHPLUS AFFILIATED PROVIDERS

INSIDE

NEW PROVIDER CUSTOMER SERVICE PHONE LINE:
1-855-211-7766

HealthPlus welcomes new vice president and chief medical officer

Michael Genord, M.D., has joined HealthPlus as the organization's new vice president and chief medical officer. Dr. Genord has held leadership positions in the Beaumont Health System, United Physician Organization, and both local and state medical societies. He has more than 17 years of experience and he established and operated Esprit Women's Health, P.C. in Royal Oak Mich. His professional affiliations include :

Michael Genord, M.D.
Vice President, Chief Medical Officer

- Member, Michigan State Medical Society board of directors
- Member, American Medical Association
- Member, Oakland County Medical Society
- Fellow, American College of Obstetrics and Gynecology
- Diplomate, American Board of Obstetrics and Gynecology

At HealthPlus, Dr. Genord provides executive oversight of :

- Pharmacy services
- Quality improvement
- Medical management
- Utilization and referral management
- Health and lifestyle management
- Case management and behavioral health services

A graduate of the Michigan State University College of Human Medicine and the Eli Broad Graduate School of Management, Dr. Genord possesses a blend of medical and business training that will support and strengthen the superior service HealthPlus provides to its members and provider network.

"The addition of Dr. Genord to the HealthPlus executive team positions HealthPlus well for continued success," said HealthPlus President and CEO Bruce Hill. "His insights as an experienced and respected health care provider, along with his business acumen, bring balanced perspective to the HealthPlus functions he leads. I am pleased to welcome him to our strong organization."

HealthPlus scores triple play in national rankings

For the second straight year, the National Committee for Quality Assurance has recognized HealthPlus' private health maintenance organization/point of service (HMO/POS), Medicare HMO and Medicaid HMO plans as being among the the highest-rated plans in the nation* in their respective categories.

NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations. It also recognizes clinicians and practices in key areas of performance. NCQA's Healthcare Effectiveness Data and Information Set® is the most widely used performance measurement tool in health care. The organization released its national rankings of health plans Sept. 19.

*According to NCQA's Private Health Insurance Plan Rankings 2013-2014, NCQA's Medicare Health Insurance Plan Rankings 2013-2014 and NCQA's Medicaid Health Insurance Plan Rankings 2013-2014.

Transition of Blue Cross Blue Shield of Michigan MIChild, MIChild Dental members underway

The Michigan Department of Community Health is working to transition current Blue Cross Blue Shield of Michigan MIChild enrollees to Medicaid managed care plans, effective Oct. 1, 2013. In addition, MDCH is working to transition MIChild Dental members who currently have Blue DentalSM coverage with Blue Cross Blue Shield of Michigan to Delta Dental.

Letters regarding these transitions were sent to health care and dental care providers earlier this year. BCBSM enrollees are receiving notification directly from MDCH advising them to select a health plan. Enrollees who do not select a plan will be auto-assigned to a plan by the state. For your reference, a set of frequently asked questions from MDCH is included in the supporting materials that accompany this newsletter.

Member transitions for counties in the HealthPlus service area will occur for October and November 2013. The MIChild product for HealthPlus is under the HealthPlus Commercial HMO provider contracts as benefit packages MI and MY. We hope you will recommend HealthPlus to any of your patients that may be part of this transition.

credits

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ProviderPlus is the bi-monthly newsletter for health care professionals published by HealthPlus of Michigan, HealthPlus Partners and HealthPlus Insurance Company.

If you have questions or comments e-mail sboenema@healthplus.org.

Help you and your patients avoid flu

Getting vaccinated against the flu is the single most important thing you can do to protect yourself, your patients and even your loved ones against influenza this flu season. The timing of flu season is very unpredictable and can vary from year to year. Get vaccinated now so that you will be protected when flu season begins. In the United States, it usually begins in October and can last until May. Flu vaccine is needed EVERY year because flu viruses are constantly changing.

The Centers for Disease Control and Prevention (CDC) recommendations have not changed since last year. Its recommendation is that everyone age six months or older get the flu shot. Any parent who wants to decrease their child's risk of getting the flu should have their child vaccinated. To avoid missed opportunities for vaccination, health care providers should offer it during routine health care visits or during hospitalizations whenever the vaccine is available.

While everyone over the age of six months should get a flu shot, remember the following high risk groups who should make it a priority:

- Adults 65 and over
- Children age 6 to 23 months
- Pregnant women
- People with chronic health problems such as asthma, heart disease and diabetes
- Anyone with a weakened immune system
- Health care workers

The CDC cautions that people allergic to eggs or who have had other serious illnesses consult their doctors before receiving the vaccine.

Flu shots are covered benefits for HealthPlus members. For services that are paid a percent of charges, the payment enhancement does not apply.

Weight management can't wait

The HealthPlus member population is no exception to the obesity epidemics at local, state and national levels. In 2010, 72.8 percent of our members were overweight (BMI >25), and 36.7 percent were obese (BMI > 30). In 2012, these rates rose to 72.5 percent and 37.5 percent, respectively. Our member diabetes diagnosis rates are climbing as well. Our records indicate 6.8 percent of our members were diabetic in 2010, and that rate rose to 7.1 percent in 2012. Although our diabetic members are being referred to nutritional counseling, our obese members are not. HealthPlus members are entitled to at least six visits to a dietician or nutrition class every year. By using codes S9470 (dietitian visit) and S9452 (nutrition class), your patients can take the first step, free of charge, to a healthier life.

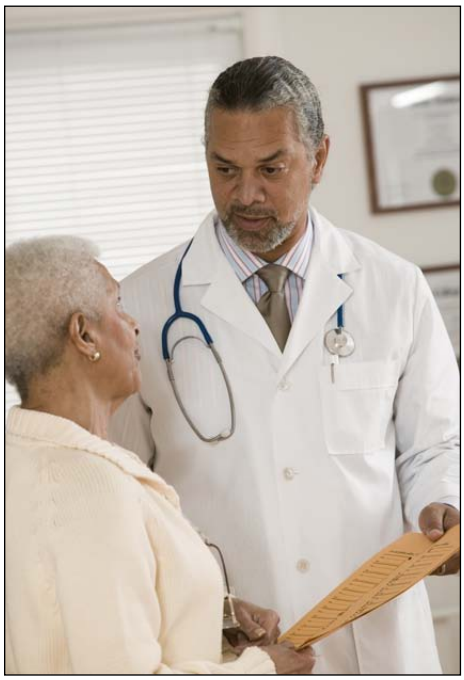
Below are the health systems that have available nutrition services:

Genesys	810-606-7720	genesys.org/GRMCWeb.nsf/0/1754080F5EA040B98525727D004EB9B9
Hurley	810-262-2310	hurleymc.com/services/services/nutrition-services
Covenant	989-583-5190	covenanthealthcare.com
McLaren	810-342-2185	mclaren.org/flint/NutritionalCounselingFlint.aspx
St. Mary's	989-907-8984	stmarysofmichigan.org/
Henry Ford	313-972-1919	henryford.com
Beaumont	248-898-3054	beaumont.edu/nutrition-services
Crittenton	248-652-5660	crittenton.com/medical-services/diabetes-services/
Sparrow	517-364-8080	sparrow.org/diabetes-clinical-programs
University of Michigan	734-936-4000	med.umich.edu/pfans/services/ncc.htm

HealthPlus advanced illness management program helps patients with life-limiting illness

The advanced illness management program supports members with life-limiting illness, with a possible life expectancy of less than 12 months. It is intended to support care coordination and help members live with the psychosocial demands of an advanced illness. The goals of the program are to:

- assist the member with advanced planning activities (advance directives)
- provide access to symptom management
- assist with obtaining pain management services
- offer a program that promotes comfort and maintains the highest possible quality of life for as long as life remains
- help the member navigate the health care system
- coordinate complex health care needs



Advance directives

Information has been placed on the HealthPlus website, www.healthplus.org, to educate members about "advance directives." The site includes links to additional information, contact information for related resources, and free, downloadable forms.

Advanced illness management

Primary care physicians play an integral role in determining/confirming the accuracy of the diagnosis and the member's prognosis. If one of your members is identified as having an advanced illness with a possible life expectancy of fewer than 12 months, you will receive a confidential fax from the HealthPlus case management department to confirm/verify your patient's health care status. Once you have confirmed the member's prognosis, as best you are able, a HealthPlus social worker will work with your member to determine his or her needs, and the appropriate level of care in the advanced illness management program.

Your member may elect in-home palliative or hospice care or be enrolled in the advanced illness case management program.

- If the member elects in-home palliative or hospice care, a HealthPlus social worker will contact your office to facilitate the referral. Members who elect to enter palliative care can still seek curative treatment while in the program.
- If the member is not eligible or unwilling to enter palliative or hospice care, he or she may be enrolled in the advanced illness management program. If the member is enrolled in the program, he or she will receive periodic care calls from a HealthPlus social worker to ensure his or her needs are being met. If and when the member becomes eligible for palliative or hospice care, the HealthPlus social worker will work with you to facilitate a referral to a contracted home health agency that provides these services.
- For questions regarding this program, please call the HealthPlus case management department at 800-345-9956, ext. 2776.

To report fraud, waste or abuse, call the HealthPlus confidential Hotline at 1-888-706-1504 or submit a report to healthplushotline.ethicspoint.com. You may also contact our compliance official at 2050 S. Linden Road, Flint, MI, 48532.

You do not have to leave your name.

For Medicaid fraud, waste, or abuse, you may contact the Office of Health Services Inspector General at 1-855-MI-FRAUD (643-7283) or write to them at P.O. Box 30479, Lansing, MI, 48909 or at www.michigan.gov/fraud. For other reporting options, visit our website at www.healthplus.org.

Help patients with substance use diagnoses initiate treatment

Getting patients to initiate and engage in substance abuse treatment can be a challenge. A patient's primary care physician is often the first professional to encounter a patient with alcohol or other drug abuse issues. HealthPlus suggests a few points for practitioners to consider when encountering patients who may be experiencing problems with alcohol and other drug dependence.

What can practitioners do?

- **Ask** about alcohol and other drug use and screen for problem use.
- **Refer** to a qualified behavioral health clinician for an assessment and follow-up treatment.
- **Share** any information you have with the behavioral health clinician so they can address any discrepancies or omissions reported by the patient during their assessment, diagnosis and treatment plan development.
- **Encourage** the patient to follow through with treatment – a minimum of two sessions within 30 days of the initial appointment is recommended.
- **Be persistent,** repeatedly raise the topic, and keep it at the forefront of the patient's care - especially with patients who may want to minimize their substance abuse and do not understand the need for treatment.
- **Follow-up** by expressing interest in the patient's progress at each visit.
- **Include** the appropriate substance use diagnosis in the patient chart and on each of your claims.

In-plan substance abuse treatment provider information can be located on the HealthPlus website, healthplus.org, or by contacting the HealthPlus customer service department at 800-332-9161. Additional resources regarding substance abuse can be found at nida.nih.gov.

Evidence-based clinical practice guidelines available online

With the implementation of the Patient Protection and Affordable Care Act, it is becoming increasingly important that our health plan members and providers are as knowledgeable about their health as possible. Research has shown people are searching the internet more and more to seek out information about diseases and health topics, and HealthPlus would like to provide you with a resource to help increase your knowledge.

HealthPlus is a member of the Michigan Quality Improvement Consortium, a collaborative effort among 13 Michigan health insurance plans and several professional organizations including the Michigan Department of Community Health, Michigan State Medical Society, Michigan Osteopathic Association, Michigan Association of Health Plans, Michigan Peer Review Organization, the University of Michigan Health System, and the Michigan State University College of Human Medicine. MQIC participating health plans are either accredited or audited by the National Committee for Quality Assurance and, in order to achieve and maintain accreditation status, are assessed on how well their members are receiving important health assessments. In turn, physicians are screened on how well their patients are receiving quality care.

MQIC develops and provides Michigan physicians with evidence-based clinical practice guidelines. These are one-sided, one-page, primary care-focused clinical guidelines which include important evidence-based recommendations, along with screening tools and guidance for treating patients. MQIC guidelines address conditions such as asthma, hypertension, diabetes mellitus, in addition to preventive services for all ages, cholesterol, obesity, advance care planning and more. We suggest you visit mqic.org for these guidelines, reports and tools.

Improving patient care outcomes

HealthPlus offers a team of clinical quality nurses who are available to assist your office in assessing quality indicators and offer suggestions for improvement. Up-to-date resources and quality tools for both adults and children are available, which you may find useful as you work to streamline and improve the care you provide. HealthPlus clinical quality nurses can answer your questions about how to better meet HEDIS standards through proper documentation and claims submission. If you would like a clinical quality nurse to contact you about scheduling a visit to your office, please call Marilyn Legacy, clinical performance improvement manager at 800-345-9956, ext. 8185 or by e-mail at mlegacy@healthplus.org.

Help prevent poor medication adherence

Poor medication adherence is a concerning, expensive and potentially fatal issue. Isn't it good to know it can be prevented? As health care professionals, our involvement in the improvement of medication adherence is crucial.

Collectively, physicians, pharmacists and other health care providers play an important role in not only helping patients understand the importance of taking medications as prescribed, but in helping them avoid or reduce unpleasant adverse effects that may compromise their adherence as well. Careful monitoring and communication is an effective way to help patients better understand their health conditions and avoid situations that may prevent them from adhering to their medication regimens.

Screen for potential barriers.

- Look for markers such as no refill requests.
- Ask patient about his or her feelings regarding his or her treatment regimen.
- Ask patient if they are experiencing any side effects or problems when they take their medications.
- Ask questions to uncover non-adherence in non-judgmental manner.

Help patients problem-solve.

- Dialogue, not monologue
- Troubleshoot obstacles and identify barriers, talk to family members, uncover needs.
- Establish trust.
- Explain the importance of medication therapy – how the medication works, how to take it, what to expect.
- Don't use force
- Recommend reminders such as cell phone alarm or pill boxes.
- Explain what the patient should do if he or she experiences unpleasant side effects.
- Consult with pharmacist, nurse/case management, or social worker if needed.
- Always follow up.
- Review adherence at each visit.
- Use the teach-back method.
- Reinforce adherence with patient and family.
- Confirm agreement on treatment goals.
- Explain risks of non-adherence.
- Identify misperceptions about medication treatment.

Despite the value of medication in helping patients live with a chronic illness, many of those patients will continue to be non-adherent. Therefore, as members of a health care team, we must work together to keep the importance of medication adherence from being discounted by your patients.

Keeping an eye on vision

Health care providers are charged with a great responsibility in working with people with diabetes. Long-term complications of diabetes are a major contributor to health care costs, with over $9 billion per year spent in Michigan alone. HealthPlus has adopted clinical practice guidelines for the prevention, diagnosis and management of several medical and behavioral health conditions. These guidelines correspond with specific, well-accepted clinical treatments for these conditions and are evidence-based, so as to achieve consistent, high-quality patient outcomes. Included in these guidelines are benefits for members with diabetes to obtain a yearly dilated retinal exam. Even if a member has lost their "vision" coverage, HealthPlus will pay for a dilated eye exam once each year. This does NOT include routine eye exams for glasses. Members with diabetes do NOT need a referral from their primary care physician for a diabetic dilated eye exam.

Consider the following statistics related to diabetes and blindness:

- 4.2 million U.S. adults with diabetes (29 percent) had diabetic retinopathy; including 655,000 cases that could lead to vision loss.
- In Michigan, 21 percent of people with diabetes aged 18 and older reported having been diagnosed with retinopathy.[1,2]
- In light of these staggering figures, HealthPlus is working to encourage members with diabetes to have this yearly exam completed. Why? Consider the following:
- Regular eye exams and timely treatment may prevent as much as 90 percent of diabetes-related blindness.
- Detecting and treating diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 0-60 percent.

What Your Office Can Do to Help

- Provide all HealthPlus members with a copy of the Eye Exam Report to take with them to their eye appointment
- Evaluate diabetic patients for need for dilated retinal exam and glaucoma exam annually
- Document and share results with HealthPlus
- Fax the eye exam report to HealthPlus at 810-230-2106 if you receive a copy back from the eye provider
- Remember to place a copy of the eye exam results that your received from the eye care specialist into the patient medical record

A sample eye exam report is included with the supporting materials included with this newsletter.

[1] *Centers for Disease Control and Prevention. National Diabetes Fact Sheet: National estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011*

[2] *Michigan Department of Community Health. Diabetes Data Library. Retrieved 2/1/201 michigan.gov/mdch/diabetes*

Improve quality and satisfaction with office protocols

Office protocols can be a valuable tool to improve the care of your patients with chronic diseases and improve your HEDIS scores. This can result in saved health care dollars and contribute to higher satisfaction reports from patients, staff, and providers. Improvements in quality reported scores also result in improvements in pay for performance and other financial benefits.

By establishing office protocols and empowering staff to complete them, practices can improve efficiency and quality of care. To be successful, the education and enthusiasm of both clinicians and staff need to be an adjunct to result in the "best practices" that every health care provider strives to achieve.

Almost any chronic disease measure, or preventative care measure, may benefit from an established office protocol. The following are some of the labs/tests that need to be completed at least yearly:

- HbA1c and LDL (lipid profile) testing for all patients with diabetes
- Yearly urine microalbumin measurements for all diabetics
- LDL for all patients with a cardiovascular condition
- Serum potassium, BUN, SCr for those on an ACE/ARB, Digoxin, or Diuretic
- Drug serum concentration levels for patients on anticonvulsants
- Spirometry testing for all asthma and COPD patients
- Monitor and record a blood pressure at every visit; repeat and document blood pressure readings that are out of normal range

Point of care testing is also a valuable tool in completing office protocols, as well as providing "real time" feedback to members with chronic diseases. Having the immediate results may stimulate the needed discussions around goal setting, self-management techniques, diet, and exercise and medication adherence. It also removes the barriers that patients often encounter with time, transportation and accessibility to an off-site laboratory. Other things you can do include …

- Have "flags" built into your EHR to remind staff to order tests/schedule preventive screening.
- Have standing lab orders in patient chart and update annually.
- Send a lab slip to patients before their next scheduled appointment.
- Reschedule appointments if labs have not been completed prior to a visit.
- Order labs tests at the beginning of each calendar year.

Remember, HealthPlus reimburses providers for completing HbA1c and LDL point of care testing. If you need more information about point of care testing please contact HealthPlus' disease management manager at 810-720-8186.

Remember that health care providers can order HbA1C, LDL or microalbumin as needed. It is not a HealthPlus policy to pay for only one lab test per year.

By working together, you and your patients can manage their chronic disease conditions and help to improve their health and your quality and pay for performance scores.

Diabetes: Keep up with kidney health!

You may already know that patients with diabetes should be prescribed an ACE Inhibitor (ACEI) or angiotensin receptor blocker (ARB). You may also know that urine testing also needs to be done each year. But… are you doing the best for your patients?

ACEI and ARBs should be a part of the diabetes medication plan unless your patient has documented chronic kidney disease, hypotension (SPB <100), or another medically indicated contraindication. If your patient is not tolerating an ACEI due to cough or hypersensitivity, try an ARB! Here are some examples:

ACEI	ARB
Lisinopril (Zestril, Prinivil)	Losartan (Cozaar)
Enalapril (Vasotec)	Valsartan (Diovan)
Ramipril (Altace)	Irbesartan (Avapro)

Each year, testing for urine microalbumin and potassium levels are part of follow-up diabetes care.

How to tell if your patient needs a microalbumin test

Patients need testing done (regardless of ACEI or ARB therapy) if they do not have documented ESRD, chronic or acute renal failure, renal insufficiency, diagnosed diabetic nephropathy, dialysis or renal transplant.

Urine microalbumin testing may not be indicated if a dipstick test for urine protein or urinalysis for gross protein macroalbuminuria was performed AND was positive. A negative urine protein test still indicates that urine microalbumin testing is needed.

You may have noticed that these recommendations cover a large number of your patients with diabetes. Keeping up with all of the needed care for your diabetic patients can be a challenge! Consider adding urine microalbumin testing to your standard lab test orders for patients with diabetes – the testing is a covered benefit for Health Plus members. As always, review medications with your patients at each follow-up visit, including assessing for medication adherence issues.

HealthPlus has disease management and case management services available to help if needed. Please call with any questions, we will be happy to help!

Order inhaler spacers for ALL asthma or COPD patients on a metered-dose inhaler (MDI)

Inhaler Spacers: Inhaled respiratory medicines work more effectively when they actually reach the lungs. Valved holding chambers and spacers are plastic tubes that attach to the mouthpiece of the metered-dose inhaler, and are recommended for adults and children. The valved holding chambers are really spacers that include a one-way valve at the mouthpiece. Many spacers automatically have that now. The valve traps and holds the medicine and prevents the patient from accidentally exhaling into the tube. There are many types of spacers and valved-holding chambers to choose from.

Did You Know? Metered-dose inhalers can spray medicine as fast as 60 miles per hour! This can cause the medicine to hit the back of the throat or roof of the mouth. (American Lung Association: www.lung.org/lung-disease/asthma/living-with-asthma)

The simple act of attaching a spacer or valved holding chamber to a MDI has multiple benefits:

- Spacers hold the puff of medication between the patient and the MDI, so that it can be inhaled slowly and completely. As a result, more of the medication is introduced into the airway.
- The space helps the medicine break into smaller particles/droplets which can move easier and deeper into the lungs, making it more effective
- It prevents patients from breathing the medicine too fast; by giving time for a full deep breath, they breathe in all of the medicine.
- It makes it easier for patients to deliver their medicine especially during an acute attack, when they are trying to breathe and spray at the same time.
- It can reduce side effects.
- Many spacers will make a whistling sound upon inspiration, if the patient is inhaling too quickly. Check the directions on each model.

An inhaler spacer should be ordered for any adults or child using an MDI. For children under age 5, a mask can be attached to the spacer. They are a standard of care and a covered benefit for all HealthPlus members*, limited to four per benefit year, unless a contract excludes pharmacy benefit:

- Medicare Advantage: spacers must be obtained from participating HealthPlus DME provider as they are considered a DME benefit.
- For all other HealthPlus lines of business, spacers may be obtained at a participating HealthPlus pharmacy, as they are considered a prescription drug benefit.
- A prescription is required from the provider.
- Please write a prescription for spacers for ALL members with asthma and/or COPD, and anyone on MDI inhaled medications. And remember, children may need a prescription for two devices, one for school and one at home.
- Please educate your patients on correct use, and remind them they can only be used with MDIs.

**The member should reference contract, benefit rider, master plan document and certificate of coverage for applicable limits and copayments, including other exceptions and /or exclusions for specific coverage.*

HealthPlus HealthySolutions updates

Thank you for your continued support of our HealthySolutions members. Since our 2008 launch of the plan, we have continually monitored and evaluated its effectiveness. We have reached out to our providers and members to help us in this process. In 2012 we introduced the follow up visit for any HealthySolutions member who has a treatment plan for tobacco, BMI or blood pressure. In January 2013 we began to offer the product on a PPO platform. With five years of participation fast approaching, we offer more improvements to help our member lead healthier, happier lives. Additional details will be provided as we get closer to the dates. Here is a peek at what's new …

Nov. 1, 2013

New HealthPlus wellness offerings for all HealthySolutions members who require a treatment plan for tobacco, BMI or blood pressure – the offerings are listed on the back of the form the member receives.

Check off your recommendations to assist them in their treatment plan.

Jan. 1, 2014

All HealthySolutions treatment plan forms must be submitted on line. Access the form on the Provider site at healthplus.org/ Provider Resources. Just click, complete and submit. Use billing code 99401 for $30. The additional $10 fee for online completion will be discontinued as of Dec. 31, 2013.

HealthPlus

EYE EXAM REPORT

GLAUCOMA SCREENING AND/OR DIABETIC RETINOPATHY SCREENING

Date of Exam: _____ HealthPlus ID #: _____

Patient DOB: _____ Health Plan: **HealthPlus Medical Services**

Patient Name: _____ Fax # : **810-230-2106**

Primary Care Physician Information:

Physician: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

Glaucoma Screening Results:

☐ No glaucoma is found in either eye. ☐ Glaucoma suspect or positive in one or both eyes.

Dilated Eye Exam Findings:

☐ No diabetic retinopathy is found in either eye.

☐ Retinal exam abnormalities were detected: ***See below***

- ☐ Right *(Circle Grade)* Mild Moderate Severe
- ☐ Left *(Circle Grade)* Mild Moderate Severe
- ☐ Proliferative changes noted in:
  - ☐ Right *(Circle Grade)* Active Regressed/Stable
  - ☐ Left *(Circle Grade)* Active Regressed/Stable
- ☐ Clinically significant diabetic macular edema? Yes No

Follow Up:

☐ Routine follow-up exam is recommended in one year.

☐ Follow-up of abnormalities in my office is recommended in _____ (timeframe).

☐ Referral to Dr. _____ is recommended in _____ (timeframe).

☐ Cataracts detected **or** laser treatment is needed. Letter to follow.

Thank you for referring this patient for a comprehensive eye evaluation.

Sincerely,

_____ _____

Eye Care Professional (*Signature)* **Date of Exam**

_____ _____

Eye Care Professional Printed Name/Clinic Name **Provider Number**

Please fax or mail this document to HealthPlus with a copy of the medical records supporting the service(s) indicated above. In addition, fax or mail a copy to the patient's physician *(see above).*
Fax to Medical Services Department at HealthPlus at (810) 230-2106.
Mail to: HealthPlus of Michigan, Medical Services Dept, 2050 S Linden Rd, Flint, MI 48532

Michigan Department of Community Health
Medical Services Administration

MIChild Transition Frequently Asked Questions (FAQ)

When will this transition take place?

The transition for medical coverage will begin October 1, 2013, in those counties where there is a choice of at least two health plans other than Blue Cross Blue Shield of Michigan. Michigan has been approved by the Centers for Medicare and Medicaid Services (CMS) to have only one plan in rural counties where adequate provider choice can be documented. Currently, the counties that MDCH is certain will transition on October 1, 2013 include Genesee, Kent, Livingston, Macomb, Oakland, Washtenaw, Wayne, and all counties in the Upper Peninsula. Plans are currently working on either becoming a MIChild Health Plan or enhancing their provider networks to expand into additional counties to assure plan choice and health care coverage for the MIChild enrollees. This process requires review and approval by the Department of Insurance and Financial Services. These processes will take an indeterminate amount of time. As a result, Blue Cross Blue Shield of Michigan will continue beyond October 1, 2013, in several counties until such time plan choice (or adequate provider choice in rural areas) is available.

The transition for dental coverage will follow a similar time line, but final decisions regarding alternate dental plans are still under development.

When will providers know which plans are available in which county?

This transition will take place over the next several months. Additional health plans are currently applying to become new MIChild Health Plans. MDCH will post county specific lists as new plans are approved to provide MIChild medical and dental coverage. Please visit www.michigan.gov/michild for the most up to date information. The following health plans are currently providing medical coverage in some counties: Priority Health, Molina Healthcare, Grand Valley Health Plan, United Healthcare, HealthPlus of Michigan, CoventryCares, Midwest Health Plan, Total Health Care, and Upper Peninsula Health Plan.

Delta Dental is available statewide and Golden Dental is available in some counties.

To provide services to MIChild enrollees, must providers have a contract with a MIChild Health Plan?

In most cases, the answer is yes. However, for some specialized medical services, out-of-network arrangements may be made with the MIChild Health Plan.

What should I tell my patients that have MIChild?

Enrollees will receive communication from the MIChild program when it is time to choose a plan. You should tell them what plan(s) you participate with (or plan to participate with) to assist them in their decision making.

How will this impact families that have MIChild and Children's Special Health Care Services (CSHCS)?

Currently, all individuals that have both MIChild and CSHCS are automatically enrolled into Blue Cross Blue Shield of Michigan. Due to this transition, the CSHCS/MIChild enrollees must choose a different plan. The MIChild plans that are also Medicaid Health Plans currently serve the CSHCS/Medicaid population and are prepared to serve CSHCS/MIChild enrollees. CSHCS/MIChild enrollees will be notified when it is time to select a new plan. If you serve the CSHCS/MIChild population it is very important that you communicate which plans you participate or plan to participate with to help ensure continuity of care.

Will the MIChild benefit change?

The MIChild benefit package will remain unchanged.

MIChild Transition Frequently Asked Questions (FAQ)

How will the MHPs pay out-of-network providers?

MDCH is creating a MIChild-specific fee schedule similar to the Medicaid FFS fee schedule. The health plans will be required to use this fee schedule when paying for out-of-network services.

Will there be any changes to dental coverage for MIChild members?

Yes. Blue Cross Blue Shield of Michigan will no longer be a MIChild Dental Plan effective October 1, 2013. Current dental enrollees will be transitioned in a similar manner as the medical enrollees to other MIChild dental plans. Dental providers will receive a specific letter regarding the details of the dental transition.

Will there be any changes to vision coverage for MIChild members?

Vision coverage remains a MIChild benefit. Contact the MIChild Health Plan for more information about the vision vendor with which they contract (it may be different plan to plan).

I am treating a MIChild member who is expecting a baby. Can I continue to provide her with prenatal care? Will my services for delivery and postnatal care be covered?

Prenatal care, labor, delivery and postnatal care remain MIChild covered benefits. Contact the MIChild Health Plan to become a contracted provider. If you do not wish to contract with the MIChild Health Plan, you may continue to serve the enrollee and the MIChild Health Plan is required to pay you for the services out-of-network without prior authorization through the postnatal period since care was already established.

I have questions and want to contact the MIChild program. Where can I call?

Providers can contact Provider Support at 1-800-292-2550 or ProviderSupport@michigan.gov to receive answers to questions regarding the MIChild program and this transition. Additional information is also available on the MDCH MIChild website at www.michigan.gov/michild.