Transitions of Care (TRC)

It is important to time-stamp and document in the patient's medical record each step of your patient's transition of care from one healthcare setting to another. This includes the:

1. **Notification of inpatient admission**
2. **Receipt of discharge information or summary**
3. **Patient engagement after discharge with medication reconciliation**

The TRC guidelines improve the coordination of care for patients, both during and after the inpatient admission, which helps avoid adverse drug events and unnecessary readmissions back into the hospital.

Review the four components below to clearly understand TRC:

Notification of Inpatient Admission

- Document on the day of admission or within two days after admission, with the same date time-stamped in the medical record
- Notifications can happen by phone, email, or fax from the hospital (e.g., emergency department, case management), health plan, ongoing care provider or specialist
- Documentation of pre-op exam

Receipt of Discharge Information

- Document that the office was informed of discharge with time stamp for the date of discharge or within two days after
- Information must include:
  - The practitioner responsible for the patient's care during the inpatient stay
  - Procedures or treatment provided
  - Diagnosis at discharge
  - Current medication list
  - Testing results or tests pending
  - Instructions for patient care post-discharge

Patient Engagement after Inpatient Discharge

- Engage with the patient within 30 days after the date of discharge
- Complete an office visit, telehealth visit, home visit, or a telephone visit
- Can be completed by any office staff

Transitions of Care (TRC)

Medication Reconciliation Post-Discharge

- Complete a medication reconciliation from the date of discharge through 30 days after discharge (31 total days to complete)
- Document that the discharge and current medications were reconciled
- Medication reconciliation can be completed by a prescribing provider, a registered nurse, or a clinical pharmacist

Description	Codes◆
Medication Reconciliation	99483, 99495, 99496, 1111F
Engagement	**Outpatient Visits:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483, G0402, G0438, G0439, G0463, T1015
	Telephone Visits: 98966-98968, 99441-99443
	Transitional Care Management Services: 99495, 99496
	Telehealth Modifier: 95, GT
	Telehealth POS: 02
	Online Assessments: 98969-98972, 99421-99423, 99444, 99458, G2010, G2012, G2061-G2063

◆Codes listed are specific to the subject matter of this flyer. While Meridian encourages you to use these codes in association with the subject matter of this flyer, Meridian recognizes that the circumstances around the services provided may not always directly support/match the codes. It is crucial that the medical record documentation describes the services rendered in order to support the medical necessity and use of these codes.

Make the most out of a patient's follow-up appointment by reviewing the following:

- Medication adherence, especially for hypertension, diabetes, and/or cholesterol medications
  - › Update any 30-day prescriptions to 90-day fills and encourage medication delivery via mail-order pharmacy
- Four components of the Care for Older Adults (COA) measure
  - › Advance care planning
  - › Medication review (must be completed by a prescribing provider or a clinical pharmacist)
  - › Pain assessment
  - › Functional status assessment or ability to perform activities of daily living (ADLs)
- Any outstanding preventive care screenings or condition management testing

Contact your Provider Network Management Representative with any questions or call Meridian at **888-437-0606**

Fax medical records to: **313-202-0006**

Email us at **MIHEDIS@mhplan.com** for any Healthcare Effectiveness Data and Information Set (HEDIS) questions or secure electronic medical record submissions

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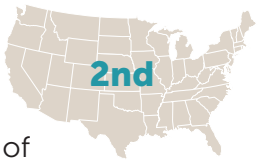
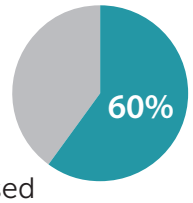
Colorectal Cancer Screening (COL)



Colorectal cancer is the second leading cause of cancer-related deaths among men and women combined in the United States.



If all adults 50 years of age and older had regular screenings, as many as 60% of deaths caused by colorectal cancer could be prevented.

One in three people are not up to date with their colorectal cancer screening.

FREQUENTLY ASKED QUESTIONS

What colorectal cancer screenings are covered? Meridian and WellCare cover colorectal cancer screenings for members who are high-risk or are 50 years of age and older:

- Colonoscopy
- Fecal immunochemical test (FIT) - DNA test or Cologuard®
- Fecal occult blood test (FOBT)
- Flexible sigmoidoscopy
- Computed tomography (CT) colonography

The Cologuard® screening is not a covered benefit for Medicaid and may require prior authorization for Medicare and Medicare-Medicaid Plans (MMP). Please verify the coverage prior to performing this type of screening.

How do I report patients who do not need these screenings? If your patient had a total colectomy or diagnosis of colorectal cancer any time during his/her medical history, please fax medical record documentation to **313-202-0006.**

For medical record documentation, please include:

- Date and type of colorectal cancer screening performed
- The result or finding
- If FOBT was performed, include the type of test (guaiac or immunochemical/FIT) and the number of returned samples

Codes to identify Colorectal Cancer Screenings:

Description	CPT◆	HCPCS◆
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398	G0105, G0121
CT colonography	74261-74263	
FIT - DNA	81528	G0464
FOBT	82270, 82274	G0328
Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345-45347, 45349, 45350	G0104

◆Codes listed are specific to the subject matter of this flyer. While Meridian encourages you to use these codes in association with the subject matter of this flyer, Meridian recognizes that the circumstances around the services provided may not always directly support/match the codes. It is crucial that the medical record documentation describes the services rendered in order to support the medical necessity and use of these codes.

Sources: www.cancer.org | www.fightcolorectalcancer.org

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Colorectal Cancer Screening (COL)

People with an average risk of colorectal cancer should begin screening at age 50. One of the following strategies is recommended:

Type of Screening	Time frame
Stool Tests	
FOBT	Every year
FIT - DNA	Every three years
Visual Examination Tests	
Flexible sigmoidoscopy	Every five years
Colonoscopy	Every 10 years
CT colonography	Every five years

Recommendations from the U.S. Preventive Service Task Force

Screening for colorectal cancer in adults begins at age 50 and continues until age 75. The risks and benefits of these screening methods vary. Do not screen for colorectal cancer in:

- Adults age 76-84 (There may be consideration that supports colorectal cancer screening in an individual patient)
- Adults age 85 and older

The recommended colorectal cancer screening plan depends on the risk of the colorectal cancer. The following situations can influence a patient's care plan for colon cancer prevention.

Patients with Higher Risk of Colorectal Cancer

The patients that fall into these scenarios are at an increased risk of colorectal cancer. These patients should begin screening for colon cancer earlier in life. Screening should begin at age 40, or 10 years younger than the earliest diagnosis in their family, whichever comes first.

Inflammatory Bowel Disease

People with ulcerative colitis or Crohn's disease have an increased risk of colon cancer. The best screening plan depends on how much of the colon is affected and how long the patient has lived with the disease.

Family History of Colorectal Cancer

The patient meets any of the following:

- Has a first-degree relative (parent, brother, sister, or child) with colorectal cancer or adenomatous polyps at a young age
- Has two first-degree relatives diagnosed at any age
- Has a first-degree relative who experienced colorectal cancer or adenomatous polyps at age 60 or older

Genetically-Based Colon Cancer Syndromes

These less common genetic conditions require more aggressive screenings and preventive treatments. Individuals with either of the conditions below should be managed by a clinician with clinical expertise in these syndromes:

- Familial adenomatous polyposis (FAP)
- Hereditary nonpolyposis colorectal cancer (HNPCC)

CONTACT INFORMATION:

Contact your Provider Network Management Representative with any questions

Colorectal cancer screening results may be faxed to: **313-202-0006**

Email us at **MIHEDIS@mhplan.com** for any Healthcare Effectiveness Data and Information Set (HEDIS®) questions or secure electronic medical record submissions

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Care for Older Adults (COA)

Ensuring older adults receive comprehensive care as they age involves assessing functional status and pain, medication regimens, and advance care planning. This gives providers the opportunity to offer guidance and counseling to their patients and help prevent future health problems.

The Care for Older Adults (COA) measure looks at the percentage of patients 65 years of age and older who had each of the following during the measurement year:

Advance Care Planning

Medication Review

Functional Status

Pain Screening

Using the COA Attestation Form

The COA Attestation Form helps providers address four areas that can impede good health for older adults. By completing each section annually with your patient, you can help them receive critical assessments that are vital to maintaining and optimizing their health. Be sure to save this form in the patient's chart.

Frequently Asked Questions

1. I received a COA Attestation Form with a list of patient names attached, but I've never seen some of these patients before. What should I do?

Members are assigned a Primary Care Provider (PCP) upon enrollment. Reach out to these patients to establish care and complete the form with them during the initial visit.

2. Where can I find more copies of the COA Attestation Form?

Contact your Provider Network Management Representative for this and other attestation forms or request one via email at **MIHEDIS@mhplan.com.**

3. I already filled out a COA Attestation Form for this patient this year. Why did I receive it again?

You may receive the form again if all four components were not filled out, the form was not signed by the provider, the credentials were missing, or if it was filled out but not returned.

4. How often do I have to fill out the COA Attestation Form?

The form provides an annual assessment, therefore it only needs to be completed and sent once per calendar year. However, you can complete it more than once and file it in the patient's chart.

5. How can I submit completed COA assessment information?

There are three ways to submit:

1. Submit the completed COA Attestation Form via secure email at **MIHEDIS@mhplan.com** or fax to **313-202-0006**
2. Submit the billing codes (listed on back) once the COA component was assessed
3. Submit medical record documentation supporting assessment of all four COA components (listed on back) via secure email or the fax number listed above

Care for Older Adults (COA)

These four components should be notated in the patient's medical record each year.

Advance Care Planning

It's important to talk with patients about their decisions for resuscitation, life-sustaining treatment, and end-of-life care. Please indicate in the medical record:

- **Date of advance care planning discussion *OR***
- **Notation that the patient previously executed an advance care plan *OR***
- **Presence of patient's advance care plan in medical record**

Examples include an advance directive, actionable medical orders, living will, or surrogate decision maker.

Description	CPT♦	CPT Category II♦	HCPCS♦	ICD-10♦
Advance Care Planning	99497, 99483	1123F, 1124F, 1157F, 1158F	S0257	Z66

Functional Status Assessment

This assessment measures the patient's ability to perform daily tasks and helps to identify any functional decline. Please indicate in the medical record:

- **Date and notation that Activities of Daily Living* (ADL) were assessed *OR***

  *Bathing, dressing, eating, transferring to/from the toilet, or walking

- **Date and notation that Instrumental Activities of Daily Living* (IADL) were assessed *OR***

  *Shopping, driving or using public transportation, meal preparation, housework, taking medications, using the telephone, home repair, or handling finances

- **Result of any standardized functional status assessment and the date when it was performed**

  SF-36®, Assessment of Living Skills and Resources (ALSAR), Barthel ADL Index Physical Self-Maintenance (ADLS) Scale, Bayer ADL (B-ADL) Scale, Barthel Index, Extended ADL (EADL) Scale, Independent Living Scale (ILS), Katz Index of Independence in ADL, Kenny Self-Care Evaluation, Klein-Bell ADL Scale, Kohlman Evaluation of Living Skills (KELS), Lawton & Brody's IADL scales, Patient-Reported Outcomes Measurement Information System (PROMIS) Global, or Physical Function Scale

Description	CPT♦	CPT Category II♦	HCPCS♦
Functional Status Assessment	99483	1170F	G0438, G0439

Medication Review

Perform an annual medication review of the patient's medications, including prescription medications, over-the-counter medications and herbal or supplemental therapies. This must be completed by a prescribing provider or a clinical pharmacist.

Please indicate in the medical record:

- **Date of medication review with medication list *OR***
- **Notation that the member is not taking any medication and the date when it was noted**

Description	CPT♦	CPT Category II♦	HCPCS♦
Medication Review	90863, 99483, 99605, 99606	1160F	
Medication List		1159F	G8427
Transitional Care Management Services	99495, 99496		

Pain Assessment

Perform an annual comprehensive pain assessment to screen the patient for the presence of pain and to assess pain intensity. Please indicate in the medical record:

- **Documentation that the patient was assessed for pain and the date when it was performed *OR***
- **Results of any assessment using a standardized pain assessment tool**
  - Numeric rating scales, Face, Legs, Activity, Cry Consolability (FLACC) scale, verbal descriptor scales, Pain Thermometer, pictoral pain scales, visual analog scale, Brief Pain Inventory, Chronic Pain Grade, PROMIS Pain Intensity Scale, or Pain Assessment in Advanced Dementia (PAINAD) Scale

Description	CPT Category II♦
Pain Assessment	1125F, 1126F

Contact Information:

Contact your Provider Network Management Representative with any questions

Fax COA Attestation Forms or medical records to: **313-202-0006**

Email us at **MIHEDIS@mhplan.com** for any Healthcare Effectiveness Data and Information Set (HEDIS) questions or secure electronic medical record submissions

♦*Codes listed are specific to the subject matter of this flyer. While Meridian encourages you to use these codes in association with the subject matter of this flyer, Meridian recognizes that the circumstances around the services provided may not always directly support/match the codes. It is crucial that the medical record documentation describes the services rendered in order to support the medical necessity and use of these codes.*

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MONTHLY Provider Update

meridian

JULY 2021 MICHIGAN

Welcome to the Provider Update for July 2021. Have you been enjoying these monthly updates? Visit the Bulletins page to fill out our sign-up form to receive the monthly update directly to your inbox!

COVID-19

COVID-19 Vaccine
Encourage your patients to get the COVID-19 vaccination! The COVID-19 vaccine is an important tool to help stop the spread of the pandemic. Below are a few helpful resources to help your patients find a vaccination site near them.

- Visit the CDC COVID Vaccine Finder at **vaccinefinder.org/search**
- Check the website of the local health department or hospital to find out their process or for registration forms
- Check additional vaccination sites, such as local pharmacies like Meijer, Rite Aid, Walgreens, CVS, Kroger, Walmart (Mid/Central and Northern MI), or Snyder Drugs (U.P. residents)

Take time to listen to your patients concerns, address their questions, and provide them additional resources.

QUALITY

The Emergency Broadband Benefit Program
Telehealth is a convenient way for your patients to stay up-to-date on important appointments. In effort to provide more access to these services, the Emergency Broadband Benefit (EBB) program is a Federal Communications Commission (FCC) program that provides a temporary discount on monthly broadband bills for qualifying low-income households. If your patient's household is eligible, they can receive:

- Up to a $50/month discount on broadband service and associated equipment rentals
- Up to a $75/month discount if your patient's household is on qualifying Tribal lands
- A one-time discount of up to $100 for a laptop, tablet, or desktop computer (with a co-payment of more than $10, but less than $50)

FOR MORE INFORMATION ON THESE UPDATES:

Visit the Bulletins page on **mhplan.com** via the steps below:

- Select your state in the top right corner
- Choose a plan at the bottom of the page then click "Providers"
- Under the "News" tab, click "Bulletins"

Complete the sign-up form on our Bulletins page to receive these updates in your inbox.

Contact your **local Provider Network Management Representative**

Contact Provider Services at **888-773-2647**

To receive the connected device discount, consumers need to enroll in the EBB program with a participating provider that offers connected devices. The service provider will provide the discount to the consumer.

For more information or to find out if your patients are eligible, go to **www.getemergencybroadband.org** or call Lifeline Support Center at **800-234-9473**.

PAYMENT INTEGRITY

Practice Information Updates
In a timely manner, please let Meridian know in if your practice information changes. Updates include provider name, specialty, address, phone, fax, email, hospital affiliations, accepting patient status, accepted lines of business, and office hours. Large organizations, such as Provider Hospital Organizations (PHOs) and Delegated Entities, are required to submit full rosters quarterly. These updates can be communicated through the following options:

- Mail: Meridian, 1 Campus Martius, Ste. 700, Detroit, MI 48226
- Email: **ProviderHelp.MI@mhplan.com**
- Contacting your local Provider Network Development Representative

OPERATIONS

Improving Vaccinations Rates for Pediatric and Adolescents
Michigan Department of Health & Human Services (MDHHS) Immunization Call to Action:
Below are strongly recommended strategies from MDHHS, Division of Immunization:

- Notify and schedule annual physical exams, required MHSAA sports participation visits, and other medical visits for school-aged patients
- Focus efforts to send recall letters using the Michigan Care Improvement Registry (MCIR), and/or EHR messages to patients that are behind on vaccines (instructions are here). Some recommended age groups are:
    - Children (4 - 6 years old)
    - Adolescents (11-13 years old)
    - Older Adolescents (14-18 years old)
- Identify and contact patients that are or will be due for a vaccination

Medicare Prior Authorization List

Effective 8/1/2021

WellCare Health Plans requires prior authorization as a condition of payment for many services. This Notice contains information regarding such prior authorization requirements and is applicable to all Medicare products offered by WellCare.

WellCare is committed to delivering cost-effective quality care to our members. This requires us to ensure our members receive only treatment that is medically necessary according to current standards of practice. Prior authorization is a process initiated by the physician in which we verify the medical necessity of a treatment in advance using independent objective medical criteria and/or in network utilization, where applicable.

It is the ordering/prescribing provider's responsibility to determine which specific codes require prior authorization.

Effective Aug. 1, 2021, prior authorization will be required for the following services:

Please verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered. NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED.

For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on Health Plan website at **Authorization Lookup | WellCare**.

Service Category	Services/Procedures	Comments
Acupuncture	An alternative form of medicine in which thin needles are inserted into the body. Medicare doesn't cover acupuncture (including dry needling) for any condition other than chronic low back pain. Limited to 20 visits	**Prior Auth Required:** • Health Net Medicare Advantage for California • Arizona Complete Health • Oregon Health Net Medicare Advantage • MHS Indiana • Sunflower • Louisiana Healthcare Connections • Superior HealthPlan • Medicare Advantage from MHS Health Wisconsin • Western Sky Community Care • Ascension Complete **Contracted Providers:** Visit ashlink.com **Non-Contracted providers:** Call (800) 972-4226

Quality care is a team effort.
Thank you for playing a starring role!

WellCare®
Beyond Healthcare. A Better You.

Service Category	Services/Procedures	Comments
Ambulance Nonemergent Fixed Wing	Requires prior authorization before transport	
Behavioral Health Services	Day Treatment Electroconvulsive Therapy (ECT) Inpatient Psychiatric Intensive Outpatient Therapy Neuropsychological Testing Partial hospitalization Psychological Testing Substance Use Disorder Treatment/ Rehabilitation	
Bronchial Thermoplasty	Outpatient procedure for the treatment of asthma	
Chiropractor Services	Medicare coverage for chiropractic services extends only to treatment by means of manual manipulation of the spine to correct a subluxation, provided such treatment is reasonable and medically necessary	**Prior Auth Required:** • Health Net Medicare Advantage for California • Arizona Complete Health • Oregon Health Net • Allwell from Louisiana Healthcare Connections **Contracted Providers:** Visit ashlink.com **Non-Contracted providers:** Call (800) 972-4226
Clinical Trials: Notification Only	A clinical trial is one type of clinical research that follows a predefined plan or protocol	
Cochlear Implants & Surgery	Provides direct electrical stimulation to the auditory nerve, bypassing the usual transducer cells that are absent or nonfunctional in deaf cochlea	
Cosmetic Procedures/ Dermatology	Includes any surgical procedure directed at improving appearance, except when required for the prompt (that is, as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member Including, but not limited to: • Chemical exfoliation, electrolysis • Dermabrasion/chemical peel • Laser treatment • Skin injections and implants	

Service Category	Services/Procedures	Comments
Drug Testing	Quantitative tests for drugs of abuse	
Durable Medical Equipment (DME)	Ambulatory Infusion Pumps Bone Growth Stimulator Continuous Glucose Monitor Hospital Bed/Mattress Implantable Neurostimulator Lift Devices including Hoyer Lymphedema Pumps and Supplies Oxygen Concentrators TENS Units Vagus Nerve Stimulator Ventilators Wheelchairs, Custom Wheelchairs, Power Wound Vacuum (Negative Pressure) Devices	
Enhanced External Counterpulsation (EECP)	The noninvasive outpatient treatment for patients with coronary artery disease (CAD)	
Experimental/ Investigational Services	Any item or service potentially considered investigational or experimental must be authorized in advance	
Gender Reassignment	General term to describe a surgery or surgeries that affirm a person's gender identity	
Genetic Counseling and Testing	Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins	
Infertility	Drug Therapy, Testing, Treatment	
Home Health Services	Home Health Aide Occupational Therapy Physical Therapy Skilled Nursing Visits Social Work Visits Speech Therapy	
Hospice: Notification only	Home or Inpatient	

Service Category	Services/Procedures	Comments
Hospital Admission	Acute Inpatient Hospital Inpatient Rehabilitation Hospital Long Term Acute Care Hospital (LTAC) Skilled Nursing Facility (SNF)	
Hyperbaric O2 Therapy	Includes HBO therapy administered in a chamber	
Neuropsychological Testing	Evaluations for members with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning	
Nutritional Supplements and/or services	Formula administered via a enteral feeding tube	
Observation Stay	Prior Authorization required if >48 hours	
Orthotics/ Prosthetics	Prosthetic devices needed to replace a body part or function Limited coverage options for orthotic shoes and devices, including artificial limbs and eyes as well as braces for arms, legs, back, or neck, penile prosthetics	
Outpatient Therapy • Occupational Therapy • Physical Therapy • Speech-Language Therapy	Therapeutic treatment: as a remedial treatment of mental or bodily disorder or an agency (as treatment) designed or serving to bring about rehabilitation or social adjustment	Prior Auth Required after the initial evaluation for Meridian Medicare products. visit **www.radmd.com**
Pain Management	Facet Injections Median Branch Block Radio Frequency Ablation Sacroiliac joint injection (SI) Trigger Point	
Part B Drugs		See attached Appendix A
Radiation Therapy	Intensity modulated radiotherapy (IMRT) Neutron beam therapy Proton beam therapy Stereotactic radiotherapy	

Service Category	Services/Procedures	Comments
Radiology	Cardiac Imaging CT MRA MRI, MRA, PET Scan, CT, Cardiac Imaging PET	All health Plans **Excluding** • Medicare Advantage • from MHS Health Wisconsin • visit www.radmd.com
Sleep Studies	Surgery and treatment Hospital Sleep Study	
Surgeries, regardless of place of service	Abortion Bariatric Surgery Blepharoplasty Breast Augmentation (except following mastectomy) Breast Reduction Capsule Endoscopy Chondrocyte Implants Cochlear Implant Facial Osteotomy Hysterectomy Joint Replacements Mastectomy for Gynecomastia Oral Surgery – Temporomandibular Joint Surgery Otoplasty Reconstructive and Plastic Surgery Rhinoplasty Sacral Nerve Neuromodulation Septoplasty Spinal Surgeries including Fusion, Stabilization, Discectomy Uvulopalatopharyngoplasty/ Uvolopharyngoplasty Veins (ablation, ligation, stripping, sclerotherapy) X-Stop: Spinal Surgery	
Transplants	All transplant evaluations and procedures, including but not limited to evaluation, transplant consult visits, HLA typing, donor search and transplant procedure	

To:	<Provider Name>
From:	MeridianHealth
State:	Michigan
Line of Business:	Medicaid
Date:	June 2021
Re:	Care Coordination/Care Management (CC/CM) Code Incentive Program

Dear Provider,

MeridianHealth (Meridian) is pleased to announce two additional incentives now available to eligible PCMH providers as part of our 2021 Patient-Centered Medical Home (PCMH) provider incentive program.

CC/CM Extra Mile Incentive:
Extra $10 bonus incentive offered to eligible PCMH providers for the first CC/CM code billed per unique member for services completed between 1/1/2021 – 9/30/2021.

CC/CM Champions Incentive:
Extra $500 bonus incentive offered to eligible PCMH providers who reach the maximum number of CC/CM incentivized codes (60 codes per NPI). Services must be completed by 9/30/2021.

The incentive kicker is available for the following billed CC/CM codes:

Code Description	Code
Comprehensive Assessment	G9001
In-Person Encounter	G9002
Care Team Conference	G9007
Provider Coordinated Care Oversight Services	G9008
Telephone CC/CM Services	98966, 98967, 98968
Education/Training for Patient Self-Management	98961, 98962
Care Transition	99495, 99496
End of Life Counseling	S0257

Claims for the CC/CM Extra Mile and CC/CM Champions incentive programs must be submitted to Meridian by 10/31/2021 to be eligible for the bonus.

For more information, contact your local Provider Network Management Representative or the Provider Services department at **888-773-2647**.

We look forward to our continued partnership and working together to provide the best care for our members!

Sincerely,

MeridianHealth

To:	<Provider Name>
From:	MeridianHealth
State:	Michigan
Line of Business:	Medicaid
Date:	June 2021
Re:	Provider Incentive Program

Dear Provider,

MeridianHealth (Meridian) is pleased to announce an additional incentive program in addition to our 2021 Pay for Performance (P4P) Provider Incentive Program and Quality Bonus Program (QBP).

The incentive kicker is a targeted initiative and available for:

- Lead Screening in Children (LSC)
- Childhood Immunizations Status – Combination 3 (CIS Combo 3)
- Immunizations for Adolescents – Combination 1 (IMA Combo 1)
- Comprehensive Diabetes Care Eye Exam (CDC Eye Exam)

Providers will receive an additional $50 per member per measure in addition to incentives paid through our P4P and QBP programs. The incentive will be paid for services provided to **select members** who live in targeted counties from 6/1/2021 – 6/30/2021. The targeted member counties include Wayne, Oakland, Kent, Macomb, Genesee, Berrien, Kalamazoo, Saginaw, Muskegon, Calhoun, Ingham, Jackson, Washtenaw and Van Buren.

A list of members eligible for this program is included and based on assigned membership as of May 2021. If a date is noted on the member list that indicates the member is due to complete the corresponding measure by the date listed. Following regular Healthcare Effectiveness Data and Information Set (HEDIS®) guidelines for the CDC Eye Exam measure, members can complete the screening before the end of the year, but for the purposes of this program the services need to be completed by the date listed. **The member/measure combinations that appear on this list are the only member/measure combinations eligible for this additional incentive.**

In addition, incentive amounts for select measures in the 2021 P4P Provider Incentive Program have increased, and now range from $5 – $50 for services such as immunizations, well-child visits, prenatal and postpartum care, management of chronic conditions, and more. Details on eligible services and the updated incentive payment structure for 2021 will be available in the form of a flyer on the Meridian website.

Program Information:

All procedures must be completed within strict HEDIS® and Michigan Department of Health and Human Services (MDHHS) guidelines. For a complete list of eligible services and covered CPT codes for these measures, or to view the drug formulary for a list of covered drugs, visit **mhplan.com**.

Incentive is paid upon completion of all qualifying services in compliance with HEDIS® measurement year 2021 guidelines. **Claims must be submitted to Meridian by 9/30/2021.** For more information, contact your local Provider Network Management Representative or the Provider Services department at **888-773-2647**.

We look forward to our continued partnership and working together to provide the best care for our members!

Sincerely,

MeridianHealth

Your assigned Medicaid members who could be incentivized are:

First Name	Last Name	Date of Birth	CIS Combo 3	LSC	IMA Combo 1	CDC Eye Exam
<Member First Name>	<Member Last Name>	<DOB>	< DATE>	< DATE>	< DATE>	< DATE>

Meridian's COVID-19 Vaccine Support Grant

Application Form

Please complete the enclosed application for grant consideration. Follow the application carefully. Incomplete or inaccurate forms are not accepted.

Organization Name *

Please include requesting organization's legal name.

Organization Type *

Medical Clinic/Institution, Education Institution, Community Development, Other

Contact (First Name) *	Contact (Last Name) *
Contact Phone Number *	**Organization Phone Number ***
(###) ###-####	(###) ###-####
Contact's Email Address *	**Organization's Website Address**
[contact]@[website].[org or com]	http://www.[address].[org or com]

Organization's Mission *

Organization's Physical Address *
Street Address

Apt, Suite, Bldg. (optional)

City	State/Province/Region
Postal/ZIP Code	**Country**

Amount Requested *

Please use numbers only (For example: 1500 NOT 1500.00 or 1,500)

Grant Funding Focus (Check all that apply) *	Target Audience (Check all that apply) *
☐ Mobile Vaccination Unit *(vehicle and/or insurance costs)*	☐ Low-income Families
☐ Building Alterations *(for purposes of enhancing vaccine security)*	☐ Children/Youth
☐ Supplies or Equipment *(associated with the ability to administer vaccine)*	☐ Seniors, Adults or Children with Disabilities
☐ Operational Costs *(including staffing allocation or salaries)*	☐ Moms or Moms-to-be
☐ Promotion of Vaccine Confidence and/or Administration	☐ Seniors
☐ Other	☐ Homeless
	☐ Homebound
	☐ Other
If other, please describe	**If other, please describe**

Objective and Impact of Grant *

Please provide 1-3 sentences to describe any specific objective(s) and the anticipated impact of to your organization and/or to the community

Please submit completed applications to communications@mhplan.com

Meridian's COVID-19 Vaccine Support Grant Program

Learn

In response to the COVID-19 vaccine administrative efforts and in alignment with the state of Michigan's vaccination-based milestones, Meridian is fully committed to ensuring accessibility and safety. Through our COVID-19 Vaccine Support Grant Program, healthcare providers, community-based organizations and other types of entities have the opportunity to receive direct funding for purposes of vaccine administration and/or promotion. Examples of the focus of the grant funding could include mobile vaccination units, necessary building alterations, supplies or equipment or other operational costs.

Apply

To qualify for this COVID-19 Vaccine Support Grant, applicants must invest in increasing the state-wide COVID-19 vaccination rate. Please complete the grant application form and email it to communications@mhplan.com. Grant applications will only be accepted from August 4, 2021 to August 13, 2021 by 5:00 p.m. Applicants must answer all of the required questions on the form in order to be considered.

Awards

Grants will be awarded in amounts between $500 and $5,000. Awardees will be notified both by phone and in writing if they have been selected to receive a grant. Grant funds will be distributed once the required paperwork has been received by Meridian. No reporting or administrative follow-up is required after receipt of an award.

Frequently Asked Questions

- Whom can I contact if I have questions or need more information about the COVID-10 Vaccine Support Grant or Meridian?
  - To learn more, please email our communications department at communications@mhplan.com.
- What are the requirements to apply for this grant?
  - Organizations must be based in Michigan and be a contracted provider.
- How long does the grant process take?
  - The period for grant applications is from August 4, 2021 to August 13, 2021. Awardees will be notified within days after the application process is closed.

To:	<Provider Name>
From:	MeridianHealth
State:	Michigan
Line of Business:	Medicaid
Date:	June 2021
Re:	Provider Incentive Program

Dear Provider,

MeridianHealth (Meridian) is pleased to announce an additional incentive program in addition to our 2021 Pay for Performance (P4P) Provider Incentive Program and Quality Bonus Program (QBP).

The incentive kicker is a targeted initiative and available for:

- Lead Screening in Children (LSC)
- Childhood Immunizations Status – Combination 3 (CIS Combo 3)
- Immunizations for Adolescents – Combination 1 (IMA Combo 1)
- Comprehensive Diabetes Care Eye Exam (CDC Eye Exam)

Providers will receive an additional $50 per member per measure in addition to incentives paid through our P4P and QBP programs. The incentive will be paid for services provided to **select members** who live in targeted counties from 6/1/2021 – 6/30/2021. The targeted member counties include Wayne, Oakland, Kent, Macomb, Genesee, Berrien, Kalamazoo, Saginaw, Muskegon, Calhoun, Ingham, Jackson, Washtenaw and Van Buren.

A list of members eligible for this program is included and based on assigned membership as of May 2021. If a date is noted on the member list that indicates the member is due to complete the corresponding measure by the date listed. Following regular Healthcare Effectiveness Data and Information Set (HEDIS®) guidelines for the CDC Eye Exam measure, members can complete the screening before the end of the year, but for the purposes of this program the services need to be completed by the date listed. **The member/measure combinations that appear on this list are the only member/measure combinations eligible for this additional incentive.**

In addition, incentive amounts for select measures in the 2021 P4P Provider Incentive Program have increased, and now range from $5 – $50 for services such as immunizations, well-child visits, prenatal and postpartum care, management of chronic conditions, and more. Details on eligible services and the updated incentive payment structure for 2021 will be available in the form of a flyer on the Meridian website.

Program Information:

All procedures must be completed within strict HEDIS® and Michigan Department of Health and Human Services (MDHHS) guidelines. For a complete list of eligible services and covered CPT codes for these measures, or to view the drug formulary for a list of covered drugs, visit **mhplan.com**.

Incentive is paid upon completion of all qualifying services in compliance with HEDIS® measurement year 2021 guidelines. **Claims must be submitted to Meridian by 9/30/2021.** For more information, contact your local Provider Network Management Representative or the Provider Services department at **888-773-2647**.

We look forward to our continued partnership and working together to provide the best care for our members!

Sincerely,

MeridianHealth

Your assigned Medicaid members who could be incentivized are:

First Name	Last Name	Date of Birth	CIS Combo 3	LSC	IMA Combo 1	CDC Eye Exam
<Member First Name>	<Member Last Name>	<DOB>	< DATE>	< DATE>	< DATE>	< DATE>