Blue Cross complete of Michigan

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Winter months can cause an increase in prior authorization requests

During the colder months, medical practices often see an increase in the number of prior authorization requests for antibiotics, cold, flu and RSV medications. This rise in authorization requests is typically due to changes in prescription coverage, updates to drug lists and renewal criteria.

You can help ensure your patients receive the medicine they need promptly by taking advantage of the NaviNet platform, which is cost-free for healthcare providers and staff. Through NaviNet, healthcare providers can access and electronically submit:

- Prior authorizations
- Real-time clinical Healthcare Effectiveness Data and Information Set alerts
- Claims information and updates
- Member eligibility information
- Benefit information
- Drug authorizations

Healthcare providers can register for a NaviNet account at register.navinet.net/.*If you have any questions, contact your Blue Cross Complete provider account executive, or call Blue Cross Complete's Provider Inquiry at **1-888-312-5713**.

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Condition Optimization Program: Partnering with providers to improve member care

Blue Cross Complete recognizes the important role primary care physicians play in helping members manage chronic and complex health conditions. The Condition Optimization Program, or COP, provides an additional opportunity for providers to support these members while maintaining complete and accurate member health information.

The COP identifies members whose claims and encounter history suggest chronic or complex health conditions that may benefit from provider review and validation. Under its contract with the Michigan Department of Health and Human Services, Blue Cross Complete is responsible for collecting and submitting complete and accurate encounter data for all services furnished to its members.

Purpose of the COP

The COP provides incentive opportunities for completing eligible administrative activities that support accurate encounter data and member engagement. The COP helps identify members whose chronic conditions may require review or validation based on available claims and encounter data. By reviewing and completing eligible COP activities, providers may have the opportunity to earn available program incentives while supporting more accurate clinical documentation and condition reporting.

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How to participate?

- Review pending COP activities in NaviNet
- Schedule routine visits as clinically appropriate
- Assess and document all conditions evaluated during the encounter
- Submit complete encounter and claims data
- Complete eligible COP activities



Check your available opportunities

Many practices have active COP opportunities waiting for review. Your Blue Cross Complete account executive can help you:

- Understand your available COP opportunities.
- Review estimated incentive potential.
- Access provider-specific reports.
- Navigate the COP functionality within NaviNet.

Providers are informed about COP members through pending activities in the Patient Roster Report under the Practice Documents workflow in NaviNet. A pending activity appears for a COP member when one of the following occurs:

- No claims were submitted by the primary care provider for that member within the previous six months.
- Claims were submitted by the primary care provider within the previous six months, but the claims didn't include all the chronic/comorbid diagnosis codes found in the member's claims history.

Need Assistance?

If you are not currently using NaviNet regularly, or would like a refresher on the COP workflow, our team is available to provide:

- Quick NaviNet demonstrations
- COP program education
- Provider-specific reporting support
- Guidance on identifying and completing opportunities

Blue Cross Complete encourages providers to check their Practice Documents regularly through NaviNet to identify members who require action. Incorporating this review into existing administrative or care management workflows can help practices stay current on member information and identify patients who may need additional outreach or follow-up care.

When reviewing COP activities, providers should continue to follow appropriate clinical documentation and coding guidelines. **The Condition Optimization Program User Guide** provides detailed instructions for accessing and completing COP activities in NaviNet. If you have any questions, contact your Blue Cross Complete provider account executive, or call Blue Cross Complete's Provider Inquiry at **1-888-312-5713**.

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HEDIS Corner

2027 maternity bundled global CPT code changes

The American Medical Association and the American College of Obstetricians and Gynecologists have collaborated to restructure CPT coding for maternity care. New obstetric codes will now replace the bundled global obstetric payment for maternity care services. This will move from the traditional global billing model to a more granular structure that separately reports antepartum care, labor management, delivery and postpartum services. The changes are intended to better reflect modern team-based obstetric care in the United States.

- **Deletion of global codes:** Effective Jan. 1, 2027, global obstetric/maternity codes (such as 59400, 59510 and 59610) are permanently deleted and will no longer be billable.
- **Granular, visit-level reporting:** Providers must now bill for maternity care through an itemized, visit-level structure.
- **Four phases of care:** Care must be billed separately for antepartum care, labor management, delivery, and postpartum services

To ensure that key stakeholders, including physicians, payers, medical coders and electronic health record vendors have sufficient time to prepare, the AMA is building awareness and offering education about the revisions.

Sources

https://providernews.anthem.com/new-york/articles/2027-maternity-care-coding-restructuring-allows-for-more-det-30315

https://www.acog.org/practice-management/coding/coding-library/payment-for-obstetric-services

https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes

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Social determinants of health and low birth weight

Low birth weight remains a significant maternal and infant health concern in Michigan, with potential consequences that can extend well beyond the newborn period.

Babies born weighing less than five pounds, eight ounces may face increased risk for health complications, developmental challenges and other adverse outcomes. Healthcare providers play a critical role in identifying risk factors early, connecting pregnant patients with appropriate prenatal care and resources, and promoting interventions that support healthy pregnancies. By working together to address the clinical and social factors that contribute to low birth weight, providers can help improve birth outcomes.

LBW affects one in 12 infants in the United States and is widely recognized as a public health concern.[1] Common medical concerns associated with LBW include the need for specialized intensive care due to conditions, such as respiratory distress syndrome, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis, retinopathy of prematurity, jaundice and infections. These babies may also face other health conditions later in life, which may include diabetes, heart disease, high blood pressure, intellectual and developmental disabilities, metabolic syndrome or obesity.

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While the clinical complications of LBW are well understood, what is often less recognized is the critical role that social determinants of health, or SDOH, play in driving these outcomes. Providers are uniquely positioned to identify and address these factors during pregnancy.

SDOH, as defined by the World Health Organization, comprises the circumstances in which individuals "are born, grow, live, work, and age."[2] Pregnant individuals are especially vulnerable to adverse outcomes related to unmet basic needs within these domains. When basic social, economic, and environmental needs remain unfulfilled, the likelihood of LBW increases the following:[3]

- **Reduced access to basic needs:** Lack of stable housing, nutritious food, safe water and reliable transportation impacts maternal health and prenatal care.
- **Stress and mental health:** Maternal stress, domestic violence, language barriers and limited social support increase biological and behavioral risks.
- **Environmental exposures:** Pollution, unsafe neighborhoods and poor working conditions contribute to adverse birth outcomes.
- **Structural inequities:** Limited access to high-quality, culturally responsive care prolongs disparities, especially among minority and underserved populations.

Providers intervention can support patients

Clinical interventions alone cannot address the multifactorial origins of low birth weight. However, through comprehensive prenatal care, providers can play a pivotal role in mitigating the impact of SDOH on birth weight. Here are a few ways providers can offer their support.[3]

- **Screening:** Systematically incorporate SDOH screening into prenatal visits to identify needs related to housing, nutrition, transportation and mental health at an early stage.
- **Connection:** Establish partnerships with community organizations to link patients to resources (e.g., food assistance, housing support, transportation services, counseling).
- **Education:** Offer targeted education on nutrition, stress management and health literacy to empower patients through pregnancy.
- **Advocacy:** Champion policy and program changes that expand access to maternal health services, reduce inequities and improve long-term outcomes.

Benefits of addressing SDOH

Delivering culturally competent care, including language access, respectful communication and awareness of systemic barriers empower pregnant individuals to be more open about their actual needs and stay on top of getting the care they need throughout their pregnancy. Building trust encourages pregnant individuals to be proactive with their conversations about risks and supports better care coordination.

Low birth weight is not only a clinical complexity, but it also has roots in the social, economic and environmental conditions that are affecting pregnant individuals. Through collaboration and integrating SDOH into clinical care, healthcare providers and community partners can help reduce disparities in birth outcomes, improve maternal health and infant survival, and strengthen families and communities in the long term.

References
1. "Low Birthweight," March of Dimes, June 2021, **https://www.marchofdimes.org/find-support/topics/birth/low-birthweight**, accessed February 13, 2026.

2. "Social determinants of health," World Health Organization, **https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1**, accessed February 13, 2026.

3. Guillermina Girardi, et al., "Social determinants of health in pregnant individuals from underrepresented, understudied, and underreported populations in the United States," Int J Equity Health, Vol. 22, No. 186, September 6, 2023, **https://doi.org/10.1186/s12939-023-01963-x**, accessed February 13, 2026.

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New asthma measure emphasizes timely follow-up care



The National Committee for Quality Assurance, or NCQA, introduced *Follow-Up after Acute and Urgent Care Visits for Asthma*, or AAF-E, as a new reported measure, effective for HEDIS Measurement Year 2026.

According to the NCQA, AAF-E helps bridge the gap between acute treatment and ongoing asthma management. By ensuring patients five to 64 years of age receive timely follow-up. After an asthma-related urgent care, emergency department or hospital visit, providers have an opportunity to reassess asthma control, review medications, identify triggers and reinforce the patient's asthma management plan. This continued care can help patients better manage their condition and reduce the risk for future asthma exacerbations and acute care.

Acute and urgent care visits for asthma may indicate that a patient's asthma is not adequately controlled.

NCQA research involving Medicaid and commercial insured populations found that fewer than half of patients with asthma received timely follow-up after an emergency department visit, with differences in follow-up rates across demographic and socioeconomic groups. This research helped inform the development of AAF-E.

According to the NCQA, the intent of the new measure is to encourage coordination of appropriate follow-up care for patients experiencing asthma exacerbations.

How providers can help

Following an asthma-related acute or urgent care encounter, providers are encouraged to:

- Schedule and complete an outpatient follow-up visit within 30 days
- Assess the patient's current asthma symptoms and level of control
- Review asthma medication and reinforce proper medication use
- Discuss potential asthma triggers and barriers to managing the condition
- Reinforce the patient's asthma management plan and when to seek additional care
- Coordinate care following emergency room, urgent care, observation or inpatient services

Timely follow-up is an important opportunity to help patients better manage their asthma and potentially reduce future acute care needs. Blue Cross Complete encourages providers to incorporate AAF-E into their care coordination and outreach processes.

Source:
National Committee for Quality Assurance

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Effective strategies providers can use to help patients better manage blood pressure

High blood pressure affects nearly 50% of the U.S. adult population, according to the Centers for Disease Control and Prevention. This condition, also known as the "silent killer," increases risk of heart disease and stroke. Disparities in high blood pressure control in non-Hispanic, Black patients require a targeted approach, as this racial group displays the greatest prevalence of high blood pressure.[1]

The following best practices have been identified by multiple research studies and are recommended by the American Heart Association, Million Hearts and the CDC for providers who are working to help Black patients control high blood pressure. This article highlights health literacy, shared decision-making and resources to help teach patients how to measure their blood pressure at home.

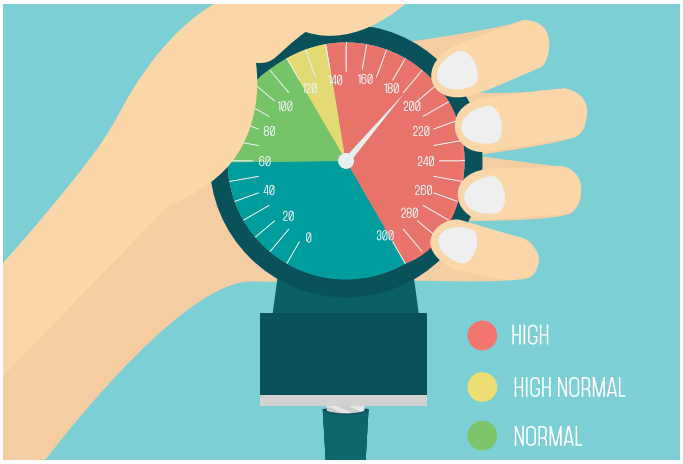
Below are tips for improving health literacy and medical outcomes among patients with hypertension.[2]

Use plain language, visual aids and technology, and incorporate effective teaching methods, such as the teach-back and show-back methods.[3] Also:

- Be aware of language differences, the patient's culture and other considerations.
- Don't use medical jargon or talk too fast.
- Encourage patients to get involved with their care and ask questions.
- Educate patients about taking medications correctly, review the medications they're prescribed.
- Develop action plans to change patients' behavior and discuss healthcare priorities.
- Teach patients about self-management activities, such as checking their blood pressure at home, exercise activity and eating a healthy diet.[4]

Shared decision-making

Providers who use a shared-decision making, or SDM, model can have a positive effect on adherence to hypertension treatment plans, including medication adherence, in Black and African American patients.[5]



Benefits of SDM

- Decreases anxiety associated with medication side effects, constant tracking of blood pressure and cost of medications
- Improves health equity by allowing patients to engage in their healthcare

Teaching patients how to measure their blood pressure at home

- Self-measured blood pressure, or **SMBP, training video** to help train care teams and patients on how to properly self-measure blood pressure.
- **Patient training checklist:** Use this as a guide when training patients during an in-person encounter. Training may be done by many members of the care team, and steps can occur in different sequences. This checklist can serve as a template and help ensure the necessary steps and components are covered.
- **7-step SMBP quick guide** (helps patients achieve and maintain blood pressure goals)
- **Self-measured blood pressure cuff selection**
- **Device calibration test** can be used the process below to calibrate a patient's SMBP device whenever self-measurement results appear to have an unreasonable discrepency compared to in-office results

By fostering trust, enhancing patient education and consistently using standardized treatment guidelines, providers can play a critical role in improving health outcomes among patient population.

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Members have access to continuous glucose monitors and diabetes testing supplies

Blue Cross Complete is committed to supporting members with diabetes by providing access to essential supplies that promote effective disease management.

Healthcare providers are reminded that Blue Cross Complete provides coverage for blood pressure monitors, continuous glucose monitors and certain blood pressure monitoring supplies for eligible members, as part of our commitment to support chronic disease management. Coverage is subject to medical necessity criteria and prior authorization requirements, where applicable. Providers are encouraged to review the coverage criteria to ensure that documentation supports the member's clinical need.

CGMs offer real-time glucose monitoring, helping patients track their blood sugar trends and respond prompting to fluctuations. These devices, with traditional blood pressure monitors and testing strips, play a vital role in managing both Type 1 and Type 2 diabetes.

For information on covered supplies and prior authorization, please refer to **the Blue Cross Complete Provider Manual**. As a reminder, when you do need to verify whether a service requires prior authorization, use the **Prior Authorization Lookup Tool** at **mibluecrosscomplete.com**. As a reminder, the results of this tool aren't a guarantee of coverage or authorization.

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Routine screenings can support better health

Routine health screenings are an important part of preventive care and can help identify health concerns before symptoms develop or conditions become more difficult to manage.



Healthcare providers play a critical role in encouraging patients to stay up to date on recommended screenings based on their age, health history and individual risk factors. Screenings for conditions, such as high blood pressure, diabetes, certain cancers, sexually transmitted infections and other health concerns, can support early diagnosis and timely treatment.

Routine screenings also provide an opportunity to identify risk factors and connect patients with appropriate treatment, education and support. Depending on the patient, preventive care may include screenings for breast, cervical and other cancers, behavioral health screenings, and testing for HIV and other STIs. Providers should follow current clinical recommendations and consider each patient's individual health needs when determining appropriate screenings.

According to the Michigan Department of Health and Human Services, providers can help improve screening rates by making preventive care part of the conversation at every appropriate patient encounter. Review care gaps, remind patients when screenings are due and explain why recommended test are important – even when patients feel healthy.

Encouraging routine screenings can help support healthier patients and communities across Michigan. Early identification of health concerns can allow patients and their providers to begin treatment sooner, better manage chronic conditions, and take steps to reduce future health risks. By consistently promoting preventive care and following up on overdue screenings, providers can help patients take a more active role in protecting their health and achieving better health outcomes.

As a reminder, Blue Cross Complete members may arrange for transportation for medical and non-emergency medical transportation for any Medicaid-covered service. These services can include routine doctor visits and trips to specialty behavioral health services, including substance use disorder, necessary medical exams and treatment, prescriptions and durable medical equipment pickups and dental appointments.

Providers are encouraged to use NaviNet* to determine which Blue Cross Complete members are due for routine screenings and conduct outreach to schedule any appointments for services they may need. We appreciate the care and access you provide to our members. If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

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Providers encouraged to attend NaviNet training in December

Blue Cross Complete is offering NaviNet training by video conference on Thursday, Dec. 3, 2026, from 10 a.m. to 12 p.m. If you're an office manager, biller or registration staff, join us for a discussion on NaviNet functionalities, such as:

- How to access NaviNet
- Understanding the benefits of the provider portal
- Accessing NaviNet's important features
- New NaviNet features available to providers

To register, send your name, provider organization, number of attendees and email address to Blue Cross Complete's Provider Communications department at **providercomm@mibluecrosscomplete.com.** If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

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Help make HIV/STI testing a routine part of care

Knowing a patient's HIV status is an important first step in HIV prevention, treatment and reducing transmission. Because HIV can be present without noticeable symptoms, routine testing provides an opportunity to identify HIV earlier, connect patients to treatment and help those who test negative access prevention services.

The Michigan Department of Health and Human Service("MDHHS") has made increasing HIV and sexually transmitted infection testing a key component of Ending HIV Together: Michigan's Equitable Plan. Blue Cross Complete encourages healthcare providers to make HIV screening a routine part of patient care and to talk openly with patients about HIV and STI prevention.

Make HIV testing routine

HIV testing should not be limited to patients who providers perceive to be at increased risk. Normalizing testing as part of routine healthcare can help reduce stigma and identify people who may not know they have HIV.

The **Centers for Disease Control and Prevention** recommend that all patients ages 13 to 64 receive an HIV test at least once as part of routine healthcare, regardless of perceived risk. Patients with ongoing risk factors should be screened at least annually, and some patients may benefit from more frequent testing.

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The CDC also recommends an opt-out approach to routine HIV screening. With opt-out screening, patients are informed that HIV testing will be performed unless they decline. Incorporating HIV screening into routine care in this way can help normalize testing and create more opportunities for early diagnosis, according to the CDC.

Testing is more than a diagnosis tool. Providers can use the conversation to discuss sexual health, STI screening and HIV prevention strategies, including preexposure prophylaxis, or PrEP, and post-exposure prophylaxis, or PEP. Integrating HIV/STI screening into routine care can help providers identify infections sooner and connect patients with prevention, treatment and other supportive resources.

For patients who receive an HIV diagnosis, prompt, linkable-to-HIV treatment is essential. Starting and remaining on effective HIV treatment plan helps reduce the amount of HIV in the blood, known as the viral load, and allows people with HIV to live longer, healthier lives. Providers can help newly diagnosed patients by reinforcing the importance of entering care promptly, taking antiretroviral therapy as prescribed, and completing recommended viral loan monitoring.

Viral load suppression is HIV prevention

Achieving and maintaining viral suppression is one of the primary goals of HIV treatment. Viral suppression protects the health of people with HIV and plays a critical role in preventing new HIV infections.

When a person takes HIV medication as prescribed and achieves and maintains an undetectable viral load, they have zero risk of sexually transmitting HIV to their partners. This is known as **Undetectable=Untransmittable, or U=U**. Providers can reinforce the U=U message with patients while continuing to emphasize medication adherence, regular medical care and viral-load monitoring. Communicating U=U can also help reduce HIV-related stigma and give patients a better understanding of the benefits of successful treatment.

Providers are essential to ending HIV

Routine testing, early diagnosis and sustained viral suppression are interconnected. Every patient encounter provides an opportunity to normalize HIV testing and make sexual health part of routine healthcare.

Blue Cross Complete encourages providers to:

- Incorporate routine HIV/STI screening into clinical workflows
- Avoid relying solely on perceived risk when determining who should be offered testing
- Screen patients with ongoing HIV risk factors at least annually
- Discuss PrEP and other prevention options with patients who test negative and may benefit
- Promptly connect patients with a positive HIV test to appropriate HIV care and treatment
- Encourage medication adherence and regular viral loan monitoring for patients with HIV
- Screen for other STIs according to recommended clinical guidelines

By making HIV testing routine and helping patients remain connected to prevention or treatment services, providers can play an important role in reducing new HIV infections and improving health outcomes for members.

Sources:
Michigan Department of Health and Human Services
HIV & STI in Michigan

Centers for Disease Control and Prevention HIV testing guidance for healthcare providers

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Improving quality, care and member experience

Blue Cross Complete is committed to providing access to high-quality healthcare in Michigan and has a 3.5 star rating from the National Committee for Quality Assurance, or NCQA. We also received the highest ranking possible, a score of 5 apples, in the Michigan Department of Health and Human Services 2026 Consumer Guide for the Taking Care of Women and Keeping Kids Healthy categories.

NCQA rates health plans on the results of care people receive and what patients say about their care. These results are obtained through the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We have maintained our accreditation with NCQA, which means we have well-established programs for service and clinical quality. These programs meet or exceed requirements for consumer protection and quality improvement.

Blue Cross Complete has held the Multicultural Health Care Distinction from NCQA since 2017 and was granted NCQA's new Health Equity Accreditation in 2024. This accreditation is awarded to organizations that engage in efforts to improve healthcare for all by making culturally and linguistically appropriate services available to members and reducing healthcare disparities.

Blue Cross Complete has an active community outreach program. To engage more with members, we supported more than 1,404 community events across Michigan in 2025. Community health navigators worked with members to screen for social determinants of health needs and schedule appointments with primary care providers, specialists and dentists to make sure their health needs were addressed.

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Members are also asked if Blue Cross Complete can assist with a variety of other concerns, including childcare and clothing. We ask if we can help with hygiene supplies or household items, such as furniture and appliances. Sometimes members need assistance with access to food, housing, utilities, transportation, education and literacy resources. We saw members with needs that included access to a phone and basic medical supplies. Blue Cross Complete was also able to provide resources to members to cope with personal and household safety concerns and address social needs to help reduce isolation and loneliness. Since the Public Health Emergency Unwind, and continuing through upcoming work requirements, community health navigators continue to assist our members and members of our community complete needed paperwork for Medicaid redetermination. These efforts were at community locations, as well as weekly sessions at our Detroit Community Wellness Center at the Durfee Innovation Society.

Each year, we also send the CAHPS survey to a random group of members asking them to rate their experience with Blue Cross Complete and their healthcare for the previous year.

For services provided in 2025, these CAHPS categories received the highest scores from our members:

- How Well Doctors Communicate
- Customer Service
- Getting Care Quickly

Members lowered their ratings for:

- Rating of healthcare
- Rating of specialist
- Discussing smoking and tobacco use cessation medications

This represents an opportunity for doctors and specialists in our network to improve member ratings by assisting members with getting the best healthcare possible and getting an appointment as soon as it is needed for check-ups or routine care, and when



members need care right away. Providers can also improve their scores by advising smoking and tobacco users to quit and discussing tobacco cessation medications and strategies. Tobacco cessation strategy and medication discussions represent a continuing opportunity to improve overall health outcomes for members.

Annually, Blue Cross Complete evaluates its Quality Management Program, including improvement initiatives, access and availability of services, and clinical care activities including, but not limited to, program components, such as HEDIS and CAHPS results, clinical guidelines. health equity, community outreach activities and population health programs. This evaluation includes opportunities and recommendations for the coming year to guide quality improvement. HEDIS and CAHPS survey results are available to providers by calling Blue Cross Complete at **1-888-312-5713** from 8 a.m. to 5 p.m. Monday through Friday. We can also mail this information to providers who do not have fax, email or internet access.

Note: *Since the publication of "Quality Improvement Programs Gives Members Better Care" in the September/October 2026 issue of Connections, information related to the program has been updated. This article reflects the most current information available.*

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Creating a better healthcare experience: CAHPS best practices

The Consumer Assessment of Healthcare Provider and Systems, or CAHPS, survey provides valuable insight into member's experience with their healthcare provider and health plan.

For Blue Cross Complete providers, every interaction with a member is an opportunity to improve the patient experience, strengthen communication and help members feel supported in managing their health. Incorporating CAPHS best practices into everyday workflows can help create a more positive healthcare experience while supporting better health outcomes.

Here are a few best practices providers can use to improve CAPHS ratings:

- **Make access to care a priority.** Timely access to care is an important part of the member experience. Practices should make every effort to offer appointments within appropriate timeframes and provide clear instructions about what patients should do when they need emergency care or assistance outside normal office hours. When scheduling delays occur, staff can discuss available options.
- **Communication clearly and listen to patients.** Effective communication can build trust and help patients become active participants in their care.

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- **Coordinate care and follow-up.** Patients may receive care from multiple providers. Help make the experience easier by coordinating referrals, reviewing available information from other providers and discussing relevant test results or specialist recommendations.
- **Discuss medications.** Medication conversations are another important part of patient-centered care. Review medications with patients. Explain why medications are prescribed and encourage patients to ask questions about side effects or difficulty taking medications as directed.
- **Encourage routine care.** Use patient encounters as opportunities to review preventive care needs and identify potential care gaps.

The patient experience begins before a member enters the examination room. Front office staff, clinical teams and providers all contribute to how patients perceive their care. Courteous communication, respect for privacy, reasonable wait times and clear explanations about appointments, referrals and next steps can make a meaningful difference.

CAPHS is more than a survey. It can serve as a tool for identifying opportunities to strengthen the care experience. By focusing on access, communication, care coordination, preventative services and respectful interactions, Blue Cross Complete providers can help members feel heard, informed and confident in their care.

As a reminder, CAHPS survey results are available to providers by calling Blue Cross Complete at **1-888-312-5713** from 8 a.m. to 5 p.m. Monday through Friday.

Source:
Centers for Medicare & Medicaid Services and Agency for Healthcare Research and Quality



What is CAHPS

The survey measures member's experience with their healthcare providers and health plan. The standardized survey asks members about important aspects of their care, including how easily they can get needed care, how quickly they receive care and appointments, how well their doctor communicates and their experiences with health plan customer services.

CAHPs results help health plans and providers identify opportunities to improve the member experience. Providers can make a difference by ensuring timely access to care, listening carefully to patients, explaining information clearly, addressing questions and concerns, and helping patients understanding their next steps.

Every patient appointment is an opportunity to create a positive healthcare experience.

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Blue Cross Complete will transition its pharmacy benefit management services to Optum Rx

Effective Jan. 1, 2027, Blue Cross Complete will transition its pharmacy benefit management services to Optum Rx. Blue Cross Complete will conclude pharmacy benefit management operations with PerformRx on Dec. 31, 2026.

Optum Rx will manage claims processing, rebates, mail order, and network contracting. AmeriHealth Caritas' Pharmacy Department will manage the drug list, clinical programs, prior authorizations, and member services.

- The change to Optum Rx will not affect the covered drug list.
  - The online drug list is periodically updated. Consult the list regularly to find the most current covered drugs as well as those drugs that require prior authorization.
  - The online drug list for Blue Cross Complete can be found at mibluecrosscomplete.com/providers/resources/pharmacy-resources/.

The telephone number or process for requesting prior authorizations will remain the same during this transition.

  - Prior authorizations will be processed internally at AmeriHealth Caritas.
  - The telephone number for questions about prior authorizations is **1-888-989-0057**.
  - The process and prior authorization forms for submitting a prior authorization request can be found at mibluecrosscomplete.com.

- We are working to ensure all pharmacies available in our current network will remain available after our transition to Optum Rx. The change to Optum Rx may affect some of the contracted pharmacy network available to our members. Members will be made aware if their pharmacy is affected.
- If a pharmacy that is not already part of the Optum Rx network chooses not to join, we will assist your patient in locating a new pharmacy within the Optum Rx network.



  - The contracted pharmacies for Blue Cross Complete can be found at mibluecrosscomplete.com.

- The Pharmacy Provider Services telephone number will not change. The number is **1-888-989-0057**. Providers can call this number to ask about prior authorizations and other questions that they may have about pharmacy benefits and services.
- The Pharmacy Member Services telephone number will not change. The number is **1-888-288-3231**. Members can call this number to ask about prior authorizations and other questions that they may have about pharmacy benefits and services.

If you have any questions, contact your Blue Cross Complete provider account executive or Blue Cross Complete's Provider Inquiry departmen at **1-888-312-5713**.

*Our website is mibluecrosscomplete.com. While website addresses for other organizations are provided for reference, Blue Cross Complete does not control these sites and is not responsible for their content.



Working together: Blue Cross Complete's care coordination roles and responsibilities

Strong care coordination depends on clear communication and shared understanding between our organization and our provider partners. To support collaborative care management and reduce duplication, gaps in care and member confusion, we maintain a standardized process for defining and communicating care coordination roles and responsibilities.

What this means for providers

As a valued partner, providers play a key role in coordinated care delivery. Under this approach, providers are expected to:

- Deliver services within their scope of licensure and contractual requirements.
- Participate in care coordination activities as outlined in partner communications.
- Communicate changes in member status, service delivery issues or coordination needs in a timely manner.

Our role as your collaborator

Blue Cross Complete is responsible for establishing care coordination policies and procedures, defining internal roles related to care planning and oversight, and ensuring expectations are clearly communicated through formal partner materials, such as contracts, agreements or provider communication materials.

Shared commitment to members

Care coordination is a shared responsibility. Together, Blue Cross Complete and the provider community work to ensure continuity of care, reduce service duplication and support the timely exchange of information in accordance with applicable laws and agreements. This collaborative approach helps ensure members receive seamless, well coordinated care.

Ongoing communication

Roles and responsibilities between Blue Cross Complete and providers are reviewed periodically and updated as care coordination practices or partner relationships evolve. Providers will continue to receive formal communications when updates occur to ensure clarity and alignment.

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Promoting health equity, cultural competency

We're committed to promoting effective, equitable, understandable and respectful quality services that are responsive to our members' and participants' diverse cultural health beliefs, practices, preferred languages, health literacy and other communication needs. Our plans use the National CLAS Standards and the National Committee for Quality Assurance health equity standards as a blueprint to advance health equity, improve quality and help eliminate healthcare disparities.

We foster cultural awareness both in our staff and in our provider communities by encouraging everyone to report race, ethnicity and language data to help ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. The race and ethnicity of our providers are confidential. However, the languages reported by providers are published in our plan's *Provider Directory* so that members and participants can easily find doctors who speak their preferred language.

Our websites offer resources and educational tools that can assist you and your practice with questions about delivering effective health services to diverse populations. For additional information, visit **mibluecrosscomplete.com**:

1. On the blue bar, click Providers.
2. In the drop-down menu, click Training.
3. Scroll down to Cultural Diversity Training and then click Cultural awareness and responsiveness training opportunities.

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The importance of collecting race, ethnicity and language data

In an increasingly diverse society, the ability to deliver equitable and personalized healthcare has never been more crucial. Blue Cross Complete emphasizes the importance of healthcare providers collecting and reporting race, ethnicity and language, also known as REL, data to ensure every member receives culturally competent care, and to meet requirements outlined by Culturally Linguistically Appropriate Services, or CLAS.

CLAS are national standards and guidelines established in 2000 (and enhanced in 2013) by the U.S. Department of Health and Human Services, Office of Minority Health, to advance health equity, improve quality and help eliminate health disparities by providing a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate care.

Why is collecting REL data important?

- **Addresses health disparities:** Health outcomes often vary significantly across different racial, ethnic and linguistic groups. Collecting REL data allows Blue Cross Complete and its providers to identify and address disparities in care. Having consistent and reliable data is important when identifying and tracking health disparities.
- **Promotes equitable care:** REL data is an equitable service for patients. By promoting diversity among healthcare providers, we can better accommodate a diverse patient population and thus improve health outcomes for disenfranchised groups.
- **Empowers patients:** Sharing REL data gives patients the tools and autonomy to choose a provider who meets their preferences.
- **Promotes values of cultural and linguistic competency:** For some patients, racial and ethnic concordance with their physician allows for greater physician understanding of the social, cultural and economic factors that influence their patients. This enhances the patient-physician relationship through promoting trust and communication.

How do we collect REL information?

- Blue Cross Complete requests that its contracted provider network voluntarily share REL data, as well as their office support staff's languages.



- Blue Cross Complete requests and collects network provider REL data using the same Office of Management and Budget categories it uses to collect enrollees REL.

How do we store and share this information?

REL data is housed in a database that is made available to enrollees:

- Gender data is available through the Blue Cross Complete provider directory.
- Provider's language, staff's language and additional language services are also available through the provider directory.
- Information on race and ethnicity is only made available to enrollees upon request.
- Research by the National Institutes of Health shows that race, culture or ethnicity concordance within the patient-provider relationship aren't strong indicators of overall quality care. However, cultural competence and awareness are critical to build rapport, comfort and trust with diverse patients. REL data is one essential tool that health plans use to establish, enhance and promote cultural competence.
- When the health plan is able to share other languages spoken by the provider network, members have the autonomy to select a provider that matches their cultural and linguistic preferences.

Blue Cross Complete provides CLAS training and evaluates providers' compliance with these standards. If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

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Help us keep the Blue Cross Complete provider directory up to date

Accurate provider directory information is crucial to ensuring members can easily access their healthcare services. Confirm the accuracy of your information in our online provider directory so our members have the most up-to-date resources. Some of the key items in the directory are:

- Provider name
- Phone number
- Office hours
- Hospital affiliations
- Address
- Fax number
- Open status
- Multiple locations

To view your provider information, visit mibluecrosscomplete.com, then click the Find a doctor tab and search your provider name. If any changes are necessary, you must submit them in writing using Blue Cross Complete's Provider Change Form also at mibluecrosscomplete.com. Go to the Providers tab, click Forms and then click Provider Change Form.

Send completed forms by:

- Email: bccproviderdata@mibluecrosscomplete.com
- Fax: **1-855-306-9762**
- Mail: Blue Cross Complete of Michigan
  Provider Network Operations
  Suite 1300
  4000 Town Center
  Southfield, MI 48075

If you have any questions, contact your Blue Cross Complete provider account executive.

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Keep medical records up to date for your patients

According to the National Committee for Quality Assurance, healthcare providers are required to maintain accurate and timely medical records for Blue Cross Complete members for at least 10 years in accordance with all federal and state laws. Providers must also ensure the confidentiality of those records and allow access to medical records by authorized Blue Cross Complete representatives, peer reviewers and government representatives within 30 business days of the request at no charge.

As a reminder, medical records must include, at a minimum:

- A record of outpatient and emergency care
- Specialist referrals
- Ancillary care
- Diagnostic test findings, including all laboratory and radiology
- Therapeutic services
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals
- Allergies and adverse reactions
- Problem list
- Immunization records
- Documentation of clinical findings and evaluations for each visit
- Preventive services risk screening
- Other documentation sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided

Medical records must be signed, dated and maintained in a detailed, comprehensive manner that conforms to professional medical practice, permits effective medical review and medical audit processes and facilitates an organized system for coordinated care and follow-up treatment.



Providers must store medical records securely and maintain written policies and procedures to:

- Allow access to authorized personnel only.
- Maintain the confidentiality of all medical records.
- Maintain medical records so that records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information.
- Train staff periodically on proper maintenance of member information confidentiality.

Blue Cross Complete provides training and evaluates providers' compliance with these standards. If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

Source:
Healthcare Effectiveness Data and Information Set, or HEDIS®

HEDIS is a registered trademark of the National Committee for Quality Assurance. Bright Start is a registered trademark of AmeriHealth Caritas.

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Report suspected fraud to Blue Cross Complete

Healthcare fraud affects everyone. It significantly affects the Medicaid program by squandering valuable public funds needed to help vulnerable children and adults access healthcare.

If you or any entity with which you contract to provide healthcare services suspect another Blue Cross Complete provider, employee or member is committing fraud, notify Blue Cross Complete's Special Investigations Unit:

- Phone: **1-855-232-7640** (TTY: 711)
- Fax: **1-215-937-5303**
- Email: fraudtip@mibluecrosscomplete.com
- Mail: Blue Cross Complete
  Special Investigations Unit
  P.O. Box 018
  Essington, PA 19029

Blue Cross Complete's Special Investigations Unit supports local and state authorities in investigating and prosecuting fraud. You can also report suspected fraud related to

Blue Cross Complete to the Michigan Department of Health and Human Services Office of Inspector General in one of the following ways:

- Website: michigan.gov/fraud*
- Phone: **1-855-643-7283**
- Mail: Office of Inspector General
  P.O. Box 30062
  Lansing, MI 48909

Reports can be made anonymously.

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*The content presented is for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients and should not use the information presented to substitute independent clinical judgment.

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