McLaren HEALTH PLAN

Provider Network Update

November 2018

UPDATE: Pharmacy Benefit Manager Transition Effective January 1, 2019

McLaren Health Plan (MHP) is excited to announce that we are transitioning to a new Pharmacy Benefit Manger (PBM), MedImpact for all lines of business. Beginning **January 1, 2019**, Magellan will no longer be our PBM. What does this mean to you? The only change on your part will be where to send your Prior Authorization (PA) requests. We are taking all measures necessary to minimize any disruption you might experience because of this change.

E-Prescribing

E-prescribing is available to you through SureScripts. E-prescribing allows the physician to see which drugs are on the formulary, what generic alternatives are available, what prior authorizations or step therapies are required and a review of the patient's medication history. All can be done BEFORE the prescription is submitted. E-prescribing enhances physician and pharmacy efficiency and patient safety to help prevent adverse drug reactions and lowers costs.

Pharmacy Prior Authorization (PA)

Providers can process PAs real time at the point of care to reduce disruption, lower costs and improve clinical quality and safety for better member care. If you do not yet have access to electronic Prior Authorization (ePA) in your EMR, sign up for a free account on the Surescripts Prior Authorization Portal. The Surescripts Prior Authorization Portal makes it easy to submit electronic PA requests for all MHP members.

Get started now by logging into https://providerportal.surescripts.net/providerprotal/. Any existing PA currently approved will be transferred to the new PBM without disruption to you or your patients. Faxed PAs should use the appropriate pharmacy *PA Form* found at McLarenHealthPlan.org. Note that certain drugs have their own *PA Form*. All new PA requests will need to be submitted directly to MedImpact beginning **January 1, 2019**. Please use the following dedicated MHP PA information below when inquiring about and submitting PA requests:

MedImpact Prior Authorization (PA) Department
Electronic PA: https://surescripts.com/enhance-prescribing/prior-authorization
Phone: (888) 274-9689

Retail/Specialty/Mail Order Pharmacy Network

CVS and Target pharmacies will be considered out-of-network beginning **January 1, 2019**. For a complete listing of in-network pharmacies (available **January 1, 2019**), please see the provider directory on our website at McLarenHealthPlan.org or call Customer Service at (888) 327-0671, TTY: 711.

The MHP preferred specialty pharmacy vendor will be AllianceRX Walgreens Prime Pharmacy. All specialty drugs will need to be obtained through the preferred specialty pharmacy. Members currently utilizing a specialty pharmacy, will need a new prescription. Please refer to the information below when prescribing a specialty drug:

AllianceRx Walgreens Prime Pharmacy
Phone: (888) 282-5166

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McLarenHealthPlan.org

The MHP preferred mail order pharmacy will be MedImpact Direct. Members currently utilizing a mail order service will need a new prescription. Please use the information below when a patient requests mail order delivery:

MedImpact Direct
Phone: (855) 873-8739

If you have questions about the new PBM on or after **January 1, 2019**, please contact a MedImpact representative at (888) 274-9689. If you need assistance prior to **January 1, 2019**, please contact MHP Customer Service at (888) 327-0671, TTY: 711.

UPDATE: McLaren Health Plan Community (MHP Community) Authorization Update - Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (SP)

Effective **January 1, 2019**, MHP is implementing a Pilot Program that removes the preauthorization requirement for **in-network** PT, OT, and ST for our MHP Community (Commercial HMO/POS) members. MHP Community members have a defined visit limit benefit for PT, OT, and ST services.

Although the administrative requirement of requesting authorization from MHP is being removed, it is always necessary for members to coordinate care with their Primary Care Physician to ensure that all care is medically necessary.

MHP will perform post-payment audits reviewing claims by diagnosis, number of visits, location and member. These audits will be performed to ensure medical necessity of services being performed. The audit process may result in requests for medical documentation. If it is determined that care has been given that is not medically necessary, claims will be re-adjudicated and offsets will occur on future claims payments.

UPDATE: Coordination of Benefits Agreement (COBA) – Medicare Primary Coverage

MHP is pleased to announce that our connection to the CMS COBA system is active. COBA standardizes the way that eligibility and Medicare claims payment information with a claims crossover is exchanged. COBA permits MHP to send eligibility information to CMS. In return, MHP receives Medicare claims data for processing supplement insurance benefits. What does this mean for you? When you are seeing a patient that has Medicare primary and MHP coverage secondary, you only need to submit the claim to Medicare. Once Medicare adjudicates the claim, it will be forwarded to MHP by CMS. MHP will then process the claim for secondary benefits. You will no longer need to submit a secondary claim directly to MHP when a patient has Medicare primary.

ACTION REQUIRED: Gaps in Care Reports

Gaps in Care reports are sent to MHP Primary Care Providers (PCP). These gaps in care reports identify a PCP's assigned membership and services that have not been completed for the member based on current HEDIS specifications. Gaps in care are closed when a member receives the service and a claim has been billed to MHP. It is necessary for all MHP PCPs to review your gaps in care reports and ensure that all services provided have been submitted to MHP. If you find that you have billed a service but your gaps in care report still shows it as

outstanding, please contact MHP's Quality Management Department at (810) 733-9524 to confirm receipt of the claim or to discuss why the claim did not meet the gap closure.

You can supplement your claim data by faxing medical records to MHP at (810) 733-9653. Supplemental medical records can be sent to MHP for the following measures:

- Adult BMI
- Child BMI and nutrition and physical activity counseling
- Diabetes Care – HbA1c testing, Nephropathy Testing and Eye Exams
- Chlamydia Screening
- Breast Cancer Screening and any possible exclusion
- Cervical Cancer Screening and any possible exclusion

If you have questions, please contact MHP Customer Service at (888) 327-0671 and ask for the Quality Department.

ACTION REQUIRED: CHAMPS Enrollment Requirement – Claims Will Deny January 1, 2019

ALL Providers rendering services to Medicaid beneficiaries, must be enrolled with the MDHHS CHAMPS System. **If you are not enrolled your claims will deny effective January 1, 2019**. Register today by logging into www.michigan.gov/mdhhs

1. Click on "Doing Business with MDHHS" icon
2. Click on "Health Care Providers" icon
3. Click on "Providers" (middle of page)
4. Click on "CHAMPS" button
5. Click on "MI LOG In"
6. Click "Sign Up"

During registration, be sure to "associate" with MHP. This will ensure that MHP is notified of your registration and your claims are processed appropriately.

All new providers enrolling with CHAMPS will receive a Welcome Letter from MDHHS upon approval. MDHHS recommends all organizations keep a list of their user IDs.
CHAMPS Training is available by emailing ProviderOutreach@michigan.gov

REMINDER: Culturally and Linguistically Appropriate Services (CLAS) Training Requirement

CLAS is a way to improve the quality of services provided to all individuals. By tailoring services to an individual's culture and language preference, health professionals can bring about positive health outcomes for diverse populations.

CLAS training is an NCQA requirement for all providers and staff. MHP is pleased to offer CLAS training online at McLarenHealthPlan.org. The training provides an overview of CLAS standards, legal requirements, communication standards, continuous improvement recommendations and member diversity.
We are requesting each provider location to complete the CLAS training online and sign the attestation, included in the presentation (one attestation per office location). **Fax your completed attestation to (810) 733-9651.**
(If you have completed CLAS training with another health plan, we will accept a copy of their signed attestation)

REMINDER: Authorization Updates, Changes, and Clarifications

Updates, changes, and clarification to authorization requirements will be completed on a quarterly basis. Any updates, changes, or clarifications will be effective January, April, July and October of each year. A list of service codes requiring preauthorization is available at McLarenHealthPlan.org. If you have any questions, please contact Customer Service at (888) 327-0671.

REMINDER: Electronic Submission of Primary and Secondary COB Claims

Effective immediately, MHP can accept and process electronic secondary claims. To ensure appropriate adjudication of secondary claims, primary insurance payments must be reported at the line level, not at the claim level.

MHP utilizes ENS Optum Insight as clearinghouse for the submission of electronic claims. MHP's payer IDs are as follows:

- McLaren Health Plan Medicaid/Healthy Michigan Plan – 3833C
- McLaren Health Plan Community (Commercial HMO) – 38338
- McLaren Health Advantage – 3833A
- McLaren Medicare Supplement – 3833S

REMINDER: Online Provider Change Form

McLarenHealthPlan.org now contains a new *Provider Change Form* quick link for providers to submit changes to MHP (e.g., demographic change, Pay to Change).

Reminder: All changes must be submitted to MHP at least 60 days prior to the effective date.

If you have any questions, please contact Customer Service at (888) 327-0671 and ask to speak to your Network Development Coordinator.

McLaren Health Plan thanks you for the quality care you deliver!

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