McLaren HEALTH PLAN

McLaren HEALTH PLAN COMMUNITY

McLaren HEALTH ADVANTAGE

Provider Newsletter

Partners in Health

September 2018

In this Issue

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Make every office visit count.

McLaren CONNECT

In our ongoing efforts to provide you easy access to important McLaren Health Plan, Inc. (MHP) information, we are pleased to announce that a new provider portal is now available for your use.

McLaren CONNECT is the new provider portal that will replace the two provider portals currently being utilized (Health Edge and FACTSWeb). McLaren CONNECT will allow you to access information on members for all lines of business. It is a secure, web-based system that allows you to:

- Verify member eligibility
- View member claims and print explanation of payments (EOPs)
- View and print member eligibility rosters
- View and print member benefit information
- View a member's demographic information
- Contact MHP Provider Team

To login to McLaren CONNECT:

- Go to mclarenhealthplan.org
- Navigate to McLaren CONNECT located on the top left corner
- Choose the McLaren CONNECT provider portal
- Once on the McLaren CONNECT landing page click on Register Account
- Your provider TIN and NPI will be required for the login process

Security Statement: You must always sign in with your user name and password to access the features of the portal. Without this information, you will not be able to access your account. McLaren CONNECT is secure and safe!

If you have any questions or need assistance with McLaren CONNECT, please call Customer Service at 888-327-0671 (TTY: 711).

Providers Must Enroll in CHAMPS

Health care providers that serve Medicaid beneficiaries are facing an upcoming enrollment deadline that is necessary for them to continue to receive payments from Medicaid.

While the Michigan Department of Health and Human Services (MDHHS) has revised the timeline to give providers additional time to enroll, the department is urging providers to complete the CHAMPS enrollment process as soon as possible.

For dates of service on or after Jan. 1, 2019, MDHHS will prohibit contracted Medicaid Health Plans and Dental Health Plans from making payments to typical providers not actively enrolled in Community Health Automated Medicaid Processing System (CHAMPS) – the state's online Medicaid enrollment and billing system.

Typical providers are health care professionals that provide health care services to beneficiaries. They must meet education and state licensing requirements and have an assigned National Provider Identifiers (NPI). Examples include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.

At this time, contracted Integrated Care Organizations (ICOs), Prepaid Inpatient Health Plans (PIHPs) and MI Choice Waiver agencies are exempt from this requirement. CHAMPS enrollment neither requires nor mandates providers in a managed care network to accept Fee-for-Service Medicaid beneficiaries. CHAMPS enrollment is used solely to screen providers participating in Medicaid.

For dates of service on or after July 1, 2019, MDHHS Fee-for-Service and Medicaid Health Plans will prohibit payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS. More details on prescriber enrollment will be forthcoming in early 2019.

The federal Affordable Care Act and the 21st Century Cures Act require all providers who serve Medicaid beneficiaries to be screened and enrolled in the state Medicaid enrollment system. The purpose of this requirement is to protect beneficiaries by strengthening program integrity and care quality.

For information about the Provider Enrollment process and how to get started, visit www.michigan.gov/MedicaidProviders and click on "Provider Enrollment."

Providers also can learn more details by viewing future Provider Bulletins from MDHHS. Providers who have questions about the enrollment process or require assistance may contact the MDHHS Provider Enrollment Help Desk at 1-800-292-2550.

PHARMACY BENEFIT MANAGER (PBM) TRANSITION

We are excited to announce that we are transitioning to a new pharmacy benefit manager (PBM), MedImpact. 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 PA requests . We are taking all measures necessary to minimize any disruption you might experience because of this change.

Pharmacy Prior Authorization (PA):

Any PA currently approved on file will be transferred to the new PBM without disruption to you or your patient. Faxed prior authorizations should use the appropriate pharmacy prior authorization form found at MclarenHealthPlan.org. Note that certain drugs have their own prior authorization form. All new PA requests will need to be submitted directly to MedImpact beginning January 1, 2019. Please use the following dedicated MHP prior authorization 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 our in-network pharmacies, 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. All specialty drugs will need to be obtained through the preferred specialty pharmacy. Please refer to the information below when prescribing a specialty drug.

AllianceRx Walgreens Prime:

Phone: (888) 282-5166

The MHP preferred mail order pharmacy will be MedImpact Direct. Please use the information below when a patient expresses interest in having their medications mailed to them.

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.

Pharmaceutical Management

Pharmaceuticals Management promotes the use of the most clinically appropriate, safe and cost-effective medications. McLaren Health Plan's (MHP) Medicaid Drug Formulary is based upon the Michigan Medicaid Common Drug Formulary (Common Formulary). The use of the Common Formulary is a requirement of all Medicaid health plans in the state of Michigan. One or more medications are available in all required drug classes. The MHP Medicaid Drug Formulary can be found at McLarenHealthPlan.org or through the Epocrates system.

In addition to the MHP Medicaid Drug Formulary, MHP has created a Quick Formulary Guide (Quick Guide). The Quick Guide is a list of commonly prescribed medications which are covered by MHP. The Quick Guide is sorted by drug class and can be found on our website or by calling our Customer Service at (888) 327-0671.

Covered Benefits

- Medications listed on the Common Formulary
- Federal legend drugs identified on the MHP Medicaid Drug Formulary
- Select over-the-counter (OTC) items, identified on the Medicaid Pharmaceutical Product List (MPPL), prescribed by a provider
- Diabetic supplies limited to needles, syringes, alcohol swabs, lancets and test strips*

*MHP has a preferred manufacturer of diabetic test strips.

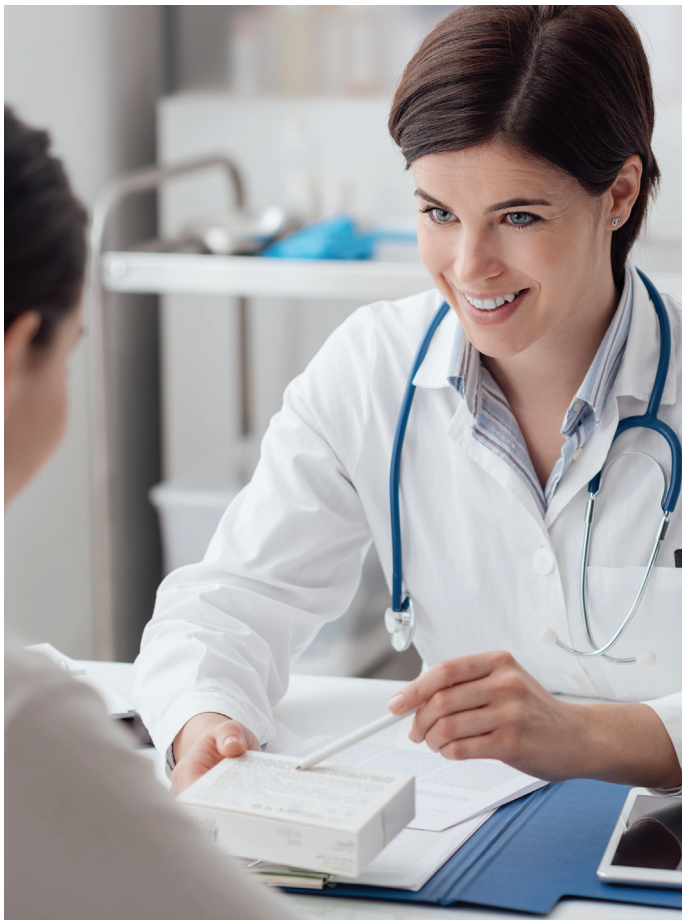
Non-Covered Benefits

- Medications that are not listed on the MPPL
- Medications prescribed for cosmetic or convenience purposes
- Experimental or unproven use of medications. Medications that are excluded from coverage under Michigan Medicaid:
    - o Diet aids
    - o Cough and cold medications
    - o Sexual Enhancements or Erectile Dysfunction medications
    - o Medications used to promote fertility

- Medical foods or agents that are not regulated by the Food and Drug Administration (FDA)

In addition, the drug benefit does not reimburse for drug products acquired for, or administered at, an inpatient hospital, an outpatient hospital, emergency room/clinic, a physician's office/ clinic.

Opioids



Effective June 1, 2018, the state of Michigan requires health care professionals to provide opioid education before prescribing an opioid to a patient. Education may be provided using the state's Start Talking form (MDHHS-5730), or similar form, when prescribing an opioid medication. If providers use a similar form, it must still cover all the topics identified by the Opioid Start Talking form. The form must be completed, signed and saved in the patient's medical record.

Effective June 1, 2018, before prescribing or dispensing to a patient a controlled substance in a quantity that exceeds a 3-day supply, a licensed prescriber shall obtain and review a MAPS report concerning that patient.

Effective July 1, 2018, if a prescriber is treating a patient for acute pain, that the prescriber shall not prescribe the patient more than a 7-day supply of an opioid within a 7-day period.

Additional information can be found at the Michigan Department of Health & Human Services (MDHHS) website or the state's Frequently Asked Questions document on Michigan opioid laws, also available on MDHHS website.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Opioid overdose continues to be a major public health problem in the United States. It has contributed significantly to overdose deaths among those who use or misuse illicit and prescription opioids. In fact, all U.S. overdose deaths involving opioids (i.e., unintentional, intentional, homicide, and undetermined)

increased to more than 42,000 deaths in 2016. Overdoses are experienced by both men and women of all ages, ethnicities, and demographic and socioeconomic characteristics.

The Substance Abuse and Mental Health Services Administration (SAMHSA) funds continuing medical education courses that are available to providers at no charge from the Providers Clinical Support System (PCSS) at pcssnow.org.

The CDC provides training on their website, www.cdc.gov/drugoverdose/training/index.html to Providers on Applying CDC Guidelines for Prescribing Opioids.

Helpful information for laypersons on how to prevent and manage overdose is available from Prevent & Protect at prevent-protect.org.

RESOURCES FOR PRESCRIBERS

Additional information on prescribing opioids for chronic pain is available at the following websites:

- www.opioidprescribing.com: Sponsored by the Boston University School of Medicine, with support from SAMHSA, the OpioidPrescribing.org site presents course modules on various aspects of prescribing opioids for chronic pain. Continuing medical education credits are available at no charge.
- pcssnow.org: Sponsored by the American Academy of Addiction Psychiatry in collaboration with other specialty societies and with support from SAMHSA, the Providers Clinical Support System offers multiple resources related to opioid prescribing and the diagnosis and management of OUD. The site also is the source for Drug Addiction Treatment Act of 2000 waiver education requirements.
- www.drugabuse.gov/nidamed-medical-health-professionals/cmece-activities#opioids: NIDAMED's mission is to disseminate science-based resources to health professionals on the causes and consequences of drug use and addiction, and advances in pain management. Continuing medical education credits are available at no charge.
- www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm163647.htm: The Risk Evaluation and Mitigation Strategy website provides physician training and patient education on OUD treatment medications as required by the FDA for extended-release and long-acting opioid analgesics.
- prescribetoprevent.org: Compiled by prescribers, pharmacists, public health workers, lawyers, and researchers working on overdose prevention and naloxone access, this privately funded site provides health care providers with resources to educate patients on how to reduce overdose risk and provide naloxone rescue kits to patients.
- store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-PocketGuide/SMA16-4892PG: SAMHSA's Medication-Assisted Treatment for Opioid Use Disorder Pocket Guide provides practical information for clinicians on medications to treat OUD.
- store.samhsa.gov/product/SMA18-5063FULLDOC: SAMHSA's Treatment Improvement Protocol 63: Medications for Opioid Use Disorders provides in-depth information for health care and addiction professionals, policymakers, patients, and families.

The Michigan Prescription Drug and Opioid Abuse Commission recently released the following Best Practices for prescribing recommendations.

Acute Care Opioid Treatment and Prescribing Recommendations: A Summary of Best Practices

These recommendations are to be used as a clinical tool,
but they do not replace clinician judgment.

Dental

Pre-Procedure

- Opioid prescriptions should not be written prior to completing a dental procedure.
- Communicate a conservative philosophy by emphasizing the efficacy and appropriateness of over the counter medications' analgesic properties.
- Address dental pain through clinical intervention rather than opioid pain relief.
- Refer patients to a free or low-cost dental program in the absence of insurance or financial constraints.

Prescribing

- The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law.
- Conduct full dental and medical history of the patient and include analysis of current medications.
- Identify any high-risk behaviors or diagnoses (previous substance use disorders, alcohol or tobacco use, psychiatric comorbidities including depression or anxiety).
- Non-opioid therapies (e.g., acetaminophen, ibuprofen) should be encouraged as the primary treatment.
- Non-pharmacologic therapies (e.g., acupuncture, mindful practice) should be encouraged when the patient is open to these alternative solutions to pain control.
- For breakthrough or severe pain, short-acting opioids (e.g., hydrocodone, oxycodone) should be prescribed at the lowest effective dose for no more than 3-5 day courses.
- Do not co-prescribe opioids with other sedatives or CNS depressant medications (e.g., benzodiazepines).
- Consider offering a naloxone co-prescription to patients who may be at increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving higher doses of opioids (e.g., >50 MME/Day).

For patients discharged with an opioid prescription

- Discuss the expectations regarding recovery and pain management goals with the patient.
- Educate patient and parent/guardian (for minors) regarding safe use of opioids, potential side effects, overdose risks, and developing dependence or addiction as required by Michigan law.
- Emphasize not using opioids concomitantly with alcohol or other sedative medications (e.g., benzodiazepines).
- Educate patient on tapering of opioids as dental/oral pain resolves.
- Refer to Michigan-Open.org for additional patient resources.

Acute Care Opioid Treatment and Prescribing Recommendations: A Summary of Best Practices

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Emergency Department (ED)

For patients presenting with acute exacerbation of chronic non-cancer pain	• Non-opioid therapies should be used as first line therapy. • Lost or stolen prescriptions should not be replaced. • The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law. • Consider care coordination and/or effective ED-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) with patients that have suspected risky opioid use or frequent ED visits.
For patients in methadone maintenance programs	• Replacement methadone should NOT be provided in the Emergency Department (ED).
For patients presenting with acute painful conditions	• Non-opioid therapies (e.g., acetaminophen, ketorolac) are encouraged as primary or adjunctive treatments. • Non-pharmacologic therapies (e.g., ice, splinting) should be utilized. • The prescription drug monitoring program (PDMP) must be accessed prior to prescribing opioids, in compliance with Michigan law. • Meperidine (Demerol) should not be used.
For patients discharged from the ED with an opioid prescription for acute pain	• Long-acting opioids (e.g., fentanyl, methadone, OxyContin) should NOT be prescribed. • Short-acting opioids (e.g., hydrocodone, oxycodone) should be prescribed for no more than three-day courses. • Do not prescribe opioids with benzodiazepines and other sedatives. • Information should be provided about opioid side effects, overdose risks, potential for developing dependence or addiction, avoiding sharing and non-medical use, and safe storage and disposal. • Consider offering a naloxone co-prescriptions to patients who may be at an increased risk for overdose, including those with a history or overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving a higher doses of opioids (e.g., >50 MME/day).

Acute Care Opioid Treatment and Prescribing Recommendations: A Summary of Best Practices

These recommendations are to be used as a clinical tool,
but they do not replace clinician judgment.

Surgical Department

Preoperative Counseling: For patients not using opioids before surgery	• Discuss the expectations regarding recovery and pain management goals with the patient. • Educate the patient regarding safe opioid use, storage, and disposal. • Determine the patient's current medications (e.g., sleep aids, benzodiazepines), and any high-risk behaviors or diagnosis (e.g., substance use disorder, depression, or anxiety). • Do NOT provide opioid prescription, for postoperative use, prior to surgery date.
Intraoperative	• Consider nerve block, local anesthetic catheter or an epidural when appropriate. • Consider non-opioid medications when appropriate (e.g., ketorolac).
Postoperative	• Meperidine (Demerol) should NOT be used for outpatient surgeries. • If opioids are deemed appropriate therapy, oral is preferred over IV route. • Ensure all nursing, ancillary staff and written discharge instructions communicate consistent messaging regarding functional pain management goals.
For patients discharged from surgical department with an opioid prescription	• The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law. • Non-opioid therapies should be encouraged as a primary treatment for pain management (e.g., acetaminophen, ibuprofen). • Non-pharmacologic therapies should be encouraged (e.g., ice, elevation, physical therapy). • Do NOT prescribe opioids with other sedative medications (e.g., benzodiazepines). • Short-acting opioids should be prescribed for no more than 3-5 day courses (e.g., hydrocodone, oxycodone). • Fentanyl or Long-acting opioids such as methadone, OxyContin and should NOT be prescribed to opioid naïve patients. • Consider offering a naloxone co-prescription to patients who may be at increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving higher doses of opioids (e.g., >50 MME/Day). • Educate patient and parent/guardian (for minors) regarding safe use of opioids, potential side effects, overdose risks, and developing dependence or addiction. • Educate patient on tapering of opioids as surgical pain resolves. • Refer to opioidprescribing.info for free prescribing recommendations for many types of surgeries.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

To provide our members with a smooth transition into this plan, we are working to ensure that CSHCS members have access to our provider network. Participation in MHP's Medicaid network extends to our CSHCS enrollees.

Primary Care Physicians (PCPs) who meet the requirements for treating CSHCS members receive a per-member per-month (pmpm) care management fee for all CSHCS MHP members assigned to their practices:

- $4/pmpm: TANF (Temporary Assistance for Needy Families)
- $6/pmpm: HMP (Healthy Michigan Plan)
- $8/pmpm: ABAD (Aged, Blind and/or Disabled)

The designation of TANF, HMP and ABAD for CSHCS is determined by MDHHS.

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

Childhood Immunizations

The Michigan Care Improvement Registry (MCIR) is an important tool that records and tracks a child's immunization history. The tool, located at www.MCIR.org, can save time and money and ensures that vaccines are not missed.

The secure website includes immediate patient immunization history and what's due, future dose dates, reminder and recall notices for due or overdue immunizations, printable official immunization records, and batch reports. All MHP providers are required to submit vaccination information to MCIR.

MHP is sending a notice to your office on a monthly basis of children that are 18 months of age that are still due for immunizations.

Vaccine Immunization Statement

Vaccine recipients in Michigan, their parents or their legal representatives must receive the Michigan version of Vaccine Immunization Statements (VIS).

This version has information regarding the Michigan Care Improvement Registry (MCIR). Check www.michigan.gov/immunize to make sure your VIS stock is current, as some versions have been recently updated.

VACCINE AND AGE

Inactivated Poliovirus (IPV)
- 2 & 4 months old
- 6-18 months old
- 4-6 years old

Influenza
- 6 months-13 years old (yearly)

Measles, Mumps, Rubella (MMR)
- 12-15 months old
- 4-6 years old

Varicella
- 12-15 months old
- 4-6 years old

Rotavirus
- 2-6 months old (2 or 3 doses)

Human Papillomavirus Vaccine (HPV)
- 11-12 years old (2 doses) at least

6 months apart Meningococcal (MCV)
- 11-13 years old

Hepatitis A (HepA)
- 12-23 months old

Hepatitis B (HepB)
- Birth
- 1-2 months old
- 6-18 months old

Diphtheria-Tetanus-Pertussis (DTAP)
- 2 months old
- 4 months old
- 6 months old
- 15-18 months old
- 11-13 years old

Haemophilus Influenza Type B (HIB)
- 2 months old
- 4 months old
- 6 months old
- 12-15 months old

Pneumococcal Conjugate (PCV)
- 2 months old
- 4 months old
- 6 months old
- 12-15 months old

Flu Vaccination

The time to administer flu vaccinations is now! Flu vaccinations are a covered benefit for our members when administered by a contracted MHP Provider. If your office does not supply flu vaccinations, please call Customer Service at (888) 327-0671 for assistance in finding an in-network location for your patients to receive their flu vaccinations. Flu vaccinations are also available at local retail pharmacies.

Reminder: Infants should receive two influenza vaccines between 6 and 24 months of age.

HEDIS 2018 Plan Results

MHP thanks you for the quality of care you are providing our members. Below are our overall plan ratings for key measures. Ongoing initiatives continue at MHP that focus on improving care and access for our members. If you would like your specific HEDIS results, please contact us at (888) 327-0671.

MHP's HEDIS Manual is available on our website and includes specifications and tips to increase your HEDIS rates. The manual can be found under the Provider Quality tab.

Measure	Commercial 2018	Medicaid 2018
Living With Illness		
Diabetes Care, HbA1c Testing	91 percent	90 percent
Diabetes Care, Nephropathy Screening	91 percent	89 percent
Diabetes Care, Eye Exam	46 percent	64 percent
Controlling High Blood Pressure	65 percent	61 percent
Taking Care of Women		
Breast Cancer Screening	70 percent	6 percent
Cervical Cancer Screening	73 percent	61 percent
Timeliness of Prenatal Care	84 percent	77 percent
Postpartum Care	85 percent	66 percent
Keeping Kids Healthy		
Childhood Immunization, Combo 2	81 percent	73 percent
Childhood Immunization, Combo 3	79 percent	71 percent
Well-Child Visits in First 15 months, 6+ Visits	79 percent	70 percent
Adolescent Well Care Visits	40 percent	45 percent
Blood Lead Level (on or before age 2)	N/A	84 percent
Access to Care		
Adult Access (ages 20-44)	89 percent	78 percent
Children's Access to PCP (25 months- age 6)	85 percent	83 percent

Thank You to Our Providers: 2018 CAHPS Scores Show Increased Results

Working Together for Patient Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an industry standard survey tool required by the National Committee for Quality assurance (NCQA) to evaluate and improve patient satisfaction.

The CAHPS survey was recently distributed to a random sample of McLaren Health Plan (MHP) members.

Listed below are a few topics addressed in the survey regarding patient care:

- Getting Needed Care
- Getting Care Quickly
- How Well the Doctors Communicate

When we work together to ensure a positive patient experience, there may be many important benefits to your practice:

- Increased patient retention
- Increased compliance with clinical recommendations
- Improved overall health outcomes
- Preventive care needs addressed timely
- Reduced no show rates

2018 PRIMARY CARE PROVIDER ACCESS AND AVAILABILITY

The 2018 Primary Care Provider Availability Survey was recently sent to all PCP offices. Thank you for taking the time to provide feedback and return the survey. We had a great response!

Based on the survey results, MHP's PCP Access Standards exceed our goal for three of the four standards:

Standard Type	Standard	Compliance	Comments
Urgent Care	Within 48 Hours	99 percent	1% received care within seven days
Regular/Routine Care	Within 14 Days	99 percent	1% received care within 30 days
Preventive Care/Physicals	Within 14 Days	90 percent	9% received care within 30 days
In-office Wait Time	30 Minutes	90 percent	46% offices had <15 min wait time

Managing Persistent Asthma

Help your persistent asthmatic patients have better control of their asthma by ensuring they are on appropriately prescribed asthma controller medications, such as long-acting inhaled corticosteroids, and that they remain on the appropriately prescribed medications during the treatment period.

Asthma ICD-10 Diagnosis:	J45.20- J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901-J45.902,J45.909, J45.990-J45.991, J45.998

Persistent asthmatics can be identified by:

- At least one ED visit with a principal diagnosis of asthma
- At least one acute inpatient encounter with a principal diagnosis of asthma
- At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events
- At least four asthma medication dispensing events

Health Risk Assessment

Health Risk Assessment (HRA): For all McLaren Healthy Michigan Plan (HMP) members, an HRA must be completed annually. As a MHP contracted provider, you are eligible for the HRA $50 Provider Incentive. See below for the ***HRA $50 Provider Incentive*** details. If you would like a list of your HMP members who still need an HRA, please call Customer Service at (888) 327-0671.

MHP Healthy Michigan Plan HRA process:

- The member will receive a blank copy of the HRA in their new Member Packet or a blank copy of the HRA is available at McLarenHealthPlan.org
- The member should complete sections 1-3 at the PCP office in addition to the PCP completing section 4
- All HRAs must have the PCP attestation (signature) in order to be considered complete and eligible for the incentive
- Fax completed HRA forms back to MHP at (877) 502-1567

Procedure Code	MHP Healthy Michigan Incentive
96160	$50.00

For all of your assigned MHP Healthy Michigan Plan members who are seen for an appointment and have a Healthy Michigan Plan HRA completed with your attestation, simply bill the procedure code listed above, **in addition to the services rendered.** Return the completed HRA to MHP, and you will receive a $50 payment for each HRA completed annually. The completed, attested HRA and claim for services must be received by MHP within 30 days of the visit.

MQIC Guidelines

MHP has adopted the Michigan Quality Improvement Consortium's (MQIC) Clinical Practice Guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health care services.

These guidelines may be found at www.mqic.org and www.mclarenhealthplan.org/medicaid-provider/provider-guidelines-mhp.aspx.

The MQIC guidelines are evidence based. The guidelines include physical conditions, such as asthma and diabetes, and behavioral health conditions, such as depression and attention-deficit/hyperactivity disorder for children and adolescents. The guidelines are reviewed at least every two years for needed updates.

There's Power in the Pad...

The prescription pad, that is! There are new studies that show that prescribing exercise to adults may encourage them to be more active. Many physicians have found this works better than just telling patients to exercise.

Exercise has proven health benefits, and getting a prescription for exercise might be just what patients need to get started.

Consider prescribing exercise for your patients just as you would prescribe medication.

Diabetes Core Measures

Help your diabetic patients by making sure they complete their core measures annually. MHP encourages our diabetic members to regularly visit their PCPs and get these necessary tests. All of the diabetic core measures are covered benefits for MHP members, including their annual diabetic eye exams. See page 22 for current HEDIS specifications for diabetes.

Strategies for Decreasing Emergency Department Utilization

Access to healthcare through the emergency department (ED) presents an avenue for people not necessarily suffering from life-and-limb –threatening conditions. Overuse leads to needless expense, crowding and reductions in access to those in true need.

A few strategies to help reduce unnecessary ED visits include:

1. Increase communication with the hospital systems through the use of Michigan Health Information Network (MiHIN) admit, discharge and transfer electronic health data. Educate members on the appropriate use of ED and quickly schedule follow up appointments;
2. Increase education and reminders for patients during routine visits regarding appropriate use of ED;
3. Increase office hours to include earlier/later or weekend hours to accommodate working patients;
4. Offer triage services for members calling for care after hours.

MHP's case management and outreach teams also contact members over utilizing or inappropriately utilizing emergency department services. MHP also provides member education through newsletters, special mailings and case management, when appropriate.

Helping your Patients Quit Smoking

MHP is committed to our members obtaining appropriate health screenings that aid in the promotion of healthy lifestyles. It is important that you communicate to your patients the hazards of smoking at each visit. Please be sure you:

- Advise smokers to quit
- Offer smoking cessation strategies
- Offer medical assistance with smoking cessation

As a reminder, the following smoking and tobacco-use counseling codes are reimbursable CPT codes and covered benefits for MHP members. Please be sure you document in your medical records, and bill for tobacco cessation counseling services.

- 99406- Smoking and tobacco-use cessation counseling – Intermediate > 3-10 minutes
- 99407- Smoking and tobacco-use cessation counseling – Intensive > 10 minutes

MHP's 2017 CAHPS Survey (which is a random sample of MHP adult members) indicated the following:

- 75% were advised by a medical professional to quit smoking
- 53% were offered smoking cessation strategies
- 60% were offered medical assistance with smoking cessation

Smoking Cessation Information

MHP is committed to helping our members stop smoking. In an effort to help our providers with this endeavor, MHP is pleased to offer the Michigan Tobacco Quitline, in conjunction with the American Cancer Society. MHP members who are ready to quit smoking will receive help by calling the Quitline. MHP members can access the Tobacco Quitline FREE of charge by calling: (800) QUIT-NOW or (800) 784-8669.

The program offers:

- Initial readiness assessment
- Self help materials
- Enrollment in telephonic counseling

Reminder: Healthy Michigan Dental Coverage

As a reminder to our PCPs, all McLaren Health Plan Healthy Michigan members have dental coverage through Delta Dental.

We are sure you are aware of the importance that good dental care plays in keeping the entire body health. Please be sure to ask each of your patients if they have a dental home.

Oral health, inextricably linked to overall health, is essential for healthy development and healthy aging. The consequences of oral disease are often minimized or discounted, yet oral complications reflect, exacerbate, and may even initiate other health problems, and they can have a profoundly negative impact on quality of life. A series of intriguing new reports demonstrate the potential for significant savings in total health care costs across a spectrum of conditions (including pregnancy, diabetes and cardiovascular disease) with the successful treatment of periodontal disease.

Member benefits include: cleanings, x-rays, fluoride treatments, fillings, crowns and other dental services.

Referrals may be made to an in-network Delta Dental provider. If you have any questions about the Healthy Michigan Plan dental services, or need the name of a participating dentists, call the Delta Dental Customer Services department at (800) 524-0149. You can also look on their website at www.deltadentalmi.com.

Pregnant Women Dental Benefit for Medicaid Beneficiaries

Effective July 1, 2018, the Michigan Department of Health and Human Services (MDHHS) has expanded its managed care dental coverage for non-Healthy Michigan Plan (HMP) pregnant women eligible for Medicaid.

Medicaid members who are pregnant or become pregnant can receive dental services during their pregnancy and 90 days postpartum.

Pregnant members will be able to see dentists who are contracted with Delta Dental. In addition, MHP will provide transportation assistance to pregnant Medicaid members who need transportation to and from scheduled dental appointments.

Letters are being sent to female members, of child bearing age, informing them of this new dental benefit. The letter explains that to receive dental services, members must notify MHP of the pregnancy and due date by calling Customer Service at (888) 327-0671. Members must also inform their caseworker of the pregnancy and due date. If you have any questions please contact Customer Service at (888) 327-0671.

Pregnancy Notification

Upon pregnancy notification our Medical Management team will:

- Perform outreach to engage members with our team and provide support for community resources
- Refer MHP Medicaid and Healthy Michigan member for Maternal Infant Health Program (MIHP) services
- Provide educational mailings
- Ensure Medicaid members are identified and enrolled for dental benefits beginning July 1, 2018

You can help by doing the following:

- Notify us when one of our members is pregnant
- Complete the Pregnancy Notification form available on our website or call our Customer Service department at (888) 327-0671

Breast Pumps are Covered

- As a purchase DME item
- With a prescription from the member's physician
- No authorization is necessary when the breast pump is received from an MHP in-network DME provider

McLaren Health Plan Member	Procedure Code
Medicaid	E0602 – NU (Manual)
	E0603 – NU (Electric)
Community	E0602 – NU (Manual)
	E0603 – NU (Electric)

Chlamydia Screening

The Most Often Missed Preventive Screening

The ability to screen for chlamydia using a urine sample has simplified the recommended preventive screening. However, less than 60 percent of women actually receive this important screening. How does your practice ensure all sexually active women, between 16-24 years of age, and sexually active men, ages 16-18 years of age, are screened for chlamydia?

- Is it assessed during an adolescent well exam?
- Is it included as a component of annual Pap screening for women?

Answering “No” to one of the above questions may indicate potential gaps within your practice, as well as opportunities to provide this important preventive screening.

Remember that when a patient tests positive for chlamydia, they should inform their previous sexual partners. Expedited Partner Therapy should be provided for the partners of patients with a clinical or laboratory diagnosis of chlamydia.

HEDIS Tips: Comprehensive Diabetes Care

MEASURE DESCRIPTION

Adults 18 -75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c control (<8.0%)
- Eye exam (retinal or dilated) performed
- BP control (<140/90mmHg)
- Nephropathy monitoring

If your patient is on the diabetic list in error, please submit:

1. A statement indicating the patient is "not diabetic;" and
2. At least two labs drawn in the current measurement year showing normal values for HbA1C or fasting glucose tests.

Fax the information to: (810) 733-9653.

USING CORRECT BILLING CODES

Description	Code
Codes to identify diabetes	ICD-10: E10, E11, E13, Q24
Codes to identify HbA1c tests	CPT: 83036, 83037, 3044F, 3045F, 3046F
Codes to identify nephropathy screening test	CPT: 82042, 82043, 82044, 84156, 3060F, 3061F, 3062F, 81000-81003, 81005
Codes to identify nephropathy testing	ICD 10: E08.2-E11.2, E13.2, I12, I13, I15, N00-N08, N14, N17, N18, N19, N25, N26, Q60, Q61, R80, 3066F, 4010F
Codes to identify eye exam (must be performed by optometrist or ophthalmologist)	CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 HCPCS: S0621, S0620, S3000, 3072F, 2022F, 2024F, 2026F CPT Category II: 2022F, 2026F, 2024F, 3072F

How to Improve HEDIS Scores

- Review diabetes services needed at each office visit
- Order labs prior to patient appointments
- If point-of-care HbA1c tests are completed in-office, helpful to bill for this; also ensure HbA1c result and date documented in the chart
- Adjust therapy to improve HbA1c and BP levels; follow-up with patients to monitor changes
- Take and document multiple blood pressure readings
- A digital eye exam, remote imaging, and fundus photography can count as long as the results are read by an eye care professional (optometrist or ophthalmologist)
- Use Gaps in Care lists to identify patients who need diabetic services
- MHP has a Diabetes Disease Management Program to which you can refer patients
- Send your completed Gaps in Care lists to MHP via fax to (810) 733-9653

Assuring Better Child Health and Development

Development screening should be included at every well-child visit and can be billed in addition to the well-child visit (see below). It is recommended that standardized developmental screening tests be administered at the 9, 18, 24, and 30 month visits.

The Michigan Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy requires developmental surveillance screening, and recommends providers use a tool, such as the PEDS, PEDS: DM or Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social-Emotional (ASQSE). You are encouraged to implement developmental surveillance and screening in your office to be in compliance.

CPT	96110
ICD	Z13.4
Category	Developmental Screenings
Notes	Screening tool completed by parent or non-physician staff and reviewed by the physician.
Incentive	$20 per member (ages 0-3) per year

For our contracted MHP network practitioners, MHP has purchased the rights to the ASQ screening tool. If you would like a copy of this material, please contact your Network Developmental Coordinator or call Customer Service at (888) 327-0671.

Suggestions for successful practice implementation include the following:

- Utilize a standardized screening tool such as ASQ (which MHP will provide)
- Communicate with office staff, colleagues and parents about the importance of developmental surveillance and screening
- Screen all children during well-child checks at the 9, 18 and 30 months (or 24 months) visits
- Discuss any developmental concerns with the child's parents
- Refer children to Michigan's Early On program if developmental delays are found. You may make the referral online at www.1800earlyon.org or call the statewide line at (800) EARLY-ON (327-5966)

*Should the screening indicate developmental delays, additional objective developmental testing may be performed by the physician at an outpatient office visit using CPT code 96111.

2018 Provider Incentive Program

LINE OF BUSINESS	INITIATIVE	INCENTIVE	HOW
Medicaid	**Adult BMI**	$5 for each member, annually	Based on billed claim; paid at time of submission.
MHP Community / Medicaid	**Chlamydia Screening**	$25 per eligible member screened	Based on data of billed claim; annual payout.
Medicaid	**Club 101**	$101 reimbursement for well visits, age 1–11	Based on billed claim; paid at time of submission.
Medicaid	**Developmental Screening**	$20 per annual screening for eligible population	Based on claim billed with appropriate codes; paid at time of submission.
MHP Community / Medicaid	**Expanded Access Award**	99050 / 99051 reimbursed $17.38	Based on billed claim; paid at time of submission.
MHP Community / Medicaid	**Healthy Child Incentive**	$15 total incentive ($5 for each annual component): - Weight assessment; - Counseling for nutrition; and - Physical activity for child/adolescents.	Based on billed claim with appropriate codes; paid at time of submission.
Healthy Michigan Plan	**Healthy Michigan HRA**	$50 per completed HRA for Healthy Michigan Plan members	Based on billed claim and HRA received within 150 days of enrollment.
Medicaid	**Lead Screening**	36416 reimburses $15 83655 reimburses $25	Based on billed claim; paid at time of submission.
MHP Community / Medicaid	**Mammogram**	$50 per eligible member screened	Based on billed claim; annual payout.
MHP Community / Medicaid	**Postpartum Visit for OB-GYN Providers**	$100 per eligible member	Based on billed claim and self-reported data; quarterly payout.
MHP Community / Medicaid	**Pay-for-Performance Program**	PCMH recognition and up to $2 pmpm for eligible PCP assigned membership. **Measures:** - Open access. - Well child 3-4 yrs. - Mammogram screening. - E-prescribing, EHR and E-Portal. - HIE qualified organization participation. - Achieved PCMH recognition.	Annual payout based on prior year's performance measures.

Specialty Care Medication Site of Care Injectable/Infusible Required Drug List

Effective August 1, 2018, McLaren Health Plan, Inc. (MHP) implemented Specialty Care Medication Site of Care Requirements for MHP Community and McLaren Health Advantage lines of business. The MHP Site of Care Guidelines require the following list of injectable or infusible drugs to be administered only in a non-facility setting, such as the patient's home or a non-hospital affiliated infusion center. Infusions for these medications are excluded from reimbursement when administered in a hospital outpatient infusion center. In addition, the medications listed below require pre-authorization, regardless of the site of care. Specialty Care Medications are listed below:

All MHP Community and McLaren Health Advantage members are required to receive their injectable/infusible specialty care medications in a non-facility setting, such as the patient's home or non-hospital affiliated infusion center. Exceptions may be made when an authorization request is submitted by a physician. The request should include supporting documentation, which MHP will review, indicating the contraindications for a member to receive these medications in their home or in an infusion center.

Prescribers and members will receive advance notification if they are impacted by these Site of Care Requirements.

Brand Name	HCPCS code
Actemra	J3262
Aldurazyme	J1931
Benlysta	J0490
Berinert	J0597
Bivigam	J1556
Cerezyme	J1786
Cimzia	J0717
Cinryze	J0598
Elaprase	J1743
Elelyso	J3060
Entyvio	J3380
Fabrazyme	J0180
Flebogamma	J1572
Gammagard	J1569
Gammagard S/D	J1566

Brand Name	HCPCS code
Gammaplex	J1557
Gamunex	J1561
Immune Globulin	J1599
Inflectra	Q5103
Lumizyme	J0221
Naglazyme	J1428
Octagam	J1568
Orencia	J0129
Privigen	J1459
Remicade	J1745
Renflexis	Q5104
Simponi Aria	J1602
Soliris	J1300
Stelara	J3357
VPRIV	J3385

If you have any questions regarding the Specialty Care Medication Site of Care Requirements, please call Customer Service at (888) 327-0671.

Complex Case Management

Complex Case Management (CCM) addresses how to coordinate services for members with complex conditions and promote access to needed services. Through early identification of the member requiring CCM, MHP coordinates high quality, cost effective health care services. Our goal-oriented program focuses on engaging our members, their providers of care, and the health plan in a collaborative effort to improve quality of life. The complex case manager begins with a complete assessment of the member's needs, and through ongoing communication, promotes access to services and improved health outcomes. The goal of MHP's Complex Case Management Program is to help members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. If you have a patient who you think would benefit from CCM, call Customer Service at (888) 327-0671 or fax the MHP Referral Form to Case Management. The form is available at McLarenHealthPlan.org.

Disease Management

MHP has several Disease Management programs. These programs include asthma, diabetes, depression, hypertension and obesity. Members receive educational mailings, ongoing nurse contacts, and pharmacy management. McLaren Moms, MHP's maternity management program works to ensure members receive timely prenatal and postpartum care. If you have a member you would like in our Case Management or Disease Management Programs, please call customer service at (888) 327-0671.

Continuity of Care

Continuity is a crucial aspect of a patient's medical care. MHP encourages all providers to communicate with other identified providers of care. The sharing of information between providers of care allows everyone the opportunity to be on the "same page" when identifying a patient's needs.

Behavioral Health and Substance Use Services for Medicaid Enrollees

In 2018, MHP began covering all mental health visits. Primary care providers are encouraged to work with the PIHPs to ensure their patients get the best care possible through coordination of care of services such as:

- Nutrition/dietary counseling
- Maintenance of health and hygiene
- Nursing services
- Teaching self-administration of medication

Additionally, you may be called upon to help your patient in the grievance or complaint process.

Utilization Management Program

MHP's Utilization Management Program is structured to deliver fair, impartial and consistent decisions that affect the health care of our members. There are written criteria used when determining the necessity of medical or behavioral health services. The criteria is available to you upon request by calling Medical Management at (888) 327-0671 or (810) 733-9642. If there is a utilization denial, we will provide you the member with written notification and the specific reason for the denial, as well as the member's appeal rights.

The Chief Medical Officer, or other appropriate practitioner, will be available by phone to discuss any utilization issue and the criteria utilized in the decision-making process.

Utilization decision making is based solely on appropriateness of care, service, and existence of coverage.

We do not reward practitioners or other individuals for issuing denials of coverage or service of care, nor are there financial incentives for utilization decision makers to encourage decisions that result in underutilization. Please call Medical Management at (810) 733-9642, or call Customer Service at (888) 327-0671 for more information.

MDHHS Provider Requirement

According to 42 CFR § 455.104, MDHHS does not allow MHP to contract with any provider who has been suspended, debarred or excluded from Medicaid. This also includes provider's employees such as directors, officers, partners, managing employees or other persons with five percent ownership. MHP requires all providers to follow MHP policies and procedures, federal and state laws and regulations. Additionally, providers must be registered/enrolled with the Michigan Medicaid Program. Providers are contractually required to notify MHP of any employee who has been suspended, debarred or excluded from Medicaid. MHP is required to disclose such information to MDHHS within 30 days of any provider or the provider's employees being suspended, debarred or excluded from Medicaid. Please report any such activity to MHP as soon as possible in order to maintain compliance.

Credentialing Corner

Provider Initial Credentialing

If you want to join the MHP provider network, credentialing is part of the process. This article will help give you an overview of what is involved in the credentialing process.

To join the MHP network, the first thing you will need to do is complete an enrollment application. MHP utilizes the Council for Affordable Quality Healthcare® (CAQH) to gather and coordinate the information needed for credentialing. If you do not already have one, you will need to create a profile on CAQH ProView™. MHP is unable to complete the credentialing process without access to your CAQH profile. MHP will verify that the information submitted and attested to is accurate. Depending on the type of the provider you are, we want to know you have the appropriate license, education, malpractice insurance coverage and other qualifications. That verification process is called credentialing.

Keep these tips in mind when you're completing your profile in CAQH ProView:

- After you've submitted your enrollment form to us, you should complete your CAQH ProView application within 14 calendar days.
- Already have a CAQH ProView profile? Check to ensure your attestation is up to date. Attestation must be completed within 14 calendar days of submitting your enrollment form to MHP. Otherwise we are unable to begin the credentialing process.
- New graduates can submit an enrollment form to us up to 60 days before training is completed.
- If you're relocating from out-of-state, you can submit your enrollment form 30 days before your start date.

More helpful information about CAQH ProView:

- Be careful when choosing our primary specialty in CAQH ProView. Your choice:
  - Determines whether you're designated as a PCP or specialist for managed care networks.
  - May affect the way claims are processed and paid.
  - Will be shown in our online provider directories.
- Ensure that CAQH profile contains your current malpractice insurance face sheet, a chronological work history for the past five (5) years and a signed Authorization for Release of Information form is dated in the last 12 months.
- Your CAQH attestation must be updated at least every 120 days, update more frequently if any of your information changes. You will receive automatic reminders to review and attest to the accuracy of your data. This is accomplished through a quick online visit or by calling an automated telephone system.
- CAQH Provider Help Desk open Monday-Thursday, 7 a.m.-9 p.m. and Friday, 7 a.m.-7 p.m. (EST)
  - Phone: (888) 599-1771
  - Email: providerhhelp@proview.caqh.org
- Login site: proview.caqh.org/Login
- Providers must also be registered in MDHHS CHAMPS System.

For questions regarding the credentialing process, please call Customer Service at (888) 327-0671, and ask to be connected to the credentialing department.

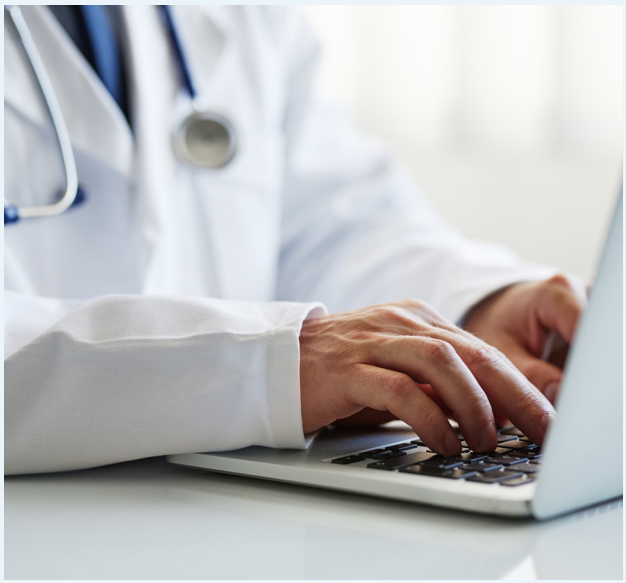
Recredentialing

MHP must process providers through recredentialing at least every 36 months, per National Committee for Quality Assurance (NCQA) accreditation requirements.

All providers need to periodically review the information they submit for credentialing via your CAQH profile. It's your opportunity to make updates and confirm existing information. As with initial credentialing, MHP will rely on the information provided in CAQH to recredential providers. It is critical your re-attestations in CAQH occur at least every 120 days. This includes uploading a current, valid malpractice insurance fact sheet in your CAQH profile.

What's on the Web

MHP utilizes McLarenHealthPlan.org, as a means to inform, educate and engage our providers, members and employers. As a member of our provider network, we appreciate that you provide high quality, accessible and cost effective health care services to our members. You will find information on our website, such as:



- Case Management Support
- Credentialing Policies and Process
- Electronic Billing
- How to Contact Us
- Provider Directories
- Provider Portal (McLaren CONNECT)
- Provider Change Request Form (All changes must be submitted to MHP at least 60 days prior to the effective date)

In addition, visit our website frequently for the most up to date information regarding:

- Pharmaceutical Management Information and Procedures
- Drug Formulary (including a full Positive list)
- Preauthorization Request Form and Referral Guidelines (updated quarterly)
- Many Clinical Practice Guidelines about (updated quarterly)
  - ADHD
  - Asthma
  - Diabetes
  - Prenatal
  - Preventive services
- Member Rights and Responsibilities
- Fraud & Abuse
- Facility and Medical Records Standards
- Provider Complaint and Appeals Process
- Developmental Surveillance and Screening
- Disease Management Programs (how to access programs and what your enrolled member receives)
- Quality Performance Improvement Plan (summary and updates)
  - Provider resources
  - Provider manual
  - Newsletters
- Utilization Management
  - Criteria availability
  - Denial process
  - Incentive statement
  - Referral process
  - HEDIS manual

If you would like a printed copy of anything on the website, please contact Customer Service at (888) 327-0671.

Claim Submission

Electronic Claims/EDI	**Clearinghouse:** ENS/OptumInsight; www.enshealth.com; (866) 367-9778 The following Payer ID's are to be used for the corresponding line of business: • MHP Medicaid - 3833C • MHP Community- 38338 • McLaren Health Advantage - 3833A • McLaren Advantage (HMO SNP) - 3833R • McLaren Advantage (HMO) - 3833R
Paper Claims	McLaren Health Plan P.O. Box 1511 Flint, MI 48501-1511

Expediting Claims Status and Claims Adjustments

In an effort to help expedite claims payment issues, MHP has developed a Claims Status Fax Form and a Claims Adjustment Request Form. As a reminder, a request for claims status may be submitted no earlier than 30 days after the claim was received by MHP. A request for a claims adjustment must be made within 90 calendar days of the MHP Explanation of Payment (EOP).

You can get a copy of the forms on our website at McLarenHealthPlan.org. To access the forms and instructions, click on Providers/line of business/Provider Materials. If you have questions about the forms or need assistance, please call Customer Service at (888) 327-0671.

In addition to claim payment, claim submissions are used for quality measurement, including pay for performance and provider incentive payments. Without a claim on file, MHP cannot determine the services you provided for a member, and you may not receive the appropriate payout for the performance incentives.

Exciting News Regarding Coordination of Benefits

Effective August 20, 2018, MHP has a Coordination of Benefits Agreement (COBA) with CMS for Medicaid claims. Providers will no longer need to send Medicare Primary/Medicaid Secondary claims. MHP will receive claim information electronically direct from WPS/CMS. If you submit claims (paper or EDI) to McLaren Health Plan, they will deny as a duplicate as the electronic CMS claim should have already been paid. We are currently going through the process for the remaining lines of business.

Report Fraud, Waste and Abuse

MHP is committed to preventing health care fraud, waste and abuse, as well as complying with applicable state and federal laws governing fraud and abuse.

Examples of fraud and abuse by a member include:

- Altering or forging a prescription.
- Altering medical records.
- Changing or forging referral forms.
- Allowing someone else to use their MHP member ID card to obtain health care services.

Examples of fraud and abuse by a provider include:

- Falsifying his/her credentials.
- Billing for services not performed.
- Billing more than once for same services.
- Upcoding and unbundling procedure codes.
- Overutilization: performing inappropriate/unnecessary services.
- Underutilization; not ordering services that are medically necessary.
- Collusion among providers.

Examples of fraud and abuse by a MHP employee include:

- Altering provider contracts or forging signatures.
- Collusion with providers or members.
- Inappropriate incentive plans for providers.
- Embezzlement or theft.
- Intentionally denying services or benefits that are normally covered.

The Deficit Reduction Act of 2005 requires information about both the Federal False Claims Act and other laws associated with:

- Fraud, Waste and Abuse.
- Whistleblower Protection.

Federal law prohibits an employer from discriminating against an employee in the terms and conditions of his/her employment because the employee initiated or otherwise assisted in a false claims action.

To report a possible violation in writing (you may remain anonymous), send the report to:

Attn: Compliance Officer
McLaren Health Plan
G-3245 Beecher Rd.
Flint, MI 48532

You may also email: **MHPCompliance@mclaren.org**, call the MHP Compliance Hotline at (866) 866-2135 or visit McLarenHealthPlan.org.

To report Medicaid Fraud, Waste, and Abuse in writing (you may remain anonymous), send the report to:

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call 1-855-MI-FRAUD (643-7283), or MDHHS-OIG@michigan.gov.

Provider Changes

When identifying changes in your practice you must provide the updated information ***at least 60 days*** in advance of the change. This ensures updates are made within all MHP systems by effective date of change.

All changes must be submitted on the *Provider Request Change Form*, available at McLarenHealthPlan.org. The *Provider Request Change Forms* must be completed online.

If you have a question regarding this, please contact your designated Network Development Coordinator.

COUNTIES	PROVIDER NETWORK DEVELOPMENT COORDINATOR	CONTACT INFORMATION
Alpena, Alcona, Antrim, Arenac, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Lake, Leelanau, Manistee, Mason, Missaukee, Montmorency, Ogemaw, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Wexford	Stephanie Anderson	stephanie.anderson@mclaren.org (231) 342-2012
Berrien, Clare, Gladwin, Macomb, Midland and St. Clair	Trish Smith	patricia.smith1@mclaren.org (810) 733-9568
Bay, Jackson, Lenawee, Monroe, Washtenaw, Wayne	Trish Smith	(888) 327-0671
Genesee, Huron, Lapeer, Saginaw, Sanilac, Tuscola	Amy Weigandt	amy.weigandt@mclaren.org (810) 733-9604
Oakland	Kelly Short	kelly.short@mclaren.org (810) 733-9664
Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Montcalm, Shiawassee	Ken Axtell	ken.axtell@mclaren.org (517) 913-2615
Allegan, Barry, Branch, Calhoun, Cass, Hillsdale, Kalamazoo, Kent, Mecosta, Muskegon, Newaygo, Oceana, Ottawa, St. Joseph, Van Buren	Beverly Hude	beverly.hude@mclaren.org (517) 913-2616