McLaren HEALTH PLAN

September 2016

Provider Newsletter

Partners in Health

In this Issue

MHP Medicaid Providers – CHAMPS Enrollment Requirement

All MHP Medicaid contracted Providers must enroll and attest to their information within the State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS).
Enrolling in CHAMPS does not require you to be a Medicaid FFS Provider.

To enroll in CHAMPS:

1. Go to www.michigan.gov/mdhhs
2. Click on "Doing Business with DMDHHS" icon (top of Page)
3. Click on "Health Care Providers" icon, left side of page
4. Click on "Providers" (middle of page)
5. Click on CHAMPS
6. Click on "Single Sign-on (SSO)" icon
7. Click "Register" button, under "Sign-Up"

If you have not done so already, please complete this requirement.

Pharmaceutical Management

McLaren Health Plan (MHP) works collaboratively with 4D Pharmacy Management, our Pharmacy Benefit Manager, to utilize the most clinically appropriate, safe and cost-effective medications. Customized drug formularies are the main tool utilized to promote the use of these preferred medications. MHP works with a panel of doctors, pharmacists and nurses to create and maintain drug formularies. Our Medicaid and Children's Special Health Care Drug Formularies are based on guidelines set by the Michigan Department of Health and Human Services (MDHHS). In addition, MHP maintains a Commercial Drug Formulary which is utilized by our Commercial and Health Advantage membership.

MHP Drug Formularies have been developed and organized based on a preferred drug list which includes representation across all therapeutic classes (except when a therapeutic class has been excluded from coverage). **Most** generic medications are included on our drug formularies and can be obtained at the lowest out of pocket expense (or co-pay). As a note, our Medicaid members do not have co-pays on formulary preferred medications covered under their MHP pharmacy benefit.

In addition to the drug formularies, MHP maintains Quick Formulary Reference Guides. These Quick Guides serve as a reference for commonly prescribed medications. Pharmaceutical Management processes such as Prior Authorization, Step Therapy and Specialty Pharmacy requirements are noted on both the Quick Guides as well as the complete drug formularies. To locate either formulary resource and other pharmacy information, please visit our website: MclarenHealthPlan.org. MHP's drug formularies can also be downloaded via Epocrates or Surescripts (which is MHP's preferred e-prescribing network).

E-Prescribing Available for All Members

- MHP's Commercial and Medicaid formulary information and prescribe through Sure Scripts
- McLaren Health Advantage formulary information and prescribe through Sure Scripts
- Take advantage of the benefits offered by E-Prescribing, such as:
  - Increase patient safety and higher quality care
  - Avoid drug to drug and drug allergy interactions
  - View patient medication history
  - Increase office efficiency due to fewer phone calls and faxes

surescripts

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 McLaren Health Plan's Medicaid network extends to our CSHCS enrollees.

Primary Care Physicians 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 practice:

$4/pmpm: TANF (Temporary Assistance for Needy Families)

$8/pmpm: ABAD (Aged, Blind, and/or Disabled)

The Designation of TANF and ABAD for CSHCS is determined by the MDCH.

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

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 CMI notice to your office on monthly basis of children that are 18 months of age that are still die 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).

These versions have information regarding the Michigan Care Improvement Registry (MCIR). Check www.michigan.gov/immunize to make sure your VIS stock is up-to-date, 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 (3 doses)

Menigococcal (MCV)
- » 11-13 years 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

Hepatitis A (HepA)
- » 12-23 months old

Well Child Visits

McLaren Health Plan's mission is to enhance our members' health status in the communities we serve by promoting:

- Preventive care and well-being
- Access to quality health services
- Strong relationships with our members, providers, and employers

In an effort to ensure that mission is followed, we encourage providers to consider all opportunities to perform a well child visit. This builds relationships, ensures access to care and contributes to the well-being of the member. When a member comes to your office, but doesn't receive preventive care, it results in a missed opportunity.

According to the National Committee for Quality Assurance (NCQA) and HEDIS®, infants (0-15 months) need at least 6 well-child visits per year, children (3-6 years) need at least 1 visit per year and adolescents (12-21 years) need at least 1 visit per year.

Make Every New Patient Visit a Well Child Visit

Consider performing a well child visit with each new patient visit. A new patient visit includes a health history, developmental history and physical exam. Adding health education and/or anticipatory guidance satisfies the requirements to qualify the visit as a well child visit.

No Wait Required for Birthdays or a Year between Well Child Visit

McLaren Health Plan pays for one well child visit per calender year for children 3-11 and adolescents 12-21. You do not have to wait for the member's next birthday and the visits do not have to be 12 months apart.

Turn a Sick Visit into a Well Child Visit

When you have a MHP member in your office for a sick visit who is also due for a well child visit, simply incorporate the elements of a well child exam into the visit, and bill MHP for both the sick and well child services performed. You can do this by adding modifier 25 to the sick visit and you will be reimbursed for both services.

Turn a Sports Physical into a Well Child Visit

Sports physicals include a health history, developmental history and physical exam. Adding health education and/or anticipatory guidance satisfies the requirements to qualify the visit as a well child visit.

Note: HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

National Lead Poisoning Prevention Week

Sunday, Oct 18, 2015 - Saturday, Oct 24, 2015

According to estimates from the Centers for Disease Control and Prevention (based on data from a 2003- 2004 national survey), nearly a quarter of a million children living in the United States have blood lead levels high enough to cause significant damage to their health. If high blood lead levels are not detected early, children with the high levels of lead in their bodies can suffer from damage to the brain and nervous system. They can develop learning and behavior problems (such as hyperactivity), slowed growth, hearing problems, and aggressive patterns of behavior.

National Lead Poisoning Prevention Week Aims to:

- Raise awareness about lead poisoning
- Stress the importance of screening the highest at risk children
- Highlight efforts to prevent childhood lead poisoning
- Urge people to take steps to reduce lead exposure

The problems caused by lead poisoning cannot be fixed until children are tested. **The State of Michigan requires all children on Medicaid be tested for lead poisoning at ages 12 and 24 months**. If you have any questions about your MHP children that need lead testing, please call your Network Development Coordinator at (888) 327-0671.

HEDIS 2016 - 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.

Measure	Commercial 2016	Medicaid 2016
Living With Illness		
Diabetes Care, HbA1c Testing	91%	89%
Diabetes Care, Nephropathy Screening	91%	92%
Diabetes Care, Eye Exam	53%	56%
Controlling High Blood Pressure	58%	61%
Taking Care of Women		
Breast Cancer Screening	73%	58%
Cervical Cancer Screening	72%	63%
Timeliness of Prenatal Care	72%	76%
Postpartum Care	85%	64%
Keeping Kids Healthy		
Childhood Immunization, Combo 2	77%	74%
Childhood Immunization, Combo 3	76%	67%
Well-Child Visits in 1st 15 months, 6+ Visits	71%	66%
Adolescent Well Care Visits	35%	46%
Blood Lead Level (on or before age 2)	N/A	92%
Access to Care		
Adult Access (age 20-44)	92%	83%
Children's Access to PCP (25 months - age 6)	90%	87%

2016 Primary Care Provider Access And Availability

The 2016 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 an astounding 33% return rate, with 842 surveys being returned!

Based on the survey results, MHPs PCP Access Standards exceeds our goal for 3 of the 4 standards:

Standard Type	Standard	Compliance	Comments
Urgent Care	Within 48 Hours	99%	1% received care within 7 days
Regular/ Routine Care	Within 14 Days	97%	3% received care within 30 days
Preventative Care/Physicals	Within 14 Days	82%	18% received care within 30 days
In-Office wait time	30 Minutes	96%	67% offices had <15 min wait time

Thank You to Our Providers: 2016 CAHPS Scores Show Increased Results

The Consumer Assessment of Health Plans Study (CAHPS) results are in. The CAHPS survey was sent to a random sample of MHP members asking them to rate their satisfaction with MHP and their health care experience. Their responses indicate they are very satisfied, specifically with:

- How well doctors communicate
- Getting care quickly
- Shared decision making
- Advising smokers to quit
- Rating of personal Doctor Specialist

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.

Flu Shots!

The time to administer flu shots is fast approaching. Flu shots are a covered benefit for our members when administered by a contracted MHP Provider. If your office does not supply flu shots, please call Customer Service at (888) 327-0671 for assistance in finding an In-Network location for your patients to receive their flu shots.

-Be reminded that infants should receive two (2) influenza vaccines between 6 and 24 months of age.

Managing Persistent Asthma

Help your persistent asthmatic patients to 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.

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 principle 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 dispensing events
- At least four asthma medication dispensing events

Description:	ICD-10 Diagnosis for asthma	
Asthma:	J45.20 - J45.22	J45.50 - J45.52
	J45.30 - J45.32	
	J45.40 - J45.42	

McLaren Health Plan offers a Disease Management Program for members with asthma. A Case Manager is assigned to help educate, coordinate and provide resources and tools to help members reach their health care goals. For more information call Customer Service at (888)-327-0671.

Health Risk Assessment (HRA): For all McLaren Healthy Michigan Plan (HMP) members, an HRA must be completed annually. As a McLaren Health Plan contracted Provider, you are eligible for the HRA $50 Provider Incentive! See below for 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.**

McLaren Health Plan Healthy Michigan Plan HRA Process:

- McLaren Health Plan will contact member to complete Sections 1-3 of the HRA
- The HRA will then be faxed to the PCP office for completion of Section 4 at the member's appointment
- If McLaren Health Plan is unable to reach the member prior to their appointment, the member receives a blank copy of the HRA in their New Member Packet or a blank copy of the HRA is available on our website 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 McLaren Health Plan at (877) 502-1567

Procedure Code	McLaren Health Plan Healthy Michigan Plan Incentive
99420	$50.00

For all of your assigned McLaren Health Plan Healthy Michigan Plan members who are seen for an appointment and have the 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 McLaren Health Plan, and you will receive a $50.00 payment for each HRA completed annually.
The completed, attested HRA and claim for services must be received by McLaren Health Plan within 30 days of the visit.

MQIC Guidelines

McLaren Health Plan 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 healthcare services. These guidelines may be found at http://www.mqic.org and on our website at http://mclarenhealthplan.org/medicaid-provide-guidelines-mhp.aspx. The MQIC guidelines are evidence-based and include both 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.

Please contact Customer Service at (888) 327-0671 with any questions regarding HEALTHY MICHIGAN

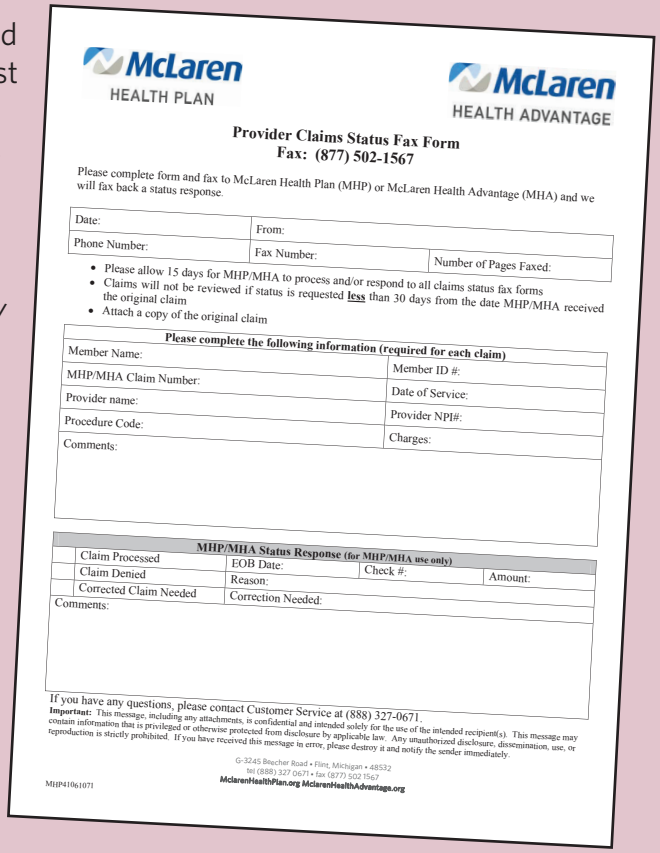
Claims Submission

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 Commercial - 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 all claims payment issues you may have, 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. Click on Providers/line of business/ Provider Materials to access the forms and instructions. If you have questions about the forms or need assistance, please call Customer Service at (888) 327-0671.



McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

Provider Claims Status Fax Form
Fax: (877) 502-1567

Please complete form and fax to McLaren Health Plan (MHP) or McLaren Health Advantage (MHA) and we will fax back a status response.

Date:	From:	
Phone Number:	Fax Number:	Number of Pages Faxed:

- Please allow 15 days for MHP/MHA to process and/or respond to all claims status fax forms
- Claims will not be reviewed if status is requested **less** than 30 days from the date MHP/MHA received the original claim
- Attach a copy of the original claim

Please complete the following information (required for each claim)	
Member Name:	Member ID #:
MHP/MHA Claim Number:	Date of Service:
Provider name:	Provider NPI#:
Procedure Code:	Charges:
Comments:	

MHP/MHA Status Response (for MHP/MHA use only)			
Claim Processed	EOB Date:	Check #:	Amount:
Claim Denied	Reason:		
Corrected Claim Needed	Correction Needed:		
Comments:			

If you have any questions, please contact Customer Service at (888) 327-0671.

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G-3245 Beecher Road • Flint, Michigan • 48532
tel (888) 327-0671 • fax (877) 502-1567
MclarenHealthPlan.org MclarenHealthAdvantage.org

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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 services you provided for a member, and you may not receive the appropriate payout for the performance incentives.

Helping your Medicaid Patients Quit Smoking

McLaren Health Plan (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 2015 Consumer Assessment Survey (which is a random sample of MHP adult members) indicates that of the members surveyed only:

- 75% indicated that a medical professional had advised them to quit smoking
- 43% were offered smoking cessation strategies
- 40% were offered medical assistance with smoking cessation

In addition, MHP is pleased to offer the Michigan Tobacco Quitline, in conjunction with the American Cancer Society. Eligible MHP members who are ready to quit smoking will receive help by calling the Quitline. MHP members can access the Quitline FREE of charge by calling (800) QUIT-NOW or (800) 784-8669. The program offers an initial readiness assessment, self-help materials and enrollment in telephonic counseling.

Smoking Cessation Information

McLaren Health Plan 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 that are ready to quit smoking will receive help by calling the Quitline. MHP Members can access the 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

If you wish to refer a MHP member to the Quitline, you can get a copy of the referral form at www.michigancancer.org/PDFs/MIProvidersTobaccoToolKit. The referring provider will receive information on the member's progress from Quitline.

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 PCP and get these necessary tests. All of the diabetic core measures are covered benefits for MHP members, including their annual diabetic eye exam. Listed below are the current HEDIS specifications for diabetes.

DIABETES

Comprehensive Diabetes Care (18-75 years)

2016 Measure	Quality Indicator
HbA1c Testing	Percent of members with one HbAlc test during year
HbA1c Poor Control (>9%)	Percent of members with HbA1c test higher than 9.0
HbA1c Good Control (> 8%)	Percent of members with HbA1c test lower than 8.0
Eye Exam: Retinal	Percent of members who have had an annual retinal exam performed by a vision provider in the measurement year, or have had a negative exam in the year prior
Medical Attention for Nephropathy	Percent of members who have had attention to the presence of nephropathy
Blood Pressure Control (<140/90 mm Hg)	Percent of members with acceptable BP <140/90 mm Hg

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 are 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 with written notification and the specific reason for the denial, as well as your 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 and service and existence of coverage. We do not specifically 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 (888) 327-0671 or (810) 733-9642 for more information.

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, McLaren Health Plan 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 members needs, and through ongoing communication, promotes access to services and improved health outcomes. The goal of McLaren Health Plan'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 to Case Management Form to Medical Management. The form is available on our website at MclarenHealthPlan.org.

Disease Management

McLaren Health Plan 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 us at (888) 327-01671

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.

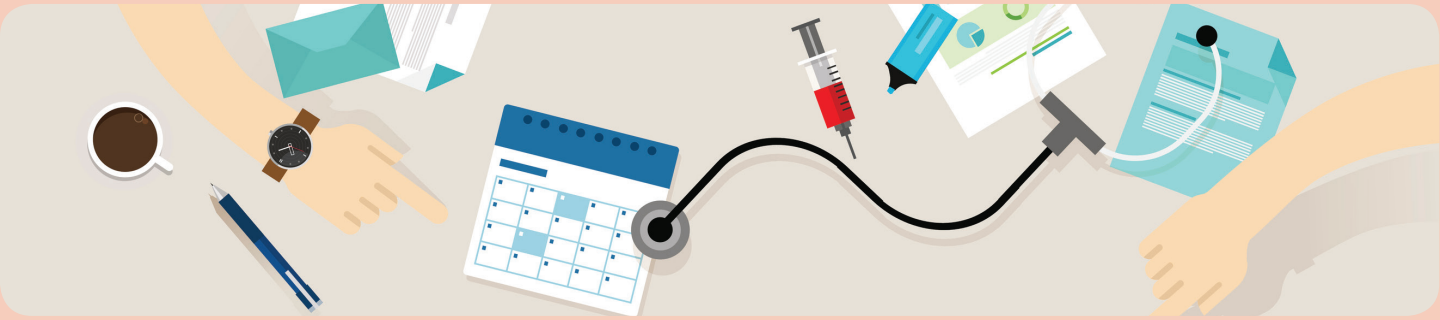
Behavioral Health and Substance Use Services for Medicaid Enrollees

As part of the McLaren Health Plan contract with the Michigan Department of Health and Human Services for Medicaid enrollees, the health plan is responsible for 20 outpatient mental health visits per year. The MDHHS is contracted with community mental health agencies (PIHPs) to provide specialized mental health and developmental disability and substance use services.

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; or
- Teaching self-administration of medication.

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



Assuring Better Child Health and Development (ABCD)

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, or 30 month visits

CPT	ICD	Category	Notes	Incentive
96110	Z13.4	Developmental Screenings	Screening tool completed by parent or non-physician staff and reviewed by the physician	$20.00 one per member (age 0-3) per year

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.

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 at (888) 327-0671.

Suggestions for successful practice implementation include the following:

- Utilize a standardized screening tool such as ASQ (which McLaren Health Plan 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 he 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 ir 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.

Michigan Department of Health and Human Services Provider Requirement

According to 42 CFR § 455.104, MDHHS does not allow McLaren Health Plan 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 McLaren Health Plan (MHP) provider network, credentialing is part of the process. This will help give you an overview of what that involves.

To join the MHP network as a new provider, the first thing you'll do is compete an enrollment application. MHP prefers that providers utilize the Council for Affordable Quality Healthcare®, or CAQH, to gather and coordinate the information needed for credentialing. If you do not already have one, you'll need to create a profile on CAQH ProView™. MHP is unable to complete the credentialing process without access to your CAQH profile. Then, we 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? Please make sure 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 being the credentialing process.
- New graduates can submit an enrollment form to us up to 60 days before you finish training.
- If you're relocating from out of state, you can submit your enrollment form to us 30 days before your start date.

More helpful information about CAQH ProView

- Be careful when choosing your primary specialty in CAQH ProView because your choice:
  - Determines whether you're designates as a primary care physician or specialist for managed care networks.
  - May affect the way claims are processes 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 Authorization for Release of Information form is signed within the past 12 months
- Your CAQH attestation must be updated at least 120 days, but 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 am-9pm and Friday 7 am-7 om (EST)
  - Phone: 1-888-599-1771
  - Email: providerhhelp@proview.cagh.org
  - Login site: https://proview.cagh.org/Login
- For questions regarding the Credentialing processes, please call (888) 327-0671, and ask to be connected to the Credentialing processes.

Re-Credentialing

MHP must process providers through re-credentialing 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 within initial credentialing, MHP will rely on the information provided in CAQH to re-credential providers, so it is critical that your re-attestations in CAQH occur at least every 120 days. This includes uploading a current, valid malpractice insurance face sheet in your CAQH profile.

Enrollment in PECOS for Medicare

Effective June 1, 2016 Medicare Part D prescription claims will only be covered if the Prescriber is enrolled in Medicare or has a valid opt-out affidavit on file with his/her Medicare Administrative Contractors (MAC).

To ensure that your patients' prescriptions continue to be eligible for coverage under the part D Plan, you must take one of the following steps to enroll:

- Enroll electronically through https://pecos.cms.hhs.gov/pecos
- Complete the application paper application, which is available at https://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html
- If you are a physician or eligible professional who wants to opt out for Medicare, you must submit an opt-out affidavit to the MAC for Michigan at www.wpsmedicare.com

Re-credentialing and MHP Providers

MHP uses the CAQH ProView™ for credentialing and recredentialing. At the time that a provider needs to be recredentialed, MHP collects the most current provider information from CAQH.

In order for this process to run smoothly, it is necessary for providers to review and re-attest to their CAQH profiles.

If you have not reviewed and re-attested to the CAQH information, MHP will contact you to update and re-attest to the information on your CAQH profile. It is imperative that you update CAQH whenever you have a change (demographics, liability coverage, settlement/sanction information). Even if there has not been a change, you should review and re-attest every 90-120 days.

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 50% of women actually receive this important screening. How does your practice assure all sexually active women between 16-24 years of age and sexually active men ages 16-18 years of age are screened fir Chlamydia.

- Is it assessed during an adolescent well exam?
- Is it included as component of annual Pap smear 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 screen.

Also, 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. Additional information can be found at the following MDHHS website: Michigan.gov/documents/mdch/EPTforChlamydia_and_Gonorrhea_Gudiance_for_Health_Care_Providers_494241_7.pdf

2016 Provider Incentives

Line of Business	Effective Date	Initiative	Incentive	How
Commercial/ Medicaid	Jan. 2016 Ongoing	Pay for Performance Program	PCMH Recognition and up to $2.00 ppm for eligible PCP assigned membership *Measures*: - Open Access - Adult Access -Well Child 3-4yrs -Mammogram Screening - E-Prescribing and Generic Prescribing Rates	Annual payout based on prior year's performance ,measures
Medicaid	Oct. 2011 Ongoing	Club 101	Reimburse $101.00 for well visits age 1-11	Based on billed claim
Commercial/ Medicaid	Jan. 2012 Ongoing	Expanded Access Award	99050 & 99051 reimburse $17.38	Based on billed claim
Medicaid	Aug. 2012 Ongoing	Lead Screening	36416 reimburses $15.00 83655 reimburses $ 25.00	Based on billed claim
Medicaid	Jun. 2013 Ongoing	Chlamydia Screening	$25.00 per eligible member screened	Based on billed claim
Commercial/ Medicaid	Jun 2013 Ongoing	Mammogram	$50.00 per eligible member screened	Based on billed claim
Commercial/ Medicaid	Oct. 2013 Ongoing	Diabetic Screenings 5 for $5.00	$5.00 per Diabetic core measure performed	Based on billed claim and report received
Healthy Michigan Plan	Apr. 2014 Ongoing	Healthy Michigan HRA	$50.00 per completed HRA for Healthy Michigan plan members	Based on billed claim and HRA received within 150 days of enrollment
Medicaid	Nov. 2014 Ongoing	Healthy Michigan 4 x 4	$5.00 for each test completed (BMI, BP reading, LDL and Glucose Level)	Based on billed claim and report received
Commercial/ Medicaid	Sept. 2015 Ongoing	Healthy Child Incentive	$15.00 Total Incentive ($5.00 for each annual component) Weight Assessment, Counseling for Nutrition and Physical Activity for Child/Adolescents	Based on billed claims, with appropriate codes
Medicaid	Jan. 2016 Ongoing	Adult BMI	$5.00 for each member	Based on billed claims
Medicaid	Jan. 2016 Ongoing	Developmental Screening	$20.00 per annual screening	Based on billed claims, with appropriate codes

What's on the Web

MHP utilizes our website 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 Directory Changes
- FACTSWeb

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

- Pharmaceutical Management Information & Procedures
- Drug Formulary (including a full Positive list)
- Pre-authorization Request Form
- Many Clinical Practice Guidelines About:
  - Asthma
  - Depression
  - 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
  - Welcome Packet
  - Newsletters
- Utilization Management
  - Criteria Availability
  - Denial Process
  - Incentive Statement
  - Referral Process

If you would like a printed copy of anything on the website, please contact Medical Management at (810) 733-9711 or call toll free at (888) 327-0671.

Electronic Health Records (EHR)

M-CETIA is Michigan's Federally-designated Health IT Regional Extension Center, and is dedicated to helping providers navigate the complex EHR marketplace by offering neutral and technical assistance throughout the adoption process. For more information on M-CETIA call (888) MICH-EHR or visit them at www.mceita.org.

Report Fraud, Waste, & 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 & 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 & 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, & 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:

McLaren Health Plan
Attn: Compliance Officer
G3245 Beecher Rd.
Flint, MI 48532

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

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

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
By telephone at: 1-855-MI-FRAUD (643-7283), or MDHHS-OIG@michigan.gov

ATTENTION

All McLaren Health Plan Providers and Office Staff

Annual CMS Required Training and Screening for Medicare Participation

Each year the Centers for Medicare & Medicaid Services (CMS) require all Medicare contracting organizations to disseminate certain documents to first tier, downstream and related entities (FDRs) and their employees who interact with our Medicare line of business. You are required to:

1. Take the CMS approved compliance-training module;
2. Review McLaren Health Plan's Compliance Program and Standards of Conduct; and
3. Screen your employees against the OIG and GSA lists of Excluded Individuals/Entities (LEIE) on a monthly basis.

Training:

If you are enrolled in Medicare Parts A and B, you have met the requirements of the Fraud, Waste and Abuse training but not the General Compliance Training requirement. This portion of the training begins on Slide 65. You can access the training on the MLN Training Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

A certificate of completion is on Slide 97. Complete the form and retain it as proof of completion.

Screening:

Make sure you retain proof of the monthly screening on each employee.

If you have any questions about training and screening requirements, call the Network Development at (888) 327-0671.