McLaren HEALTH PLAN

September 2017

Provider Newsletter

Partners in Health

In this Issue

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MCLAREN HEALTH PLAN MEDICAID PROVIDERS – CHAMPS ENROLLMENT REQUIREMENTS

All McLaren Health Plan (MHP) Medicaid contracted Providers must enroll and attest to their information within the state of Michigan's Community Health Automated Medicaid Processing System (CHAMPS). Effective Jan. 1, 2018, all Providers who provide and bill for Medicaid enrollees are required to be enrolled in CHAMPS. Failure to enroll in CHAMPS will result in denial of your claim.

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 "MDHHS" (top of page)
3. Click on "Health Care Providers" (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.

E-Prescribing Available for All Members

- MHP's Community and Medicaid formulary information are prescribed through surescripts
- McLaren Health Advantage (MHA) formulary information are prescribed through surescripts
- Take advantage of the benefits offered by e-Prescribing, such as:
  - Increasing patient safety and providing higher-quality care
  - Avoiding drug-to-drug, and drug-allergy interactions
  - Viewing patient medication history
  - Increasing office efficiency due to fewer phone calls and faxes

surescripts
How Healthcare Gets Connected™

Pharmaceutical Management Medicaid

MHP works collaboratively with Magellan Rx 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 Community Drug Formulary, which is utilized by our MHP Community and McLaren Health Advantage (MHA) membership.

MHP Drug Formularies have been developed and organized based on a preferred drug list that 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 copay). As a note, our Medicaid members do not have copays on formulary preferred medications covered under their MHP pharmacy benefits.

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 and the complete drug formularies. To locate either formulary resource or other pharmacy information, please visit McLarenHealthPlan.org. MHP's drug formularies can also be downloaded via Epocrates or surescripts (which is MHP's preferred e-Prescribing network).

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.

National Lead Poisoning Prevention Week

Sunday, Oct. 22, 2017 - Saturday, Oct. 28, 2017

Today at least 4 million households have children living in them that are being exposed to high levels of lead. There are approximately half a million U.S. children ages 1-5 with blood lead levels above 5 micrograms per deciliter (µg/dL), the reference level at which the CDC recommends public health actions be initiated.

No safe blood level in children has been identified. Lead exposure can affect nearly every system in the body. Because lead exposure often occurs with no obvious symptoms, it frequently goes unrecognized. CDC's Childhood Lead Poisoning Prevention Program is committed to the Healthy People 2020 goals of eliminating blood lead levels ≥ 10 µg/dL and differences in average risk based on race and social class as public health concerns. The program is part of the National Center for Environmental Health's Division of Environmental Health Services.

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 Customer service and ask for your Outreach Coordinator at (888) 327-0671.

HEDIS 2017 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 2017	Medicaid 2017
Living With Illness		
Diabetes Care, HbA1c Testing	90%	87%
Diabetes Care, Nephropathy Screening	91%	89%
Diabetes Care, Eye Exam	51%	58%
Controlling High Blood Pressure	66%	66%
Taking Care of Women		
Breast Cancer Screening	71%	63%
Cervical Cancer Screening	78%	57%
Timeliness of Prenatal Care	95%	86%
Postpartum Care	83%	64%
Keeping Kids Healthy		
Childhood Immunization, Combo 2	76%	79%
Childhood Immunization, Combo 3	76%	75%
Well-Child Visits in First 15 months, 6+ Visits	74%	64%
Adolescent Well Care Visits	37%	47%
Blood Lead Level (on or before age 2)	N/A	94%
Access to Care		
Adult Access (ages 20-44)	92%	82%
Children's Access to PCP (25 months- age 6)	87%	87%

2017 PRIMARY CARE PROVIDER ACCESS AND AVAILABILITY

The 2017 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 with 932 surveys returned!

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%	1% received care within 7 days
Regular/Routine Care	Within 14 Days	99%	1% received care within 30 days
Preventive Care/Physicals	Within 14 Days	90%	9% received care within 30 days
In-office Wait Time	30 Minutes	90%	46% offices had <15-min wait time

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 principal diagnosis of asthma

Asthma ICD-10 Diagnosis:	J44.9 – J44.1 J45.50 – J45.52 J45.30 – J45.32 J45.40 – J45.42 J45.901 J45.909

- 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

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.

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.

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:

- MHP will contact the member to complete section 1-3 of the HRA.
- If MHP is unable to reach the member prior to their appointment, 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.

Information About Your MHP Healthy Michigan Members

All Healthy Michigan members are required by the state of Michigan to complete a Health Risk Assessment (HRA), with their PCP within 90 days from their effective date and annually thereafter. As part of the HRA, the member must select a healthy behavior to work on throughout the year. The healthy behaviors can be one of the following:

- Increase physical activity, learn more about nutrition and improve diet and/or weight
- Reduce/quit tobacco
- Get an annual influenza vaccine
- Agree to a follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes
- Reduce/quit alcohol consumption
- Treatment for substance use disorder
- Other: explain

For doing your part we have a $50 MHP Healthy Michigan HRA Provider Incentive.

In order to receive your $50 MHP Healthy Michigan Plan HRA Provider Incentive, please follow the steps listed below:

- Complete the member's HRA as instructed above
- Fax the HRA back to MHP within 30 days of the member's visit
- Submit a claim to MHP with procedure code 96160, in addition to the services rendered. You will receive a $50 payment for each HRA completed annually.

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

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.

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.

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 2016 CAHPS Survey (which is a random sample of MHP adult members) indicated the following:

- 75% were advised by a medical professional to quit smoking
- 43% were offered smoking cessation strategies
- 40% 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

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

Diabetes

Comprehensive Diabetes Care (18-75 yrs of age)

2017 Measure	Quality Indicator
HbA1c Testing	Percent of members with one HbA1c test during year
HbA1c Poor Control (>9%)	Percent of members with HbA1c test higher than 9.0
HbA1c Good Control (>7%)	Percent of members with HbA1c test lower than 7.0
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
Statin Therapy for Patients (40-75 yrs of age) with Diabetes	Percent with diabetes who were identified as not having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year and percent who remained on statin medications of any intensity for at least 80% of the treatment period

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

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

In 2018 MHP will begin 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 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, 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.

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, and 30 month visits.

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

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 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.

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 being 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 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: https://proview.caqh.org/Login

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.

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% 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. Additional information can be found at the following MDHHS website: www.michigan.gov/documents/mdch/EPT_for_Chlamydia_and_Gonorrhea_-_Guidance_for_Health_Care_Providers_494241_7.pdf.

2017 Provider Incentive Programs

LINE OF BUSINESS	INITIATIVE	INCENTIVE	HOW
Medicaid	**Adult BMI**	$5 for each member, annually	Based on billed claim; Paid at time of submission
Commercial / 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
Commercial / Medicaid	**Diabetic Screenings 5 for $5**	$5 per Diabetic core measure performed	Based on billed claim and report received; Annual payout
Commercial / Medicaid	**Expanded Access Award**	99050 / 99051 reimbursed $17.38	Based on billed claim; Paid at time of submission
Commercial / 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	**Healthy Michigan 4x4**	$5 annually for each test completed: BMI, Blood Pressure Reading, LDL and Glucose Level	Based on billed claim and report received; Annual payout
Medicaid	**Lead Screening**	36416 reimburses $15 83655 reimburses $25	Based on billed claim; Paid at time of submission
Commercial / Medicaid	**Mammogram**	$50 per eligible member screened	Based on billed claim; Annual payout
Commercial / Medicaid	**Postpartum Visit for OB-GYN Providers**	$100 per eligible member	Based on billed claim and self-reported data; Quarterly payout
Commercial / 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	Annual payout based on prior year's performance measures

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
- FACTSWeb
- Provider Change Request Form

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
- 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
  - HEDIS manual

If you would like a printed copy of anything on the website, please contact Customer Service 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 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.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

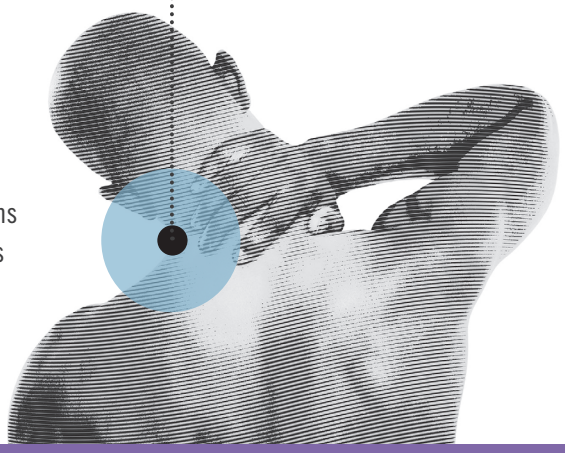
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

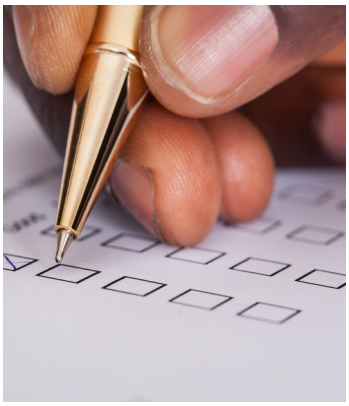
CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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

Working Together for Patient Satisfaction



The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey to evaluate patient satisfaction. The CAHPS survey is beneficial in improving the patients healthcare experience.

2016 responses indicate members are very satisfied!

Please encourage your patients to complete the survey. Below are a few questions that are included within the survey around patient care.

1. How well doctors communicate:
    - In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
    - In the last six months, how often did your personal doctor spend enough time with you?

2. Getting care quickly
    - In the last six months, when you needed care right away how often did you get care as soon as you needed?
    - In the last six months, how often did you get an appointment for a check-up, routine care, at a doctor's office or clinic as soon as you needed?

3. Getting needed care:
    - In the last six months, how often was it easy to get the care, tests or treatment you needed?
    - In the last six months, how often did you get an appointment to see a specialist as soon as you needed?

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 NETOWRK 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	Shantell Moore	shantell.moore@mclaren.org (810) 244-1667
Genesee, Huron, Lapeer, Saginaw, Sanilac, Tuscola	Amy Weigandt	amy.weigandt@mclaren.org (810) 733-9604
Oakland	Brittney Glasson	brittney.glasson@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