Partners In Health

Spring 2023

McLaren HEALTH PLAN

GROUP
INDIVIDUAL
MEDICAID
MEDICARE

"Partners in Health" is the newsletter for McLaren Health Plan physicians, office staff and ancillary providers. It is published twice per year by McLaren Health Plan Inc., which shall be referred to as "MHP" throughout this newsletter.

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FROM JODY LANDON

Vice President, Customer & Provider Services

There is a lot happening at McLaren Health Plan and I'm excited to share the news with you.

Effective April 1, the Provider Relations team will begin using a new software platform to manage provider and group demographics. This platform will optimize and connect data and internal teams, providing improved information to create our provider directories. These improvements to workflows will decrease delays in providing online data and help automate processes. You will be able to request a new contract, add or change provider demographics and change group information when needed through the user portal. More information will be available soon outlining how to access and use the portal.

The McLaren Health Plan website has recently been updated. The site has been optimized to make it easier to search for content, and "pillar" pages have been added for members, employers, agents and providers to organize content targeted to those audiences. We encourage you and your MHP patients to register on our portal for access to specific content by identification. Take a look at McLarenHealthPlan.org and send a note to your Provider Relations representative if you have any comments or questions.

Medicaid redetermination is happening and McLaren Health Plan is diligently working to educate its members about the process. Our goal is to retain every one of our members, either maintaining them in the Medicaid line of business or transitioning them into a Marketplace option with MHP. We are connected with the Michigan Department of Health and Human Services and have been notifying members to review their accounts in MiBridges to update their address and phone number to ensure they receive their redetermination information and can quickly respond when it is their time to renew. We are training Community Navigators and will have them available in our Flint and Lansing offices as well as in other locations throughout our communities to assist during the process. If your MHP members have questions about the Medicaid redetermination process, please have them call Customer Service at **888-327-0671 (TTY:711)** and we would be happy to help answer their questions.

Yours in good health,

Jody Landon

Vice President, Customer & Provider Services
McLaren Integrated HMO Group

CONTACT US

General Information About MHP's Departments and Services

Customer Service

888-327-0671 (TTY: 711)

Fax: 833-540-8648

Customer Service is responsible for assisting physicians, office staff, providers and members with questions. Representatives are available Monday through Friday from 9 a.m. to 6 p.m. Call if you have questions about:

- Transportation for MHP Medicaid and Healthy Michigan plan members
- Referrals
- Claims

MHP has **FREE** interpretation and translation services for members in any setting — ambulatory, outpatient, inpatient, office, etc. If MHP members need help understanding written materials or need interpretation services, call Customer Service.

McLaren CONNECT

If you have not yet registered for McLaren CONNECT, the provider portal, click here.

McLaren CONNECT replaces the Health Edge portal and FACTSWeb. McLaren CONNECT is a secure web-based system for all MHP lines of business that **allows you to:**

- Verify member eligibility
- View member claims and EOPs
- View and print member eligibility rosters*
- View and print member benefit information
- View a member's demographic information
- Contact the MHP provider team

Your provider TIN and NPI are required for the login process. Logins require your username and password each time, for your security.

*Member eligibility rosters are no longer mailed to primary care offices. Using McLaren CONNECT provides access to an up-to-date roster while eliminating the delay of sending a printed roster mid-month.

GetHelp.McLaren.org

Do you have patients who need help with food, education, housing, jobs or other "quality of life" situations? McLaren Health Plan offers an online program to assist members who need community-based services. Simply put a ZIP code and categories are listed with programs and services by location. There are thousands of resources to choose from, such as advocacy and legal aid, how to help pay for school, adoption and foster care services, tax preparation, mental health care, housing assistance and skills and training to enter or reenter the workforce, among much more! Let your patients know about GetHelp.Mclaren.org.

McLarenHealthPlan.org

MHP's website contains information about the plan's policies, procedures and general operations. You'll find information about quality programs; pre-authorization processes; health management and disease management programs; clinical and preventive practice guidelines; pharmaceutical management procedures; the pharmacy formulary; member rights and responsibilities; the provider complaint and appeal process and provider newsletters. **Visit often** for the most up-to-date news and information. If you would like a printed copy of anything on our website, please call Customer Service.

Interpretation and translation services are FREE to MHP members in any setting — ambulatory, outpatient, inpatient, etc. Oral interpretation services are available for people who are deaf, hard of hearing or have speech problems. If McLaren Health Plan members need help understanding MHP's written materials or need interpretation services, call 888-327-0671 (TTY: 711)

Provider Relations

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7979

The Provider Relations team is responsible for physician- and provider-related issues and requests, including contracting.

Provider Relations coordinators are assigned to physician or provider practices by county. Their services include:

- Orientations for you and/or your office staff to learn about MHP — how to submit claims, obtaining member eligibility or claims via the MHP CONNECT provider portal
- Reviewing provider incentives, quality incentives and program updates

If you have changes to your practice such as a new federal tax identification number, a payment address change or a name change, a new W-9 is required.

Current participating primary care physicians who wish to open their practices to new MHP patients can do

so at any time. Simply submit your request in writing, on office letterhead, to your Provider Relations coordinator, requesting to open your practice to new MHP members, and your representative will make the change.

For other changes, such as hospital staff privileges, office hours or services, address or phone number or on-call coverage, please contact your Provider Relations representative. Notification at least 30 days prior to any change is requested to allow time to make system changes.

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	Kylie Weidenhammer	kylie.weidenhammer1@mclaren.org 810-845-4782
Bay, Clare, Genesee, Gladwin, Huron, Lapeer, Midland, Saginaw, Sanilac, Tuscola	Evan Philburn	evan.philburn@mclaren.org 810-730-4906
Hillsdale, Jackson, Lenawee, Monroe, Washtenaw, Wayne	Dawn Dunn	dawn.dunn@mclaren.org 810-701-2182
Macomb, Oakland, St. Clair	Darrian Colborne	darrian.colborne@mclaren.org 248-804-7871
Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Mecosta, Montcalm, Shiawassee	Shantell Moore	shantell.moore@mclaren.org 517-512-5465
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

If you are uncertain of whom to contact, call us for the name of your representative.

Salesforce To Be Implemented

McLaren Health Plan will soon begin using a new software platform for managing provider and group demographics. This platform will feed our directories and will make vast improvements to workflows and decrease delays. Groups and providers will be able to request a new contract, add or change provider demographics and change group information when needed through the user portal. More information will be available soon outlining how to portal can be accessed and used.

Outreach Team

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7985

The MHP Outreach team is available to assist your office with scheduling your MHP commercial and Medicaid patients for preventive care visits and ancillary tests. The Outreach team can come to your office during the HEDIS® measurement year to provide chart review to assist in closing gaps in care.

Using Gaps in Care reports provided by MHP or by your office, the team can assist your staff by contacting and scheduling patients for these important visits.

By working together, we strive to achieve:

- Increased incentive payments
- Better patient outcomes when preventive services are provided
- Improved relationships among you, your patients and MHP

The MHP Outreach team is trained in several electronic scheduling

systems and can assist with in-office or off-site scheduling. During patient contacts, the Outreach team can assist your patients by:

- Discussing the importance of preventive care services
- Determining barriers to care and assisting with barriers, such as transportation

Call us and ask to speak to an Outreach representative if you are interested in working with the Outreach team. If you have medical records you want to send to Outreach Team for gap closure, fax directly to 810-600-7985 or email MHPQuality@mclaren.org.

Medical Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7959

Medical Management supports the needs of both MHP providers and members. Medical Management coordinates members' care and facilitates access to appropriate services through the resources of our nurse case managers.

Through case management services, nurses promote the health management of MHP members by focusing on early assessment for chronic disease and special needs and by providing education regarding preventive services. Nurses also assist the physician and provider network with health care delivery to MHP members. Nurses are available 24 hours a day, seven days a week and work under the direction of MHP's chief medical officer.

Call the Medical Management team for information and support with situations about:

- Preauthorization requests
- Inpatient hospital care (elective, urgent and emergent)
- Medically necessary determinations of any care, including the criteria used in decision-making
- Case management services
- Complex case management for members who qualify
- Disease management – diabetes, asthma, maternity care
- Preventive health education and community outreach support
- Children's Special Health Care Services (CSHCS)

Through its utilization management process, Medical Management is structured to deliver fair, impartial and consistent decisions that affect the health care of MHP members. Medical Management coordinates covered services and assists members, physicians and providers to ensure that appropriate care is received. Nationally recognized, evidence-based criteria are used when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling the Medical Management team.

If there is a utilization denial, the member and physician will be provided with written notification that will include the specific reason for the denial as well as all appeal rights. MHP's chief medical officer, or an appropriate practitioner, will be available by telephone to discuss utilization issues and the criteria used to make the decision.

Utilization decision-making is based solely on appropriateness of care and service and existence of coverage. MHP does not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to encourage decisions that would result in underutilization.

Case Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7965

Case management is offered to all MHP members. A case management nurse is assigned to each primary care office to assist you with managing your MHP members. The MHP nurses help manage medical situations and are a resource for identified issues. This enables a circle of communication that promotes continuity of care, the member's understanding of his or her health care, support for the primary care physician and the PCP office as the medical home.

MHP members are referred for case management services by physicians who identify at-risk patients. Complete a **Referral to Case Management form** found here. When MHP receives the form, a nurse begins an assessment of the member and identifies a proactive approach to managing the totality of the member's health care needs. The program focuses on preventive health management, disease management, general and complex case management and Children's Special Health Care Services (CSHCS) case management.

Program goals are to:

- **Empower** members to understand and manage their condition
- **Support** your treatment plan
- **Encourage** patient compliance

Preventive health management helps by:

- Informing members of preventive testing and good health practices

- Mailing reminders to members about immunizations, well-child visits and lead screenings
- Highlighting ways to stay healthy and fit in member newsletters
- Identifying members who are due for annual checkups and screenings and notifying PCPs of these patients
- Initiating call programs to assist members with scheduling annual checkups and screenings

If you do not know who your case management nurse is, please call Customer Service at 888-327-0671 (TTY: 711).

Complex Case Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7965

MHP has nurses trained in Complex Case Management (CCM). Members considered for CCM have complex care needs, including:

- Those listed for a transplant
- Ones who have frequent hospitalizations or ER visits
- Members with multiple health care conditions
- Are part of the Children's Special Health Care Services (CSHCS)

Virtual Case Management

Phone: 888-327-0671 (TTY: 711)

Fax: 810-600-7965

The Medical Management team at McLaren Health Plan has virtual case management services available for members. Using the "ZOOM for Healthcare" platform, case managers can connect with members on a personal level with face-to-face conversations while maintaining social distancing and the need for privacy.

Conversations about health maintenance, missed services - or services that are due - and other important health discussions can take place during these visits. Members currently receiving case

Improving the Quality of Kidney Care

About 37 million adults in the United States have chronic kidney disease (CKD) and 9 out of 10 people with CKD are unaware they are living with the disease. Early identification, regular monitoring and ongoing management or CKD are critical to slow disease progression and avoid kidney failure.

The National Committee for Quality Assurance created the **Kidney Health Toolkit** for use in improving the quality of care for patients with and at risk of CKD. This toolkit will equip you with tools that guide and facilitate strategies to promote kidney health.

The kit **includes** the following tools to help patients and their care teams navigate CKD diagnosis, monitoring and management:

- Let's Talk About Diabetes and Kidney Health: Ready-Set-Test: Provider guide on diabetes and CKD testing.
- Are Your Kidneys at Risk?: Patient infographic on CKD risk factors and testing.
- You've Been Diagnosed with Kidney Disease. Now What?: Patient pamphlet on understanding a CKD diagnosis and next steps.
- Chronic Kidney Disease: Talk, Listen, Learn: Patient and provider poster on how to talk about CKD.

Learn more by downloading the **Kidney Health Toolkit** today.

How to Help Manage Your Patients' Mental Health

There's no outward symbol to show the world when someone is dealing with mental health issues. People might be more accepting if they could "see" the condition and understand the person may be working with a doctor or behavioral health provider to improve his or her mental health.

Mental health includes emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

People from racial and ethnic minority groups are less likely to receive care for mental health. Among adults with mental illness, 48% of whites received care compared with 31% of Blacks and Hispanics and 22% of Asians. Suicide was the second-leading cause of death for Blacks and Hispanics ages 15-24.

People who are hospitalized for a mental health issue are more at risk for relapse, readmission and poor outcomes after being discharged. It's critical to have your patients follow up with you and a mental health provider within seven days of discharge.

Mental health resources are available for McLaren Health Plan members. Please have your patients call customer service at **888-327-0671 (TTY: 711)** for assistance or if they have barriers to receiving care.

- Cdc.Gov/MentalHealth
- Psychiatry.org
- 2021, U.S. Department of Health and Human Services Office of Minority Health, Mental and Behavioral Health

LEARN ABOUT THE MICHIGAN CHILD COLLABORATIVE CARE PROGRAM

The Michigan Child Collaborative Care (MC3) program provides psychiatry support to primary care providers in Michigan who are managing patients with behavioral problems. This includes children, adolescents and young adults through age 26. It also includes women who are contemplating pregnancy or are pregnant or postpartum with children up to a year. Psychiatrists are available to offer guidance on diagnoses, medications and psychotherapy interventions so that primary care providers can better manage patients in their practices. Support is available through same-day phone consultations to referring providers. Remote psychiatric evaluation through video telepsychiatry is also available. For more information, go to **Mc3.DepressionCenter.org**.

Screen Your Patients for Hepatitis C

The Michigan Department of Health and Human Services recommends screening for hepatitis C at least once in a lifetime for people **ages 18-79**. McLaren Health Plan covers the drugs used to treat hep C. Please make sure your eligible patients are screened for this contagious infection.

Help Available for Internet, Laptop Purchase for Your MHP Medicaid Patients

The Affordable Connectivity Program (ACP) is a government benefit program. It helps make sure certain households can afford the internet service they need for work, school, health care and more.

Eligible households get a discount of up to $30 per month toward internet service. There's also a one-time discount of up to $100 to purchase a laptop.

Who Is Eligible for the ACP?

A household is eligible if a member of the household meets at least one of the following:

- Has an income at or below 200% of the federal poverty guidelines
- Enrolled in programs like SNAP, Medicaid, federal public housing assistance, SSI, WIC or Lifeline
- Participates in Tribal-specific programs, such as Bureau of Indian Affairs General Assistance, Tribal TANF or a food distribution program on Indian reservations
- Receives free or reduced-price school breakfast or lunch
- Received a Federal Pell Grant during the current award year
- Is eligible for a participating provider's existing low-income program

If you think you have patients who qualify, have them visit **fcc.gov/acp** for more information.

Care Coordination and the Importance of Communicating With the PCP

The coordination of medical care is essential to a patient's overall state of health. MHP encourages physicians to communicate with each other when co-treating a patient, including for behavioral health issues. It is the responsibility of every treating provider to adequately inform the patient's PCP of all recommendations and medical treatment being proposed.

Communication among physicians and providers is one of the best ways to successfully treat a patient. The patient's primary care provider is the medical home for all health information regarding the patient's care. Consider this question: What does the PCP need to know to treat this patient in the safest and most efficient manner?

It's critical to have medical information relayed to the PCP by:

- Prompting patients to return to their PCP after a consultation or hospital stay
- Having specialists send summaries of recommendations to PCPs
- Providing communication from pharmacy data identifying polypharmacy to PCPs
- Notifying members of PCP terminations
- Improving the process for members to authorize sharing of behavioral health information with their PCPs
- Promoting the sharing of information by the PCP to the behavioral health specialists when coexisting medical and behavioral health conditions exist
- Providing behavioral health services in the primary care home

Credentialing with MHP

Here's how to avoid delays in the credentialing and re-credentialing process with McLaren Health Plan:

- Update and/or re-attest to your CAQH application at least every 120 days.
- Update your Authorization for Release of Information at least every 12 months and upload to CAQH.
- Ensure the address and contact information is correct for all practice locations.
- Leave no gaps in your most recent five years of work history section. If gaps greater than six months exist, document the reason, including the month or years and reason, e.g., leaves of absence, maternity leave, moves, etc.
- Ensure a current copy of your liability license is attached to your CAQH. After uploading a new copy to CAQH, check after three days to make sure it wasn't rejected.
- Provide a credentialing contact in case outreach is needed.

IMPORTANT: Failure to respond to requests from the MHP credentialing team could result in termination from the network due to incomplete documentation.

Provider Appeals and When To Submit a Request

Please allow McLaren Health Plan the opportunity to resolve issues before submitting an appeal. Contact Customer Service at **888-327-0671 (TTY: 711)** and ask for the Provider Team when a dispute occurs. If you continue to disagree with an action taken by MHP after informally attempting to resolve the dispute through a verbal contact or a provider claims adjustment, then a formal, written appeal may be submitted.

Supporting information (not previously submitted) regarding the reason and rationale for the appeal must be included with the appeal request. **This could include:**

- Additional medical records and/or office notes
- Diagnostic reports
- Operative notes or surgery reports
- Other information as applicable to the appeal request

You must have submitted a claim for the service in question and/or received a denial or reduction in payment from MHP before an appeal will be considered. An appeal form must be received within 90 calendar days of the disputed action. Disputed action dates are from the latter of the:

- Explanation of Payment (EOP)
- Original claim date of service
- Adjusted EOP
- Authorization decision

The right to appeal is forfeited if you do not submit a written request for an appeal within the 90-day time frame and any changes in dispute must be written off.

To submit a provider appeal request or provide appeal-related information, send to MHPAppeals@mclaren.org or fax to 810-600-7984.

The Provider Administrative Appeals form can be found **here.**

Lab Service Info for MHP Providers

If you perform lab tests in your office, you must demonstrate that you have a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. MHP has developed a list of laboratory services that are billable when performed in the office by both primary care providers and specialists. Please see the MHP In-Office Laboratory Billable Procedures form **here** for a list of CPT codes that are billable when performed in an office setting.

MHP uses Joint Venture Hospital Laboratories (JVHL) as our provider for laboratory services. JVHL has more than 400 phlebotomy locations, full-time courier service and 24/7 client support. For service center locations, the JVHL provider directory or other information, go to **Jvhl.org**.

The Importance of Communicating With Your Patients

Explaining things in a way that is easy for a patient to understand isn't always easy. It's especially important now that everyone is wearing masks. It's imperative that patients understand what you and your staff are telling them.

The annual Consumer Assessment of Health Plans Survey (CAHPS®) measures a member's overall satisfaction with his or her treating physician. Recent survey results reveal "How well doctors communicate" falls below the 75th percentile set forth by the National Committee for Quality Assurance.

Here are some tips to follow during the service encounter when communicating with your patients:

- Speak **slowly**
- Speak **loudly** enough to be heard through a mask
- Use **plain** language
- Make **eye contact**
- Use the patient's **name** during conversation
- Use **pictures**, if necessary
- **Encourage** your patients to ask questions
- **Repeat** the information back
- Always ask, "**Do you understand?**"
- **Ask** if the patient has been to an ER or urgent care or has seen a specialist since his or her last visit. Counsel if necessary.

Michigan Medicaid Eligibility Requirements To Reset Following Recent Federal Legislation

Beginning in June, Medicaid beneficiaries will need to renew their coverage as Michigan resumes Medicaid eligibility redetermination to comply with federal legislation.

During the COVID-19 Public Health Emergency, Congress enacted the Families First Coronavirus Response Act that required state Medicaid agencies to continue health care coverage for all medical assistance programs, even if a person's eligibility changed. Michigan's Medicaid caseload grew by more than 700,000 people during the pandemic. This requirement ended on December 29, 2022, under the federal Consolidated Appropriations Act of 2023 as the public health emergency drew to a close.

Last month, the Michigan Department of Health and Human Services announced all Michigan Medicaid beneficiaries will be required to **renew their coverage this year**. Renewals for traditional Medicaid and the Healthy Michigan Plan beneficiaries will begin in June 2023 and continue through May 2024. Monthly renewal notices will be sent three months prior to a beneficiary's renewal date. Residents who no longer qualify for Medicaid will receive additional information about other affordable health coverage options.

For full details on the renewal process, including information on how Michigan Medicaid beneficiaries can prepare, visit Michigan.gov. If you have any questions, contact your McLaren Health Plan Provider Relations representative or Provider Inquiry at **888-327-0671**.

Changes to Medicaid Dental Coverage

To help improve access to dental care and provider participation, the Michigan Department of Health and Human Services (MDHHS) will implement a new service delivery model for adult dental benefits effective April 1, 2023.

Medicaid beneficiaries ages 21 years and older, including Healthy Michigan Plan beneficiaries and pregnant women who are enrolled in an MHP, ICO or PACE, will receive dental benefits through the health plan. The health plan becomes responsible for the beneficiary's dental services on the enrollment effective date, and dental services must be obtained through the health plan's dental provider network. The new service delivery model replaces Healthy Michigan Plan and pregnant women dental benefits.

Questions regarding eligibility, prior authorization or the provider network should be directed to McLaren Health Plan.

- Dental services for Healthy Michigan Plan beneficiaries ages 19 or 20 years old, including pregnant women, will be provided by **McLaren Health Plan**.
- Dental services for beneficiaries who aren't enrolled in an MHP, ICO or PACE will be provided through the **Medicaid FFS program**.
- Dental services for Healthy Kids Dental beneficiaries under 21 years of age, including pregnant women, will be provided by **Healthy Kids Dental**.

Additionally, changes will be made to covered dental services for health plans, including the Healthy Kids Dental program, and FFS. Refer to the Dental chapter of the MDHHS Medicaid Provider Manual for additional coverage information and a list of covered procedure codes.

For more information, visit Michigan.gov and see bulletin MMP 23-13. If you have any questions, contact your McLaren Health Plan Provider Relations representative or Provider Inquiry at **888-327-0671**.

Medicaid Renewals Start Soon!

We need your assistance to educate all Medicaid clients about the upcoming Medicaid renewals starting in 2023. Providers are essential to how patients access care and receive information. To ensure you and your staff are able to assist patients with Medicaid renewals, we are providing you with the following talking points and how to locate a client's renewal/redetermination date with CHAMPS: Community Health Automated Medicaid Processing System

Talking points for Medicaid recipients:

- **Update contact information** — Make sure contact information is up to date in MI Bridges: Michigan.gov/MiBridges. This includes mailing address, phone number, email and other contact information. They will also be able to see their renewal date in MI Bridges.
- **Check your mail** — MDHHS will mail you a letter about your Medicaid or Healthy Michigan Plan coverage. This letter will also let you know if you need to complete a renewal form to see if you still qualify.
- **Complete you're renewal (if you get one)** — Fill out the form and return it to MDHHS right away to help avoid a gap in your Medicaid or Healthy Michigan Plan coverage.

Note: If someone loses Medicaid or Healthy Michigan Plan coverage, they have a limited time to apply and enroll in a Marketplace health plan. Tell them to visit LocalHelp.HealthCare.gov to get help from someone in their area. This service is free and can help the person better understand their health care options.

How To Find a Medicaid Clients Renewal Date:

1. Log in to MDHHS website: Michigan.gov/MedicaidProviders.
2. Select CHAMPS >> Eligibility and Enrollment tab.

Clinical Practice Guidelines Available To Assist with Decision-Making

McLaren Health Plan uses Clinical Practice Guidelines to assist practitioners and members with decision-making about appropriate health care for specific clinical circumstances. New and revised guidelines are developed and updated through collaborative efforts of the Michigan Quality Improvement Consortium (MQIC) and other evidence-based resources.

Clinical Practice Guidelines are distributed to practitioners to improve health care quality and reduce unnecessary variation in care. Documentation in your medical records should indicate you used the appropriate guideline in your practice decisions.

The Clinical Practice Guidelines were reviewed, updated and approved in September 2022 by our Quality, Safety and Satisfaction Improvement Committee.

Please review the guidelines found at MQIC.org. There is also a link on our website. Contact Medical Management at **888-327-0671 (TTY: 711)** if you have questions or would like a copy of the guidelines mailed to you.

MedImpact: PBM For All MHP Lines of Business

MedImpact is the pharmacy benefits manager for all McLaren Health Plan lines of business.

Pharmacy Prior Authorization

The appropriate pharmacy PA request forms are located at hyperlink here. Certain drugs have their own PA form. All new PA requests should be submitted directly to MedImpact. Please use the following dedicated MHP PA information when inquiring about and submitting PA requests:

MedImpact Prior Authorization Department

Electronic PA:
SureScripts.com/Enhance-Prescribing/Prior-Authorization

Phone: 888-274-9689

Retail/Specialty/Mail Order Pharmacy Network

CVS and Target pharmacies are out-of-network. For a complete list of our in-network pharmacies, go to here or call Customer Service at 888-327-0671 (TTY:711)

The MHP referred specialty pharmacy vendor for our Health Advantage and Community members is AllianceRX Walgreens Prime. These members may also use Karmanos Specialty Pharmacy.

AllianceRX Walgreens Prime

Phone: 888-282-5166

Karmanos Specialty Pharmacy

Phone: 833-577-4968 or 248-954-6820

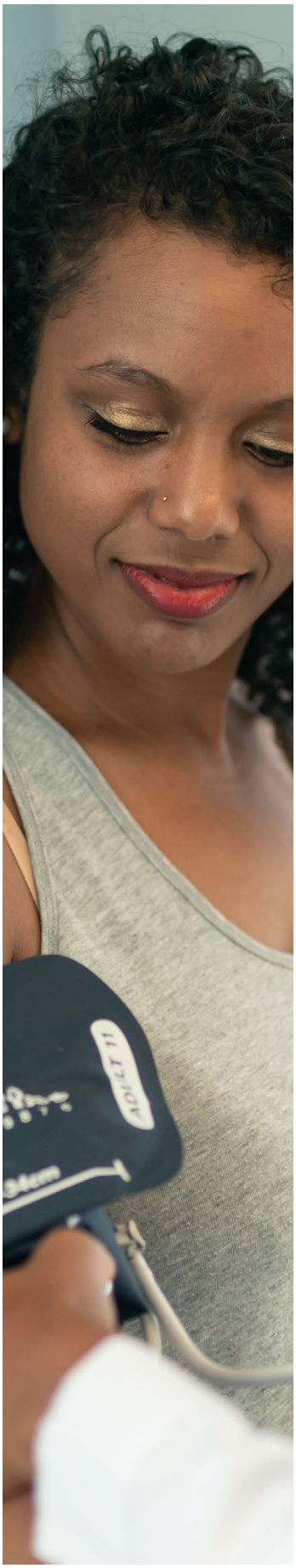
The MHP preferred mail-order pharmacy is **Birdi** (formerly MedImpact Direct). Contact Birdi if a patient expresses interest in having medications mailed to them.

Birdi

Phone: 855-873-8739

To contact a Birdi representative, please call 888-274-9689 or email customerservice@birdi.com

PCPs and Your Acceptance Status With MHP



MHP Community HMO, POS, Medicaid and Healthy Michigan members are assigned to a primary care provider upon enrollment. Every contracted PCP is listed as having an "open" acceptance status — accepting new patients — unless a request to close the practice has been made and approved.

Changing the accepting status of a practice requires six steps, completed in the following order:

1. If you are requesting an acceptance status change with MHP, you also must m be changing the acceptance status of your practice with all other health plans.
2. Create a letter on office letterhead that includes the following:
   - The **reason** for the request to limit members
   - **Attestation** that your practice is being closed to all other health plans
   - Anticipated **time frame** new enrollment is being limited
   - **Signature** of physician making the request
3. Mail the letter to your MHP Network Development coordinator:

   ATTN: <NAME OF NETWORK DEVELOPMENT COORDINATOR>

   McLaren Health Plan

   G-3245 Beecher Road

   Flint, MI 48532
4. The request is reviewed by the Network Development manager following verification of assigned membership to the PCP.
5. The Network Development manager will respond in writing to the PCP's request within two weeks, indicating approval or denial.
6. If approved, the request for the acceptance status change is effective 30 days from the date of approval and changes your acceptance status to "conversion only."

Once your acceptance status is "conversion only," PCPs are required to accept new MHP members whose enrollment was in process at the time of the acceptance status change and accept existing patients who switch from other plans to MHP.

There are exceptions to MHP's acceptance status policy, which are reviewed on a case-by-case basis. Special consideration may be made under the following circumstances:

- Exit of a partner in the practice
- Total volume of patient base in direct comparison with office space
- Leave of absence
- Provider agreement language

If a request for acceptance status change is approved by MHP, the length of the status change is limited to six months from the date of approval. After six months, the acceptance status will revert to "open" to accepting new MHP members.

Why It's Important To Refer To In-Network Providers

MHP Medicaid and MHP Community members must use providers who participate or are in-network with McLaren Health Plan for their health care needs. Go here or call Customer Service at **888-327-0671 (TTY: 711)** if you need information about in-network providers when referring a member.

MHP members with Point-of-Service (POS) plans have an Option B benefit that allows self-referral and the use of nonparticipating/out-of-network providers. These members will have higher copays and/or deductibles and will be responsible for any balance bill from a nonparticipating/out-of-network provider. Some Option B benefits require plan preauthorization regardless of the network status of the provider. Call Customer Service if you have referral, authorization or benefit questions.

Understanding the MHP Referral Process

Authorization or referral? Outpatient or inpatient? In-network or out-of-network? How do you know which CPT codes require an authorization from McLaren Health Plan, and when? You can view a list of CPT codes that require an authorization when provided in the outpatient setting at here.

The list is reviewed quarterly and may be revised and updated as appropriate.

These codes also require an authorization when performed in the inpatient setting or at an out-of-network facility. All services and/or procedures billed to MHP must be both medically necessary and coded appropriately. MHP reviews paid claims to ensure compliance and accuracy.

We have two versions of the MHP Request for Preauthorization form. The fillable PDF form is available for you to download, print and return to us by mail or fax and is located on our website at McLarenHealthPlan.org. If you'd like to scan it and email it to us, send it to MHPAuthsandCharts@mclaren.org. There's also an option to complete the form and submit it directly from our website. Go to McLarenHealthPlan.org. Print a copy of the completed request for your patient's records.

MHP is committed to the philosophy of the primary care provider as the patient's care coordinator and the medical home for its members. Ongoing coordination of care remains the responsibility of the PCP. MHP continues to educate its members about the importance of discussing all health care needs with their PCPs.

Are You Using MCIR?

The Michigan Care Improvement Registry, or MCIR, is an important tool that records and tracks immunization history and can help ensure that vaccines are not missed.

The secure website, **MCIR.org**, includes immediate patient immunization history, due dates, 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 and MCIR send reminder notices to your patients encouraging them to receive immunizations. Among the reminders being sent are ones for the 11-12- and 13-year-olds in your practice who may be easy to overlook when it comes time to think about immunizations. The CDC recommends all preteens need HPV vaccination so they can be protected from HPV infections that cause cancer. Encourage your patients to receive these important immunizations, and then submit the information to MCIR.

VACCINE	AGE
Human Papillomavirus Vaccine (HPV)	11-13 years old (3 doses) OR 2 doses at least 6 months apart
Meningococcal (MCV)	11-13 years old
Tetanus, Diphtheria, Pertussis (Tdap)	11-13 years old

Vaccine source: cdc.gov

Turn a 'Sick Visit' Into a 'Well-Child' Visit and Increase Your Reimbursement

Health screenings play an important part in a child's life. MHP encourages parents of young children to **schedule well-child visits** to make sure their kids are **up to date on immunizations** and are **meeting milestones** for growth and development.

Families get busy and many times they see the doctor only for sick visits. But did you know you can easily turn a sick visit into a well-child visit? When you have an MHP member in your office for a sick visit who also is 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.

Telehealth visits are a covered benefit and can be used for gap closure for well visits.

Well-child visits must include physical, mental, developmental, hearing and vision components and other tests to detect potential problems.

Bill age-appropriate well-child codes as indicated below. When these services are provided to an MHP Medicaid member, MHP reimburses you at a higher rate than the Medicaid fee schedule. MHP will reimburse you for one well-child visit per patient each calendar year. You do not have to wait a full calendar year to perform a well-child visit.

AGE	NEW PATIENT	ESTABLISHED PATIENT
Early Childhood (1-4 years)	99382	99392
Late Childhood (5-11 years)	99383	99393
Adolescent (12-17 years)	99384	99394

HOW TO GET FREE LEAD TESTING SUPPLIES FOR YOUR OFFICE

PCPs can earn an incentive when performing a lead test for MHP Medicaid Members.

Lead is a poison that affects virtually every system in the body. It is particularly harmful to young children. Very severe lead exposure in children (blood lead >= 70 ×g/dL) can cause coma, convulsions and even death. Lower levels can cause adverse effects on the central nervous system, kidney and hematopoetic system. Blood lead levels as low as 5 ×g/dL are associated with decreased intelligence and impaired neurobehavioral development. Other effects begin at these low blood lead levels, including decreased growth, decreased hearing activity and decreased ability to maintain a steady posture.

All children should be lead tested by their second birthday. PCPs can perform an in-office blood lead screening during a well-child visit and are eligible to receive **FREE** lead testing supplies from the State of Michigan. The kits are to be used for children receiving Medicaid benefits. MHP will assist you in obtaining the free kits.

You'll get:

- All the supplies and instruction needed to complete the lead scree test
- Prepaid envelopes to mail test samples

For MHP Medicaid members:

When using the lead screening kits from MDHHS, submit a claim to MHP with CPT code 36416 — which indicates the lead sample was obtained and sent for testing — and you'll earn a $15 incentive.

Of if you have the capability to perform the actual lead test and receive an immediate result, submit a claim to MHP with CPT code 83655 — which indicates the lead sample was obtained and tested — and you'll earn a $25 incentive.

Call your MHP Outreach representative at **888-327-0671 (TTY: 711)** if you need information about obtaining the lead testing kits or if you would be interested in hosting a lead clinic.

The Flint Registry is a project that connects people to services and programs to promote health and wellness.
It was created to help understand how the Flint water crisis has affected the Flint community. If you have patients who lived, worked or attended school or day care between April 25, 2014, and Oct. 15, 2015, at any address serviced by the Flint water system, have them register at FlintRegistry.org.

FLINTREGISTRY
Get Connected. Get Supported. Get Counted.

Assuring Better Child Health and Development (ABCD)

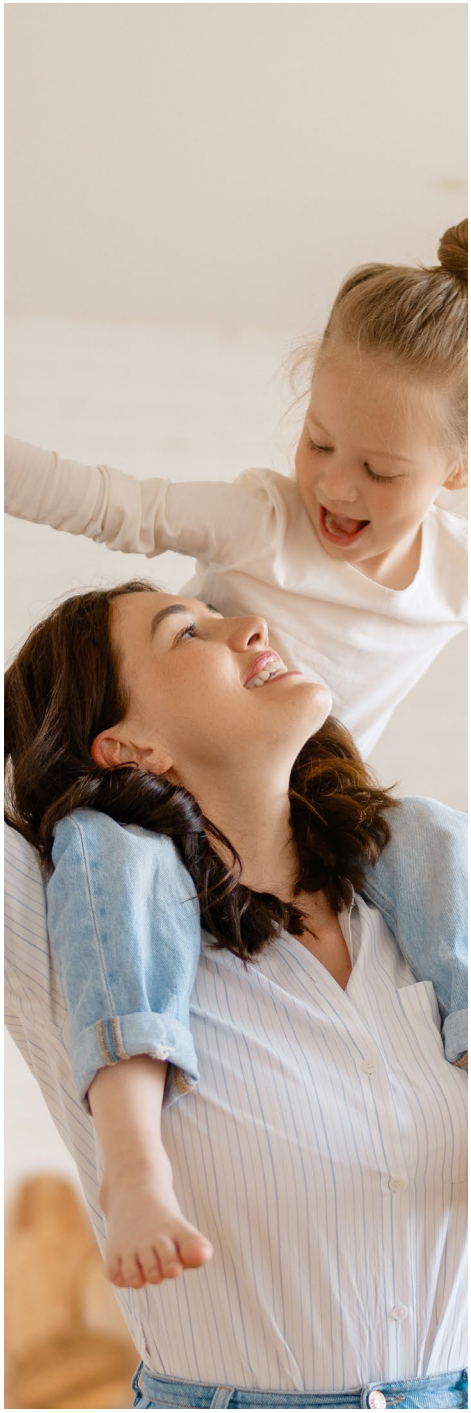
Developmental screening should be included at every well-child visit and can be billed in addition to the well-child visit (see below). It is recommended that standardized developmental screening tests be administered at the 9,18,24 or 30-month visits.

The Michigan Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy requires developmental surveillance and 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 into your office** to be compliant.

For our contracted MHP network practitioners, MHP purchased the rights to the ASQ screening tool. If you would like a copy of this material, please contact your Network Development coordinator at **888-327-0671 (TTY: 711)**.

Suggestions for successful practice implementation include the following:

- Use a **standardized screening tool**, such as ASQ.
- **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-month (or 24-month) visits.
- **Discuss** any developmental concerns with the child's parents.
- **Refer** children to Michigan's Early On program if developmental delays* are found. You can make the referral online at 1800EarlyOn.Org or call the statewide line at **800-EARLY ON (327-5966)**.



CPT CODE	ICD CODE	CATEGORY	NOTES	INCENTIVE FOR MEDICAID MEMBERS (AGES 0-3 YRS.)
96110	Z13.4	Developmental Screenings	Screening tool completed by parent or non-physician staff and renewed by the physician	$20 (one per member per year)

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

HEDIS - Measuring the Quality of Care

McLaren Health Plan supports care that keeps members at optimum levels of health while also controlling costs and meeting government and purchaser requirements. MHP is accredited by the National Committee for Quality Assurance (NCQA) Health Plan Accreditation, which builds upon more than 25 years of experience to provide a current, rigorous and comprehensive framework for essential quality improvement and measurement. It bases results on consumer experience and clinical performance, which is **HEDIS®** (Healthcare Effectiveness Data and Information Set), the most widely used set of performance measures in the managed care industry. HEDIS measures performance in health care where improvements can make a meaningful difference in people's lives.

Key Impact Areas for 2023

MHP's team of dedicated professionals will work with you to educate members about resources available to them to improve key impact areas in the HEDIS measures for 2023:

- Prevention and screening
- Respiratory conditions
- Cardiovascular conditions
- Diabetes
- Musculoskeletal conditions
- Behavioral health
- Care coordination
- Overuse/Appropriateness

- Measures collected through Medicare Health Outcomes Survey
- Measures collected through the CAHPS Health Plan Survey
- Access/Availability of care
- Experience of care
- Utilization
- Risk-adjusted utilization
- Health plan descriptive information
- Measures reported using electronic clinical data systems (ECDS)

To become accredited, MHP submits claims and medical review data to NCQA. Many HEDIS measures may include only a small number of your patients due to a continuous enrollment requirement of the specifications and a sampling of the eligible population.

Other measures can be calculated only by administrative results (claims data submitted by you, the practitioner) and some measures are calculated through a combination of claim submissions and medical record review.

A summary table and the HEDIS provider manual can be found here, or call MHP's Quality Management team at **888-327-0671 (TTY: 711)** for more information.

New HEDIS Measures

The newest additions to HEDIS address pediatric dental care, safety and appropriateness, diabetic care and social needs screenings and interventions.

- **Oral Evaluation, Dental Services (OED).*** Medicaid members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider **Intent:** Good oral health is a vital component of a child's overall health, and oral examinations are important to prevent disease, reverse disease processes, prevent progression of caries and reduce incidence of future lesions. This measure will allow plans to understand if their pediatric members are receiving dental care and to work toward improving access and utilization of dental evaluations.
- **Topical Fluoride for Children (TFC).*** Medicaid members 1-4 years of age who received at least two fluoride varnish applications. **Intent:** Dental caries is the most common chronic disease in children in the United States. Topical fluoride plays an important role in preventing tooth decay. This measure will allow plans to understand if their pediatric members are receiving fluoride varnish applications and to promote fluoride varnish treatments for their younger members.

- **Deprescribing of Benzodiazepines in Older Adults (DBO).**** Medicare members 67 years of age and older who were dispensed benzodiazepines who achieved a U20% decrease reduction in benzodiazepine dose **Intent:** The 2019 American Geriatrics Society Beers Criteria recommend that benzodiazepines be avoided in older adults. Clinical guidelines recommend deprescribing benzodiazepines slowly and safely, rather than stopping use immediately, to minimize withdrawal symptoms and improve patient outcomes. With this deprescribing measure, there is an opportunity to promote harm reduction by assessing progress in appropriately reducing benzodiazepine use in the older adult population.
- **Emergency Department Visits for Hypoglycemia in Older Adults With Diabetes (EDH).** For Medicare members 67 years of age and older with diabetes (types 1 and 2), the risk-adjusted ratio of observed to expected emergency department (ED) visits for hypoglycemia: ED visits for hypoglycemia, stratified by dual eligibility.
  - **For all members 67 and older** with diabetes (types 1 and 2), the risk-adjusted ratio of O/E ED visits for hypoglycemia during the measurement year, stratified by dual eligibility.
  - **For a subset of members 67 and older** with diabetes (types 1 and 2) who had at least one dispensing event of insulin within each six-month treatment period from July 1 of the year prior to the measurement year through December 31 of the measurement year, the risk-adjusted ratio of O/E ED visits for hypoglycemia, stratified by dual eligibility.
  - **Intent:** Older adults are more likely to experience severe hypoglycemia (low blood sugar), leading to fall-related events and fractures, increased risk of cardiovascular events and cognitive decline. Clinical practice guidelines for the treatment of older adults with diabetes emphasize prevention of hypoglycemia and encourage avoidance of intensive glycemic control. Health plans have an opportunity to identify their older patients with diabetes who are at highest risk of hypoglycemia and to implement appropriate interventions to prevent it.
- **Social Need Screening and Intervention (SNS-E).** Members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
- **Food Screening.** Members who were screened for food insecurity.
- **Food Intervention.** Members who received a corresponding intervention within one month of screening positive for food insecurity.
- **Housing Screening.** Members who were screened for housing instability, homelessness or housing inadequacy.
- **Housing Intervention.** Members who received a corresponding intervention within one month of screening positive for housing
- **Transportation Screening.** Members who were screened for transportation insecurity.
- **Transportation Intervention.** Members who received a corresponding intervention within one month of screening positive for transportation insecurity. Intent: NCQA developed this measure as part of an organization-wide effort to advance health equity and encourage health plans to assess and address the food, housing and transportation needs of their patient populations. Health plans can identify specific needs and connect members with the resources necessary to address unmet social needs.

Changes To Existing HEDIS Measures

- **Adult Immunization Status (AIS-E).** NCQA revised this measure to align with the new pneumococcal vaccination guidelines released by the Advisory Committee on Immunization Practices. NCQA also added stratifications for age and race and ethnicity.

Cross-Cutting Topics

- **Race/Ethnicity Stratification. NCQA** is continuing its work to identify and reduce disparities in care. NCQA introduced race and ethnicity stratifications to eight additional HEDIS measures: Immunizations for Adolescents, Asthma Medication Ratio, Follow-Up After Emergency Department Visit for Substance Use, Pharmacotherapy for Opioid Use Disorder, Initiation and Engagement of Substance Use Disorder Treatment, Well-Child Visits in the First 30 Months of Life, Breast Cancer Screening and Adult Immunization Status. NCQA plans to continue expanding the race and ethnicity stratifications to HEDIS measures over the next several years to help identify disparities in care among patient populations. This effort continues to build on NCQA's existing work dedicated to advancing health equity in data and quality measurement. To learn more about what NCQA is doing on this important topic, click **here**.
- **Gender-Affirming Approaches to Measurement**. To ensure that HEDIS measures appropriately acknowledge and affirm member gender identity, NCQA has revised measures that reference pregnancy or deliveries to remove the limitation to women. This change does not impact the intent or value sets of impacted measures but simply acknowledges that pregnancy and childbirth are not experienced exclusively by individuals who identify as women. This change will reduce the likelihood that transgender members are inadvertently excluded or inappropriately included in a measure due to gender identity. Moving forward, NCQA intends to explore additional opportunities to transform HEDIS measures to be more inclusive and affirming of sexual and gender minority members.
- **Optional exclusions are now required exclusions.** For consistency across measure reporting programs, and with digital measures, all optional exclusions will become required exclusions beginning in MY 2023.

Electronic Clinical Data Systems (ECDS) Reporting

- NCQA will allow voluntary ECDS reporting for the **Cervical Cancer Screening measure**.
- This year NCQA retired the administrative-only reporting method for the **Breast Cancer Screening measure**; only the ECDS reporting method will be used for this measure.

Retirement

NCQA is retiring the following measures:

- **Annual Dental Visit (ADV)**. This measure focused on access to dental care, rather than quality of dental care. This measure was replaced by the Oral Evaluation, Dental Services and Topical Fluoride for Children measures for MY 2023.
- **Frequency of Selected Procedures (FSP).** This measure summarized the frequency of select clinical procedures. During a recent review, that contribute to small sizes for individual reporting categories. it was found that this measure had low utility and was burdensome for plans to report. The measure's validity was also questioned due to the number of stratifications
- **Flu Vaccinations for Adults Ages 18-64 (FVA)**, Flu Vaccinations for Adults Ages 65 and Older (FVO), Pneumococcal Vaccination Status for Older Adults (PNU). These CAHPS Health Survey measures have been retired from HEDIS. The expansion of the age range in the Adult Immunization Status measure will ensure that the clinical data regarding vaccination status is captured across all age groups that had been represented in these measures.

PCPs: Review Your 'Gaps in Care' Reports

Gaps in Care reports are sent to MHP primary care physicians (PCPs) to identify services that have not been completed for assigned membership based on current HEDIS specifications. Rates are now measured using race and ethnicity. Eliminating health disparities is essential for providing equitable care to all members.

Reports are closed when a member receives the service and a claim has been billed to MHP. If you find you've billed a service but your report shows it outstanding, please contact the MHP Quality Management team at **810-733-9669** or MHPQuality@mclaren.org to confirm receipt of claims or to discuss why the claim(s) didn't meet the gap closure.

You can supplement claims data by faxing medical records for the following measures to MHP at **810-600-7985**.

- Adult BMI
- Child BMI and nutrition and physical activity counseling
- Diabetes care — HbA1c testing, nephropathy testing and eye exams
- Chlamydia testing
- Breast cancer screening and any possible exclusion
- Cervical cancer screening and any possible exclusion

If you have any questions, call Customer Service at **888-327-0671 (TTY: 711)** and ask for the Quality Management team.

Report Social Determinants of Health When Identified During Patient Visits

Social determinants of health (SDoH) are conditions in the places where people are born, live, learn, work, worship and play that affect a wide range of health risks and health outcomes.

There are ICD-10 codes that can be submitted with claims to help MHP identify members who have SDoH. **These code categories include:**

Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Either submit SDoH codes with claims or make a referral to MHP's case management program.

Office of Disease Prevention and Health Promotion, October 11, 2018, Healthy

MHP Aims To Improve Members' Health With Free Programs and Services

McLaren Health Plan has the following programs available in which you can enroll members by calling 888-327-0671 (TTY: 711). Members may also self-refer and can exit the programs at any time.

Upon enrollment, members receive educational mailings, ongoing nurse contacts and pharmacy management, where applicable.

Taking it Off — MHP nurses help both adults and children who want to lose weight. Members receive:

- Educational materials mailed to their home upon their request
- Phone calls to offer support
- Coordination with their PCP

McLaren Moms — Upon enrollment, pregnant members receive a $10 gift card and are entered into a quarterly drawing for an iPad or a Pack 'n Play if they receive timely care after their baby is born. A nurse talks to members; members receive information about pregnancy self-care, how to take care of the baby and the baby's growth and development. Other topics covered include:

- A flu shot is the best protection from illness for mother and baby.
- Quit smoking and do not drink alcohol
- Check with your doctor to make sure you take your current medications while pregnant.
- Go to all your prenatal visits; these are very important to track the health of you and your baby.
- See your doctor within six weeks of having a baby.
- Dental coverage is available during pregnancy and up to three months after delivery.

Stop Smoking Quit Line — MHP members can call 800-784-8669 for free counseling. You also can counsel and bill for stop-smoking services as the PCP using 99406 – Smoking and tobacco-use cessation counseling, Intermediate > 3-10 minutes or 99407 – Smoking and tobacco-use cessation counseling – Intensive > 10 minutes

Communicate the hazards of smoking, vaping and tobacco use at each visit. Several prescription medications are available that are covered benefits for MHP members.
Call 888-327-0671 (TTY: 711) for details.

Diabetes and Asthma Management Programs — MHP has nurses who understand diabetes and asthma. They work with members to help them understand their diabetes or asthma and provide them with support. These nurses will keep you informed of your members who are enrolled in the programs. Members receive:

- Support from a nurse so they know the best ways to manage their condition and assess their health status
- Newsletters with the most up-to-date information about diabetes or asthma
- Materials that will help them understand and manage their medicine and plan visits to their doctor

Down with Hypertension — Members are enrolled if their doctor diagnoses them with high blood pressure. All identified members will be mailed information about the program. MHP's pharmacists and nurses offer support by phone.

Eyes Wide Open — Members are enrolled if their doctor diagnoses them with depression.

Quarterly iPad Drawing — Every quarter, MHP randomly chooses an entry form from all eligible participants age 50 or older who get a mammogram.

Case Management/Complex Case Management — Every MHP member has a case management nurse who helps coordinate the care and services necessary to stay healthy and improve health. This nurse helps with difficult health problems and connects members with community support services.

HOW TO INCREASE COLORECTAL SCREENING RATES IN YOUR PRACTICE

Created by clinicians for clinicians, the following toolbox can help improve colorectal cancer screening in actual practice. It provides state-of-the-art science information, advice to help make screening practices more efficient and tools for use in the practice. Also available in a web-based format at **Nccrt.org/Resource/Crc-Clinicians-Guide/.**

A shorter version of the toolbox above, this brief guide pulls together the most important material from the full action plan, including charts, templates and sample materials that clinicians can use. As with the guide above, the tools are applicable to all types of clinical screening. Go to **Cancer.org/Content/Cancer/en/Health-Care-Professionals/Colon-md.html.**

Help Prevent Fraud, Waste and Abuse

McLaren Health Plan works hard to prevent fraud, waste and abuse. We follow state and federal laws about fraud, waste and abuse. **Examples of fraud, waste and abuse by a member include:**

- Changing a prescription form
- Changing medical records
- Changing referral forms
- Letting someone else use his or her MHP ID card to get health care benefits
- Resale of prescriptions

Examples of fraud, waste and abuse by a doctor include:

- Falsifying his or her credentials
- Billing for care not given
- Billing more than once for the same service
- Performing services that are not needed
- Not ordering services that are medically necessary
- Prescribing medicine that is not needed

Call MHP's Fraud and Abuse line at **866-866-2135** if you think a doctor, other health care provider or member might be committing fraud, waste or abuse. You can email MHP's Compliance department at MHPcompliance@McLaren.org. You also can write to MHP at:

McLaren Health Plan, Inc.

Attn: Compliance

P.O. Box 1511

Flint, MI 48501-1511

Contact the State of Michigan if you think a member has committed fraud, waste or abuse. **Here's how**:

- Fill out a fraud referral form at Mdhhs.Michigan.gov/Fraud OR
- **Call** the MDHHS office in the county where you think the fraud, waste or abuse took place OR
- **Call** the MDHHS office in the county where the member lives

Contact the Michigan Department of Health and Human Services Office of Inspector General if you think a doctor or other health care provider has committed fraud, waste or abuse. **Here's how:**

- Call them at **855-MI-FRAUD (855-643-7283)** OR
- Send an email to MDHHS-OIG@michigan.gov OR
- Write to them at **Office of Inspector General**, P.O. Box 30062, Lansing, MI 48909

Here's What MHP Tells Its Members

You might be the target of a fraud scheme if you receive medical supplies that you or your doctor did not order.

Take action to protect your benefits:

- Refuse medical supplies you did not order
- Return unordered medical supplies that are shipped to your home
- Report companies that send you these items

Identity theft can lead to higher health care costs and personal financial loss. **Don't let anybody steal your identity.**

Current fraud schemes to be on the lookout for include:

- People using your health plan number for reimbursement of services you never received
- People calling you to ask for your health plan numbers
- People trying to bribe you to use a doctor you don't know to get services you may not need

You are one of the first lines of defense against fraud. **Do your part and report services or items that you have been billed for but did not receive.**

- Review your plan Explanations of Benefits (EOBs) and bills from physicians
- Make sure you received the services or items billed
- Check the number of services billed
- Ensure the same service has not been billed more than once

Do Your Part!

- Never give out your Social Security number, health plan numbers or banking information to someone you do not know