



HEALTH PLAN

mclarenhealthplan.org

Partners In Health

June 2026

CONTENTS

2. Customer Service

4. Provider Relations

6. Care Management

8. Postpartum Depression

10. Hospitalizations and re-hospitalizations

11. Provider Data Attestation: Better Doctor

12. Quality Quick Tips

16. Population Health Management Annual Summary Calendar Year 2025

24. Provider Availability and Member Access to Care

26. Authorization Changes

Introduction

Welcome to McLaren Health Plan's Partners in Health newsletter. This is a monthly communication that will be sent out via email and posted on our website at [mclarenhealthplan.org/mclaren-health-plan/provider-communications](https://www.mclarenhealthplan.org/mclaren-health-plan/provider-communications).

If you would like to be added to our email distribution list to stay up-to-date on McLaren Health Plan's (MHP) processes and policies, learn about McLaren Health Plan community participation and sponsored events, Link directly to other online resources, and to receive this newsletter via email, please visit our [website](#).

Customer Service

Phone: 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:

<https://www.mclarenhealthplan.org/mhp/mclaren-connect.aspx>

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.

McLarenHealthPlan.org

MHP's website contains information about the plan's policies, procedures and general operations. You'll find information about quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the pharmacy formulary, member rights and responsibilities, the provider 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)

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 in 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; skills and training to enter or re-enter the workforce, among much more! Let your patients know about www.gethelp.mclaren.org.

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 representatives 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 initiatives 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 representative, requesting to open your practice to new MHP members and your representative will make the change.

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.

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

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 care managers.

Through care 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 Medical Director.

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

- Preauthorization requests <https://www.mclarenhealthplan.org/mhp/referral-request-form-mhp1>
- Inpatient hospital care (elective, urgent and emergent)
- Medically necessary determinations of any care, including the criteria used in decision making
- Care management services
- Complex care management for members who qualify
- Disease management – diabetes, asthma, depression, Sickle Cell, hypertension, Hepatitis C, maternity care, CKD, Obesity, HIV/PrEP
- 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 – which will include the specific reason for the denial – as well as all appeal rights. MHP's Medical Director, 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 which would result in under-utilization.

Clinical Criteria is available on our website here: <https://www.mclarenhealthplan.org/mclaren-health-plan/medical-necessity-and-clinical-criteria-mhp-link>

Care Management

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

Fax: 810-600-7965

Care management is offered to all MHP members. A care 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 their health care, support for the primary care physician and promotes the PCP office as the medical home.

MHP members are referred for care management services by physicians who identify at-risk patients. Complete a Referral to Care Management form found:

<https://www.mclarenhealthplan.org/Uploads/Public/Documents/HealthPlan/documents/Provider%20Forms/Referral%20to%20Case%20Management.pdf> . 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 care management and Children's Special Health Care Services (CSHCS) care management.

Program goals are:

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 care management nurse is, please call Customer Service at 888-327-0671 (TTY: 711).

Complex Care Management

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

Fax: 810-600-7965

MHP has nurses trained in Complex Care Management (CCM). Members considered for CCM have complex care needs including, but not limited to:

- 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)

Tobacco Cessation:

McLaren Health Plan has a tobacco cessation program for our Medicaid and Community members. We have partnered with smokefree.gov and Quitlogix by National Jewish Health to assist our members in tobacco cessation. Our Nurse Care Managers support your McLaren Health Plan patients in their tobacco cessation efforts. Members receive support from their nurse to make sure members know the best ways to stop tobacco use and materials to help members understand tobacco cessation and tobacco cessation benefits. Members are eligible to join the tobacco cessation program if they are a tobacco user. Members are enrolled in the program as a benefit of McLaren Health Plan. If members do not want to participate, they may opt out by calling us at 888-327-0671 (TTY: 711).

Mental Health

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

What is MC3?

The MC3 program offers psychiatry support prescribing outpatient health care providers in Michigan who are managing patients with behavioral/mental health concerns. This includes children, adolescents, young adults through age 26, and women who are contemplating pregnancy, pregnant or postpartum (up to one year).

Some services MC3 offers are available statewide, while others are available in select counties. Please visit [Services - MC3 - Michigan Clinical Consultation & Care](#) to learn more.

Prenatal and Postpartum Depression

The Prenatal and Postpartum Depression Screening and Follow-up Screening measure gauges health plans on the percentage of members who were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. The measurement standard is 5%. Commonly used screening tools include the Edinburgh Postnatal Depression Scale and the Patient Health Questionnaire-9 (PHQ-9). According to the American Academy of Pediatrics (2022) between 11 and 18% of Americans report depression symptoms after giving birth. This increases to 25% among low income parents. If not treated, depression can diminish parents' ability to bond with and provide care for their baby.¹ MHP encourages practitioners to screen their postpartum patients for depression and refer for treatment when needed.

Source: <https://www.aap.org/en/patient-care/perinatal-mental-health-and-social-support/integratingpostpartum-depression-screening-in-your-practice-in-4-steps/>

CDC Hear Her Campaign

Most Pregnancy Related Deaths are Preventable: Although deaths related to pregnancy are rare, too many people still die each year in the United States from complications due to pregnancy. Most of these pregnancy-related deaths are preventable. Recognizing the urgent maternal warning signs, getting accurate and timely diagnosis, Please consider referring to the CDC's Hear Her Program for resources you can post in your office such as Urgent Maternal Warning Signs (For more information on the Hear Her Campaign, visit <https://www.cdc.gov/hearher/maternal-warning-signs/index.html>)

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

Social Determinants of Health

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 six rates reported for the Social Need Screening and Intervention HEDIS measure. These include: food screening, food intervention, housing screening, housing intervention, transportation screening and transportation intervention. For more information, please visit our website here: [HEDISProviderManual.pdf](#)

Complete Core Measures for your Patients with Diabetes

McLaren Health Plan reminds its members with diabetes to regularly visit their PCP to have an annual check-up to be sure they are getting all necessary tests. All of the diabetic core measures included in these tests are covered benefits for McLaren Health Plan members, including their annual diabetic eye exams. Encourage your patients to get these necessary tests

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).

The SSD measure evaluates whether eligible patients (18-64 years old using antipsychotics without a diabetes diagnosis) received an annual diabetes screening (glucose or HbA1c test). Please assist MHP to reach our goals by completing the appropriate screenings.

Chlamydia Screening

According to the Centers for Disease Control and Prevention (CDC, 2021) Chlamydia testing is recommended as demonstrated below. McLaren Health Plan encourages our members to be screened for Chlamydia as recommended. Please join us in this effort.

Childbearing Persons	Pregnant Persons	Men who have sex with men	Trans Persons	Persons with HIV
Sexually active under 25 years of age	All under 25 years of age	At least annually for sexually active men at sites of contact regardless of condom use	Recommendations should be adapted based on anatomy	Sexually active screen at first HIV evaluation, and at least annually thereafter

Sexually active age 25 and older if at increased risk	Pregnant age 25 and older if at increased risk	Every 3-6 months if at increased risk	Consider screening at the rectal site based on reported sexual behaviors and exposure	More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology
Retest approximately 3 months after treatment	Retest during 3 rd trimester if under age 25 or at risk			
Rectal testing can be considered based on reported sexual behaviors and exposure	Test of cure 4 weeks after treatment and retest within 3 months			

<https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm>

Hospitalizations and re-hospitalizations

Reducing hospital readmissions has become a top priority in US healthcare reform (Dhaliwal & Dang, 2024). When patients are readmitted to the hospital in a short period of time, it may indicate suboptimal quality of care, inadequate education of the patient, and difficulties with the transition from hospital to home (Dhaliwal & Dang, 2024).

- Post-discharge follow-up. Your patients should see you as soon as possible after discharge (generally within 7 days)
- Medication reconciliation. Hospitals should check the patient’s medications and make sure they understand how and when to take them. Their doctor should also do this.
- Patient education. Your patient may need education on the reason for their hospitalization, the treatment they received, their treatment plan and what they should be watching for or doing after discharge.
- Address social needs. Does your patient need resources for food, housing, transportation or other things that may not be covered by their insurance? McLaren Health Plan can help. Advise your patient to contact McLaren Health Plan at (888) 327-0671 and ask for their nurse.

- Family involvement. Does your patient have family members or others helping them? Do their caregivers understand the discharge plans and post discharge care needs? Are the caregivers able to help with the things the patient needs?

Dhaliwal, J.S. & Dan, A.K. (2024). *Reducing Hospital Readmissions*. National Institutes of Health, retrieved from: <https://www.ncbi.nlm.nih.gov/sites/books/NBK606114/>

Provider Data Attestation: Better Doctor

McLaren Health Plan has partnered with Better Doctor (Quest Analytics) to gather data attestations quarterly as required by MDHHS, CMS, NCQA and other governing bodies. This process also helps ensure our directory information is accurate. Providers and offices will receive a communication every 90 days from Better Doctor asking to have a representative visit verify.betterdoctor.com and use the access code provided to confirm the demographic information MHP currently has in our systems for each practice. The process is simple and required for continuing participation with MHP.

The easiest way to attest is by sharing your provider roster each quarter with McLaren Health Plan at mhpproviderservices@mclaren.org and Better Doctor at rosters@questanalytics.com.

When providing a roster to your Provider Relations Representative, please copy Better Doctor in your email message and add rosters@questanalytics.com to your distribution list. Attesting or sharing your roster each quarter allows MHP to keep your information most up-to-date in our records, systems and provider directories while also properly documenting information for compliance and reporting purposes.

Failure to attest to your demographic information quarterly may result in being removed from the Provider Directory.

Quality Quick Tips

CAHPS

Consumer Assessment of Healthcare Providers and Systems (CAHPS) annually assesses McLaren Health Plan members about their perceptions and experiences with the healthcare system and providers they see. The goal of the CAHPS health plan survey is to provide performance feedback that is actionable and that will aid in improving members' overall experiences. Below are the results of McLaren Health Plan's CAHPS scores directly related to providers.

KEY CAHPS MEASURES - Medicaid	2023	2024	2025	Trend*	NCQA 75th
ADULT MEDICAID					
Getting Care Quickly	87.90%	81.90%	76.40%	↓	84.90%
Getting Needed Care	87.80%	81.00%	79.40%	↓	84.90%
How Well Doctors Communicate	92.10%	92.20%	91.30%	↓	94.30%
Coordination of Care	84.00%	84.50%	78.10%	↓	88.50%
Rating of Personal Doctor (9,10)	65.40%	60.90%	71.90%	↑	72.40%
Rating of Specialist Seen Most Often (9,10)	56.00%	74.70%	63.60%	↓	70.90%
Advising Smokers to Quit	72.00%	71.40%	68.50%	↓	77.10%
Smoking Cessation Strategies	46.50%	43.10%	43.00%	↓	50.10%
Medical Assistance with Smoking	50.30%	48.60%	51.20%	↑	56.60%

KEY CAHPS MEASURES - Medicare	2024	2025	Trend*	NCQA 75th
ADULT MEDICARE				
Rating of Health Care	57.10%	57.30%	↓	60.50%
Rating of Personal Doctor (9,10)	60.90%	71.90%	↑	72.40%
Rating of Specialist Seen Most Often (9,10)	74.70%	63.60%	↓	70.90%
Getting Needed Care	81.00%	83.00%	↓	84.90%

Getting Appointments Quickly	81.90%	76.40%	↓	83.80%
Care Coordination	84.50%	78.10%	↓	88.50%
Doctors Who Communicate Well	92.20%	91.30%	↑	94.30%
Ease of Filling Out Forms	95.70%	91.10%	↓	96.20%

KEY CAHPS MEASURES -Marketplace	2024	2025	Trend*	NCQA 75th
ADULT Marketplace				
Rating of Health Care	77.10%	79.30%	↑	79.00%
Rating of Personal Doctor (9,10)	90.40%	89.50%	↓	87.50%
Rating of Specialist Seen Most Often (9,10)	81.40%	85.80%	↑	87.10%
Getting Needed Care	76.20%	74.50%	↓	86.00%
Getting Care Quickly	76.30%	77.50%	↑	84.50%
Care Coordination	84.50%	85.10%	↑	86.90%
How Well Doctor's Communicate	93.90%	91.60%	↓	96.30%

TIPS TO IMPROVE

1. Use the Teach-Back Method. When educating your patients on a new concept, whether it be diet and exercise or how to administer their medications, have them tell it back to you. This way you will know if they understood what you are telling them. Be sure to use words easy to understand.
2. Promoting an environment that encourages improvements in patient-centered care should make patients feel more heard and understood. Which in turn, will make patients more satisfied with their care.
3. Understand the importance of Cultural Competence and awareness of the unique backgrounds that impact and enhance individual experiences in your practice.
4. You and your staff should be familiar with the CAHPS survey. Using verbiage from the survey when speaking with patients or their caregivers. This will help when they are filling out the survey to relate the question with what you discussed.

5. Remember to talk to your patients about tobacco cessation. MHP has a free tobacco cessation program for MHP Community and Medicaid members, call 800-784-8669 for more information.

If you have questions or would like more information, please email us at MHPQuality@McLaren.org.

Oral Health

Oral health is inextricably linked to overall health and is essential for healthy development and healthy aging. Children who have poor oral health often miss more school and have lower grades than children who have good oral health. As many as 90% of common diseases have oral symptoms and can be detected by a dentist during a routine exam. More than 120 symptoms of nondental disease can be detected through a routine oral exam. It's important to encourage your patients to obtain routine oral health care by their first birthday and then regularly thereafter in order to improve and maintain their overall health.

McLaren provides dental coverage for adult Medicaid members aged 21+, Healthy Michigan Plan members aged 19+, and pregnant women.

What's covered?

- Oral exams
- Sealants
- X-rays
- Screenings and assessments
- Extractions
- Root Canals
- Fillings
- Emergency Treatment
- Crowns
- Dentures

Some health conditions, such as diabetes, pregnancy, eating disorders and medications, can impact the patient's oral health. Please encourage your patients to take care of their oral health and obtain preventive oral screenings and treatments. You can also assist by becoming trained to administer and be reimbursed for oral health screenings and fluoride varnish services to your patients between the ages of 0-3 years. A helpful resource for Oral Health Practice Tools can be found through this link from the American Academy of Pediatrics: [Oral Health Practice Tools](#)

Your McLaren Health Plan patients can seek transportation assistance and get help finding a dental provider by calling 888-327-0671 (Monday - Friday 8:00 a.m. - 6:00 p.m.).

Lead Testing

Preventive screenings and anticipatory guidance all aid in the promotion of healthy lifestyles in children and adolescents. MDHHS and McLaren Health Plan encourages providers to recognize the new law requiring universal blood lead testing for all children under age 6. Children must be tested for lead at least once by their 1st birthday and again before age 2. For more information, go to www.michigan.gov/mileadsafe.

Are you patients at risk for lead poisoning?

Symptoms of lead poisoning can be silent and hard to recognize. Preventing lead poisoning before it happens is the best way to keep your patients safe. Asking parents the following questions can help determine if a child is at risk for lead poisoning:

- Does the child live in a home built before 1950 or have they lived in a home build before 1950 in the recent past?
- Does the child live in a home built before 1978 that was recently remodeled?
- Does the child have a brother or sister or playmate with lead poisoning?
- Does the child live with an adult whose job or hobby involves lead?
- Does the child's caregiver use home remedies that contain lead?
- Does the parent need advice about identifying and removing lead paint or remodeling their home? Refer to the Lead and Healthy Homes Section at 866-691-LEAD or www.michigan.gov/lead

Note: a lead risk assessment doesn't satisfy the blood lead test requirement for Medicaid patients, and all Medicaid beneficiaries are required to be tested regardless of the risk score or household zip code.

New requirements for blood lead testing of young children: By law, Michigan now requires blood lead testing for all children at 12 and 24 months, with additional testing based on exposure risk. It is the physician's responsibility to test or order the test

Tips & Best Practices

- Avoid missed opportunities by taking advantage of every office visit to provide lead testing
- Consider offering point of care testing if not already doing so
- Order lead testing at one year well visit or earlier and revisit at the 18-month visit
- Consider a standing order for in-office lead testing
- Educate parents about the dangers of lead poisoning and the importance of testing

- If patient is referred to a laboratory, implement a process for follow-up if order is outstanding after 30 days (sooner if the child’s second birthday is approaching within 30 days)
- Date of service and result must be documented with the notation of the lead screening test
- Lead test is considered late if performed after the child turns 2 years of age

For more information and coding details on these and all HEDIS measures, please see the McLaren Health Plan HEDIS Quality Toolkit at: <https://www.mclarenhealthplan.org/mclaren-health-plan/hedis-information>

Thank you for the quality care you deliver!

Prenatal and Postpartum Depression Screening

Perinatal depression is the most common complication of childbirth, affecting roughly one in seven patients, yet it frequently goes undetected because symptoms like fatigue and sleep disturbances are easily mistaken for normal parenthood exhaustion. Left untreated, it can lead to severe consequences, including poor prenatal self-care, disrupted maternal-infant bonding, and long-term psychiatric morbidity. To bridge this gap, clinical intuition must be replaced with universal, objective surveillance. Implementing brief, self-administered tools into routine clinical workflows ensures that all patients—regardless of background—are equitably evaluated, allowing providers to identify at-risk individuals before a mental health crisis occurs.

To standardize this care, the American College of Obstetricians and Gynecologists (ACOG, 2023) mandates a structured approach to surveillance. In its Clinical Practice Guideline No. 4: Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum, ACOG recommends that clinicians screen patients for depression and anxiety symptoms using a validated tool—such as the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire-9 (PHQ-9)—during the initial prenatal visit, at least once later in pregnancy and again during the comprehensive postpartum visit. However, because screening alone does not improve outcomes, a positive result must immediately trigger an institutional pathway of care that includes a formal diagnostic evaluation, safety assessment, and direct referral to behavioral health or reproductive psychiatry resources.

Population Health Management Annual Summary Calendar Year 2025

SDoH Screening and Referrals:

Measure	Members
Members eligible for screening	135,159

Members screened for all 3 domains*	18,837
Members with a positive need	9,606
Total members referred for services	2,987

Members that participate in additional in-person support services:

Service	Members
MIHP	464
CHW	See below
Health Promotion Events	21
Community Partner Events	38

CHW Referrals	Count
Average Monthly Assessments	531
Average Monthly Referrals	381
Average Percentage of Successful Referrals	98.62%
Average Monthly Social Service Referrals	358
Average % Successful Social Service Referrals	98.62
Average Monthly Referrals for Medical	23
Average % of Successful Medical Referrals	98.92

Changes in utilization:

2025

Top 10 DRGs By Frequency

DRG	DRGDESC	NoOfVisits2
6401	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	15,123
5601	VAGINAL DELIVERY	13,494
5602	VAGINAL DELIVERY	12,190
5401	CESAREAN SECTION WITHOUT STERILIZATION	7,002
7204	SEPTICEMIA & DISSEMINATED INFECTIONS	6,447

7203	SEPTICEMIA & DISSEMINATED INFECTIONS	5,977
5402	CESAREAN SECTION WITHOUT STERILIZATION	5,161
7202	SEPTICEMIA & DISSEMINATED INFECTIONS	4,714
6402	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	4,339
4202	DIABETES	2,923

2024

Top 10 DRGs By Frequency		
DRG	DRGDESC	NoOfVisits2
6401	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM Sev 1	1,828
5602	VAGINAL DELIVERY Sev 2	1,212
5601	VAGINAL DELIVERY Sev 1	1,068
6402	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM Sev 2	627
5401	CESAREAN DELIVERY Sev 1	485
5402	CESAREAN DELIVERY Sev 2	374
7203	SEPTICEMIA & DISSEMINATED INFECTIONS Sev 3	366
7204	SEPTICEMIA & DISSEMINATED INFECTIONS Sev 4	309
4202	DIABETES Sev 2	296
7202	SEPTICEMIA & DISSEMINATED INFECTIONS Sev 2	299

Vaginal delivery was the top reason for seeking care closely followed by sepsis.

2025

Top 10 Diagnoses By Frequency		
DiagCode4	Diagnosis4	NoOfVisits4
Z38.00	SINGLE LIVE INFANT DELIV VAGINALLY	17,933
A41.9	SEPSIS UNSPECIFIED ORGANISM	15,430
Z38.01	SINGLE LIVEBORN INFANT DELIV C-SECT	9,90113
O34.211	MAT CARE LW TRANS SCAR PREV C/S DEL	5,682
O48.0	POST-TERM PREGNANCY	4,562

E10.10	TYP 1 DM W/KETOACIDOSIS W/O COMA	4,190
J96.01	ACUTE RESPIRATORY FAIL W/HYPOXIA	4,145
J18.9	PNEUMONIA UNSPECIFIED ORGANISM	3,004
I21.4	NON-ST ELEVATION MYOCARDIAL INFARCT	2,724
J44.1	COPD WITH ACUTE EXACERBATION	2,714

2024

Top 10 Diagnoses By Frequency		
DiagCode4	Diagnosis4	NoOfVisits4
Z00.129	ENC RTN CHILD HLTH EX W/O ABNRM FIND	74,496
F41.1	GENERALIZED ANXIETY DISORDER	69,027
I10	ESSENTIAL PRIMARY HYPERTENSION	34,037
J06.9	ACUTE UP RESPIRATORY INFECTION UNS	33,522
F33.1	MAJ DEPRESS D/O RECURRENT MOD	32,510
Z00.00	ENC GEN ADULT EXAM W/O ABNORM FIND	30,929
G47.33	OBSTRUCTIVE SLEEP APNEA	30,705
R32	UNSPECIFIED URINARY INCONTINENCE	29,114
R07.9	CHEST PAIN UNSPECIFIED	26,269
F11.20	OPIOID DEPENDENCE UNCOMPLICATED	25,506

Sepsis was number one, followed by Type 1 diabetes for frequency for ER care.

2025

Top 10 ER Diagnoses By Frequency		
DiagCode10	Diagnosis10	NoOfVisits10
A41.9	SEPSIS UNSPECIFIED ORGANISM	738
E10.10	TYP 1 DM W/KETOACIDOSIS W/O COMA	310
J96.01	ACUTE RESPIRATORY FAIL W/HYPOXIA	225
J18.9	PNEUMONIA UNSPECIFIED ORGANISM	183
J44.1	COPD WITH ACUTE EXACERBATION	168
N17.9	ACUTE KIDNEY FAILURE UNSPECIFIED	152
I11.0	HTN HEART DISEASE W/HEART FAIL	144

K85.20	ALCHL INDCD ACT PANCRPTS WO NCRS/INF	113
I13.0	HTN HRT CKD W/HF STAGE 1-4/UNS CKD	110
I21.4	NON-ST ELEVATION MYOCARDIAL INFARCT	110

2024

Top 10 ER Diagnoses By Frequency

DiagCode10	Diagnosis10	NoOfVisits10
J06.9	ACUTE UP RESPIRATORY INFECTION UNS	5,031
R11.2	NAUSEA WITH VOMITING UNSPECIFIED	3,179
R07.89	OTHER CHEST PAIN	2,667
U07.1	COVID-19	2,458
B34.9	VIRAL INFECTION UNSPECIFIED	2,406
R07.9	CHEST PAIN UNSPECIFIED	2,404
R51.9	HEADACHE UNSPECIFIED	1,749
R45.851	SUICIDAL IDEATIONS	1,675
N39.0	UTI SITE NOT SPECIFIED	1,636

The main driver for medication utilization in 2025 is omeprazole.

Top 10 Medications by Frequency	
DrugName8	#Scripts8
OMEPRAZOLE	89,388
ATORVASTATIN CALCIUM	87,877
VENTOLIN HFA	75,190
IBUPROFEN	58,745
LEVOTHYROXINE SODIUM	57,134
HYDROCODONE-ACETAMINOPHEN	54,517
CETIRIZINE HCL	54,155

AMOXICILLIN	46,595
VITAMIN D2	46,445
LISINOPRIL	45,928

Outpatient CMHSP services:

Members jointly served by McLaren and PIHP	9400
High Needs	Adult – 233 Child - 118
Joint care plans McLaren and PIHP	212
Members served with direct CMHSP services	726
CMHSP Claim Count	5,876
CMHSP top service	90,834 (psychotherapy)
CMHSP top counties	Gratiot – 4,798 Ingham – 271 Genesee - 145

McLaren is committed to provide quality language services. Annually, we share population-level data on the language needs of the members we serve. McLaren uses data from MDHHS enrollment files for member language data. Data for October 2025 is reported as follows:

Languages	NoOfMembers26	%
English	221,870	98.5%
Spanish	1,659	0.7%
Arabic	813	0.4%
Swahili	248	0.1%

Your patients may qualify for additional benefits

Do you have patients who are disabled or potentially disabled? If so, McLaren Health Plan partners with Centauri Health Solutions® to help them. Supplemental Security Income (SSI) is for adults with little or no work history and children. Social Security Disability Insurance (SSDI) is for people who have a work history but can no longer work. Your patients may qualify for SSI or SSDI even if they get other disability benefits. Centauri Health Solutions® helps people to apply for these benefits. If you have patients who want to apply for these benefits and need help, advise them to contact McLaren Health Plan at 888-327-0671 (TTY: 711) and ask to speak with your nurse. The nurse will

gather a few pieces of information from the patient and contact Centauri Health Solutions® on their behalf. Someone from Centauri Health Solutions® will contact the patient to help them. At any time, they may decline or “opt out” of Centauri Health Solutions® services and be removed from their call lists.

Source: “Centauri Health Solutions®” (n.d.). *Who is Centauri?* [Brochure]

Protecting babies from HIV and Syphilis

All pregnant women should be tested for HIV, Syphilis, and other sexually transmitted illnesses (STIs) throughout their pregnancy. If a pregnant woman is found to be positive for either, it is important to protect the baby. HIV is a long-term disease that can damage the immune system. HIV cannot be cured, but it can be managed. Syphilis is a sexually transmitted infection that can cause serious health problems if not treated. Both infections can be passed to the baby during pregnancy and delivery. If you have pregnant patients, please recommend testing and discuss treatment options if the patient is positive. Pregnant women should be tested:

- At the first prenatal visit
- In the beginning of the third trimester (ideally at 28-32 weeks)
- At delivery, if appropriate (determined by the provider)

Source: Michigan Department of Health and Human Services. (n.d.). *It's Their Health Too HIV and Syphilis Testing During Pregnancy* [Brochure]

Benefits of Patient-Centered Medical Home Certification

McLaren Health Plan recognizes the critical importance of Patient Center Medical Home (PCMH) principles being incorporated into provider practices. PCMH certification enhances patient care, provider efficiency, and health outcomes by fostering a patient-centered approach seeking to improve care coordination and promote quality improvement. PCMH supports population health management using a variety of individual, organizational and cultural interventions to help improve the illness and injury burden and the health care use of defined populations.

PCMH increases effective communication, coordination and integration among primary care and specialty practices, including the appropriate flow of patient care information, and often provides clear definitions of roles and responsibilities.

Benefits to a provider practice becoming and maintaining PCMH designation also include:

- Lowering of overall cost of care
- Alignment with state/federal initiatives focusing on Value Based Care
- Improving access to care
- Increased chronic disease management.

- Reduction in the fragmentation of care
- Alignment with McLaren Health Plan's quality of care initiatives
- Increased provider practice satisfaction
- Improved patient experience

McLaren Health Plan accepts NCQA PCMH certification and Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP) designation for PCMH. We capture provider PCMH designation information and share with our members in our provider directories to assist those looking for a PCMH practice, specifically. For more information on PCMH and the accreditation process, please contact your Provider Relations Representative or Provider Services at (888) 327-0761 (TTY: 711).

Vaccines for Children Program (VFC)

The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Michigan providers have participated in VFC since 1995.

The success of this program is built upon the cooperation and collaboration of many agencies. Your participation is vital to increasing Michigan's immunization rates and ensuring all children are protected against vaccine-preventable diseases.

- Being a VFC provider is a sound investment in your practice and your patients. It reduces up-front costs by providing vaccines for VFC-eligible children. Your patients benefit by not having to go elsewhere for vaccines, and there's no charge to the provider.
- VFC providers work with their Local Health Department for support to ensure VFC requirements are followed per CDC and MDHHS guidelines.
- The LHD is a provider's main contact for VFC-related questions and can also offer additional support to improve vaccination rates and practices.

Do your providers participate in VFC? Let us know!

surveymonkey.com/r/mhp_vfc

McLaren Health Plan is capturing this information to include in our Provider Directory to assist members seeking vaccination treatment options for their children. For more information, visit Michigan.gov to access MDHHS' VFC Resource Guide MI VFC Provider Manual MI VFC Frequently Asked Questions VFC program: Vaccines for Uninsured Children, visit: cdc.gov

Provider Availability and Member Access to Care Requirements

McLaren Health Plan maintains standards and processes to ensure member access to care by contracted primary care physicians and participating specialists. Accessibility of services from providers is assessed during initial credentialing and each year thereafter for high-volume PCPs, high-volume and high-impact specialists, including but not limited to: OB-GYNs and oncology specialists, and high-volume mental health specialists through quality improvement site visit audits and surveys. The availability of physician access after-hours is also measured.

Providers are required to follow MHP's Access to Care appointment standards listed below to ensure health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, days a week to members.

The established monitoring standards are set as minimum guidelines of measurement. The following are the MHP Commercial, Marketplace, Medicaid/Healthy Michigan Plan and McLaren Medicare standards for PCP accessibility to members:

Type of Service	Standard
Emergency Services	Immediately 24 hours per day, 7 days per week
Urgent Care	Within 48 hours
Routine/Regular Care including preventive services (physicals)	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
In Office Wait Time	Patient seen within 30 minutes of time of their appointment
After-Hours Coverage (Information/advice is given to patients when medical care is needed after regular office hours)	100%

The following are the McLaren Health Plan Commercial, Marketplace, Medicaid and Medicare monitoring standards for high-volume and high impact specialty care provider accessibility to members:

Routine Specialty Care (non-urgent)	Within 6 weeks of request
-------------------------------------	---------------------------

Acute Specialty Care	Within 5 business days of request
----------------------	-----------------------------------

The following are the McLaren Health Plan Commercial, Marketplace Medicaid and Medicare monitoring standards for mental health (MH) provider accessibility to members:

Visit Type	Timeframe
MH Non-Life-Threatening Emergency	Within 6 hours of request
MH Urgent	Within 48 hours of request
MH Initial Visit for Routine Care	Within 10 business days of request
MH Follow-up for Routine Care	Within 45 business days of request

The following are the McLaren Health Plan Commercial, Marketplace, and Medicaid monitoring standards for prenatal care provider accessibility to pregnant members:

Visit Type	Timeframe
Initial prenatal appointment (Obstetrician, OB-GYN, PCP, certified nurse midwife, or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care)	If member is in first or second trimester: Within 7 business days of member being identified as pregnant.
	If member is in third trimester: Within 3 business days of member being identified as pregnant.
	If there is any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days.

Monitoring appointment access and timeliness

The information about monitoring appointment access applies to primary care, obstetrician-gynecologist, specialty and mental health practitioners. McLaren Health Plan conducts appointment access reviews annually. Reviews are conducted more frequently for practitioners who do not meet access standards.

McLaren Health Plan contacts the practitioner's office to determine access and records the next available appointment for each of the designated appointment types. Physician-specific member complaints related to access are also analyzed.

An annual evaluation and analysis is conducted by Provider Relations staff on the following:

- Primary care appointment availability for regular, routine and urgent care appointments

- Primary care after-hours availability
- Mental Health care appointment availability (a separate analysis is performed for Mental Health care providers who prescribe medication and those who do not prescribe medication)

As a reminder, providers must offer hours of operation that are no less than the hours of operation offered to commercial members, or hours of operation must be comparable to Medicaid fee-for-service office hours if the provider serves only Medicaid enrollees. McLaren Health Plan monitors for complaints to ensure providers offer and maintain hours of operations that are compliant with these expectations. Results are reported to the Quality Improvement committee.

MHP requires an 80 percent compliance rate for all access measures. Those providers who don't meet the 80 percent requirement will be notified and asked to submit a corrective action plan to MHP within 30 days. Failure to comply with this requirement may result in deparicipation.

If you have any questions, contact McLaren Health Plan Customer Service at 888-327-0761 (TTY: 711) for assistance or visit mclarenhealthplan.org.

Authorization Changes

For the most recent and upcoming authorization information, visit McLaren Health Plan's website at mclarenhealthplan.org and select the Provider tab.

- All changes and announcements are posted online at least 60 days prior to becoming effective.
- [Upcoming-Authorization-Changes.pdf](#)
- As of 6/1/2026, the following items/services are being added and require authorization. Please see the list on the website for specific codes:
 - All lines of business: Bariatric surgery
 - For all current prior authorization requirements, visit: [Prior Authorization Codes List](#)
 - For all current Medicare prior authorization requirements, visit: [Medicare Prior Authorization Information](#)

Please refer to the website for an updated authorization requirements list with effective dates of January 1, April 1, July 1, or October 1 of each year. Please also check back periodically for updates that may occur outside of these typical dates.

If you have any questions, please contact your Provider Relations Representative at 888-327-0761 (TTY: 711) for assistance.

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 2024 by our Quality, Safety, and Satisfaction Improvement Committee.

Please review the guidelines found at <https://www.mahp.org/michigan-quality-improvement-consortium/> or visit 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.

Fraud, Waste and Abuse

Health care fraud and abuse is both a state and federal offense. The HIPAA Act of 1996 indicates a dishonest provider or member is subject to fines or imprisonment of not more than 10 years, or both. In addition to fines, probation or incarceration, fraudulent or abusive activities may result in a denial, suspension or termination of the provider's license under the Michigan Public Health Code or similar action from Medicaid under the Michigan Social Welfare Act. MHP asks providers to partner with us to identify and eliminate fraud, waste and abuse.

What is Fraud, Waste and Abuse?

Fraud is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal and state law (42 CFR § 455.2).

Waste is the overuse of services or other practices that directly or indirectly result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

Abuse consists of provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or commercial health care program, or in reimbursement for services that are not medically necessary or that fail to meet

professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR § 455.2), or commercial health care program.

Examples of fraud, waste and abuse include:

- Billing more than once for the same service
- Billing for services never performed or provided
- Performing inappropriate or unnecessary services
- Providing lower-cost or used equipment and billing for higher-cost or new equipment
- Using someone else's identity altering or falsifying pharmacy prescriptions