McLaren HEALTH PLAN

mclarenhealthplan.org

Partners In Health

September 2025

CONTENTS

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.

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 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.

Provider Relations Representative Territory POD Assignments

ORANGE POD
REP II Manager, Kelly Short (Interim)
Work Cell: 810-733-9664
Kelly.Short@mclaren.org

REP I Bev Hude (light orange)
Work Cell: 517-803-7509
Beverly.Hude@mclaren.org

REP I Kylie Weidenhammer (dark orange)
Work Cell: 810-845-4782
Kylie.Weidenhammer1@mclaren.org

PROVIDER RELATIONS

Phone: 888-327-0671
Fax: 810-600-7979

Visit the McLaren CONNECT provider portal at mclarenhealthplan.org to view your claim status and verify member eligibility.

BLUE POD
REP II Manager, Kelly Short (Interim)
Work Cell: 810-733-9664
Kelly.Short@mclaren.org

REP I Darrian Colborne (light blue)
Work Cell: 248-804-7871
Darrian.Colborne@mclaren.org

REP I Jessica Kline (dark blue)
Work Cell: 810-493-1044
Jessica.Kline@mclaren.org

GREEN POD
REP II Ken Axtell
Work Cell: 517-490-2626
Ken.Axtell@mclaren.org

REP I Dawn Dunn (light green)
Work Cell: 810-701-2182
Dawn.Dunn@mclaren.org

REP I Mary Clinton (dark green)
Work Cell: 810-733-9632
Mary.Clinton@mclaren.org

McLaren HEALTH PLAN

MCL20230501 | Rev.7/2025

Danielle Devine Named Market President at McLaren Health Plan

Danielle Devine was named Market President at McLaren Health Plan after the retirement of Nancy Jenkins, president and CEO.

Devine brings more than 13 years of progressive leadership experience to McLaren Health Plan, across both the public and private sectors. She previously held a variety of leadership roles with Meridian Health Plan, serving as the primary liaison to the Michigan Department of Health and Human Services and as Meridian's representative to the Michigan Association of Health Plans.

Following the sale of Meridian, Devine was recruited as a founding partner at Apexhealth, where she led the launch of a Medicare Advantage plan.

Devine served in an advisory role in the Michigan Senate, helping to shape its health care agenda and drive forward bipartisan policy solutions. She also served in a Government Relations role at Corewell Health, where she led the organization's state-specific health system advocacy strategy, aligning public policy initiatives with organizational priorities.

Devine holds a Bachelor of Science in Health Care Administration from Grand Valley State University. A proud Michigan native, Danielle is known for her strategic foresight, operational acumen and ability to lead with clarity and conviction. She is passionate about delivering results, building high-performing teams and leading organizations to achieve meaningful impact.

Welcome, Danielle!

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
- 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.

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 at 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).

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

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:

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

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.

Post Partum Depression

The 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/integrating-postpartum-depression-screening-in-your-practice-in-4-steps/

Electronic Prior Authorization Requirement

Effective December 31, 2025, all authorization requests for Commercial lines of business must be submitted electronically through McLaren's CONNECT provider portal. The CONNECT provider portal allows providers to submit requests for prior authorization through JIVA, the preferred method of sending authorizations to McLaren Health Plan.

Out of network users must register and create a new account to access the portal by completing an Out of Network Provider Request Form at mclarenhealthplan.org and submitting it to mhpproviderservices@mclaren.org with an updated W-9. Completed forms and W-9 may also be faxed to: 810-600-7979. As a reminder, incomplete submissions will delay access to the portal or claims payment.

Providers can access McLaren CONNECT portal here: Login

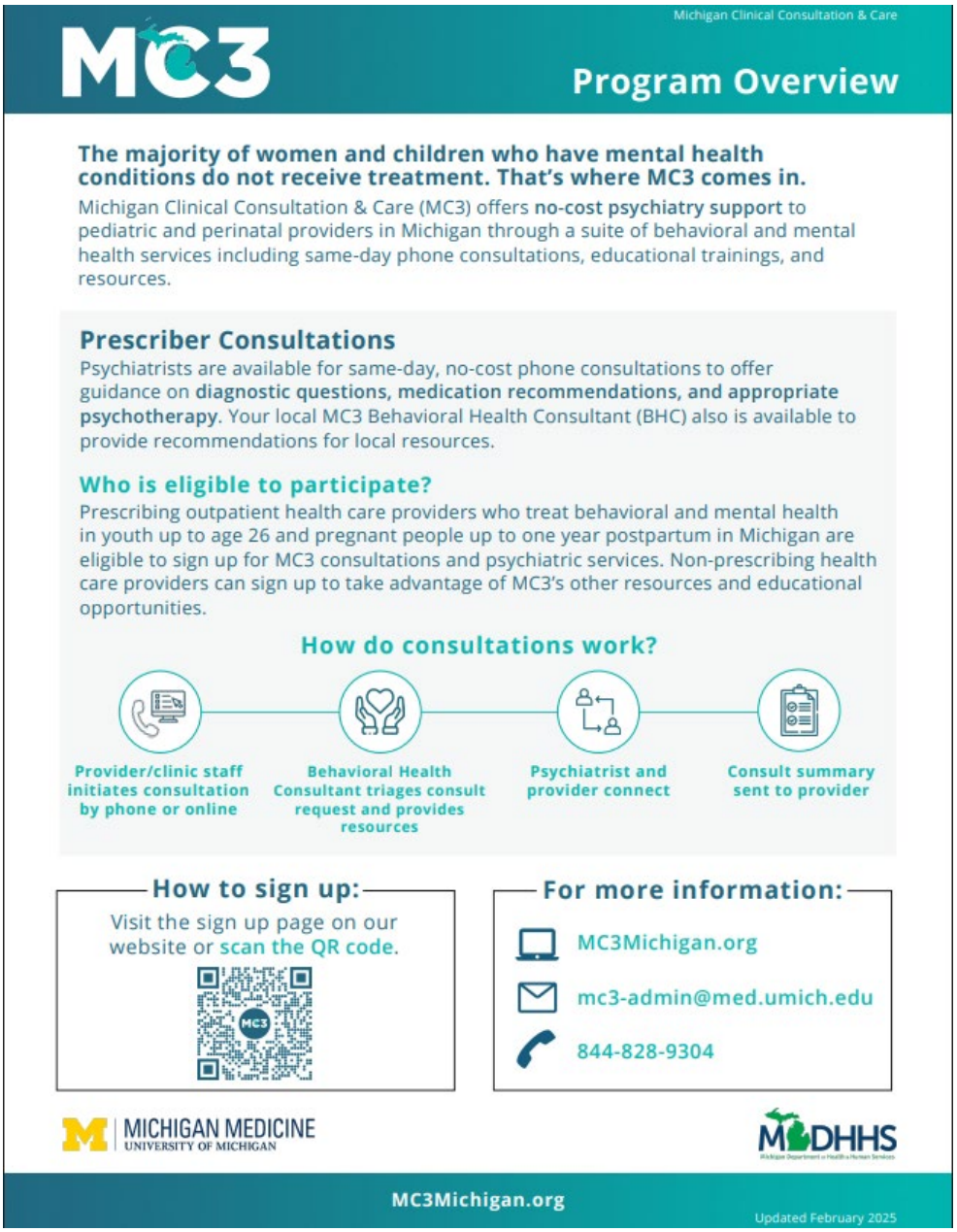
Providers rendering services to Commercial patients are encouraged to visit mclarenhealthplan.org to access current prior authorization requirements and electronic authorizations.

The list of Service Codes Requiring Preauthorization is available online at mclarenhealthplan.org > Providers > Medical Management and Authorization > Referral and Authorization Guidelines.

Authorization Updates, Changes, and Clarifications Updates, changes, and clarification to authorization requirements are completed on a quarterly basis and available online. Any updates,

changes, or clarifications will be effective in January, April, July and October of each year. For more information on how to submit authorizations electronically, please contact McLaren Health Plan Customer Service at 888-327-0761 (TTY: 711).

MC3



Other services available statewide:

- **Telepsychiatry Evaluations:** In-home, video-based evaluations for patients as a follow-up to same-day phone consultations. This opportunity is limited to patients with insurance that is accepted by the Michigan Medicine Department of Psychiatry.
- **Group Case Consultation:** Opportunities for you and your colleagues to discuss and review patients with behavioral health concerns with one of our consulting psychiatrists. No cost.

Additional services available in select counties:

- **Perinatal Patient Care:** Direct perinatal mental health services, including free same-day access to Behavioral Health Consultants who provide virtual counseling, case management, and care coordination for your patients (available only in Wayne, Oakland, Macomb, Genesee, Ingham, or Washtenaw counties). No cost.
- **School-Based Consultation:** Consultation and behavioral health education for licensed school mental health professionals and school nurses (available in select ISDs in Michigan). No cost.
- **Behavioral Resource Specialist:** Personalized assistance for your patients with navigating local resources for behavioral health services (available only in Genesee County). No cost.

What else does MC3 offer?

Education & Training

Browse our library of recorded educational presentations on mental health topics and see what live trainings we have scheduled on our website. Sign up at MC3Michigan.org to receive notifications and registration information for our upcoming training opportunities.

Resources

Explore our free online resources, including Psychopharmacology Reference Cards, Pediatric Resource Library, Perinatal Provider Toolkit, and Parent Toolkit.

What is not included in MC3?

MC3 is not an emergency service. MC3 psychiatrists do not prescribe medication or provide ongoing treatment, but rather support providers as they provide care.

MC3 is funded by the Michigan Department of Health and Human Services (MDHHS) via general funds, Medicaid Administration funds, and Health Resources and Services Administration (HRSA) funds.

MC3Michigan.org

Updated February 2025

MC3

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Clinical Pearls Video Series

Straightforward recommendations for the assessment and management of common pediatric behavioral health conditions

Attention-Deficit/Hyperactivity Disorder (ADHD)
Yavuz Ince, M.D.

Eating Disorders
Natalie Prohaska, M.D.

Suicidal and Non-Suicidal Self-Injurious Behavior
Alejandra Arango, Ph.D.

Basics of Psychotropic Medication Use
Paresh Patel, M.D., Ph.D.

Substance Use Disorders
Joanna Quigley, M.D.

Trauma-Informed Care
Alyse Folino Ley, D.O.

Aggression and Behavioral Dysregulation
Nasuh Malas, M.D., M.P.H.

Click the link or scan the QR code to learn more & watch the videos: MC3Michigan.org/clinical-pearls-video-series.

MC3Michigan.org

MC3 funded by the Michigan Department of Health and Human Services (MDHHS) via general funds, Medicaid Administration funds, and Health Resources and Services Administration (HRSA) funds.

The Low Birth Weight (LBW) Project and The MIRACLE center

The LBW project promotes equity across Medicaid Health Plans. The Medicaid Health Plans across lower Michigan comprise the collaborative group. Together with community partners we aim to make a positive impact on the LBW rate in Michigan. One of the partners is the MIRACLE Center. The MIRACLE center is a National Institutes of Health (NIH) funded Maternal Health Research Center of Excellence working to advance child bearing adults health and health equity. The statewide center includes three large projects reducing pregnancy-related illness and death in Michigan. Part of these projects are Maternity Safety Bundles developed by the Alliance For Innovation on Maternal Health Community Care Initiative (AIM CCI). A bundle is a small set of evidence-based interventions medical and improvement knowledge to arrive at better outcomes. The bundles are intended for use in outpatient and community clinical settings and other social/supportive service agencies where pregnant and postpartum individuals may interact. The center partners with many individuals in the state to create needed changes. To become a partner or for more information contact mmiracle@msu.edu. You can also visit https://obgyn.msu.edu/Research/The-MIRACLE-Center/About to learn more.

Sources:

https://obgyn.msu.edu/Research/The-MIRACLE-Center

https://www.aimcci.org/bundles/

Mental Health Toolkit

Did you know there is a mental health toolkit available on our website? Find it by going here: **https://www.mclarenhealthplan.org/mclaren-health-plan/trainings-and-webinars-mhp**

Pregnancy and CGMs

According to the American Diabetes Association (ADA) (n.d.) Continuous glucose monitors (CGMs) are increasingly being used during pregnancy.[1] Some improvement in outcomes is being shown related to CGM use during pregnancy, especially in those with Type 1 diabetes during pregnancy.[2] One major benefit of a CGM for patients is CGM alarms If the blood sugar drops when the person is sleeping. This is even more important for those who are more likely to experience low blood sugar.[1] For McLaren Health Plan Medicaid members, a prior authorization is not required for a CGM if they have a diagnosis of gestational diabetes.

Sources:

[1] https://diabetes.org/living-with-diabetes/pregnancy

[2] https://diabetesjournals.org/care/article/47/1/54/154012/Optimizing-Patient-Outcomes-in-Pregnancy-What

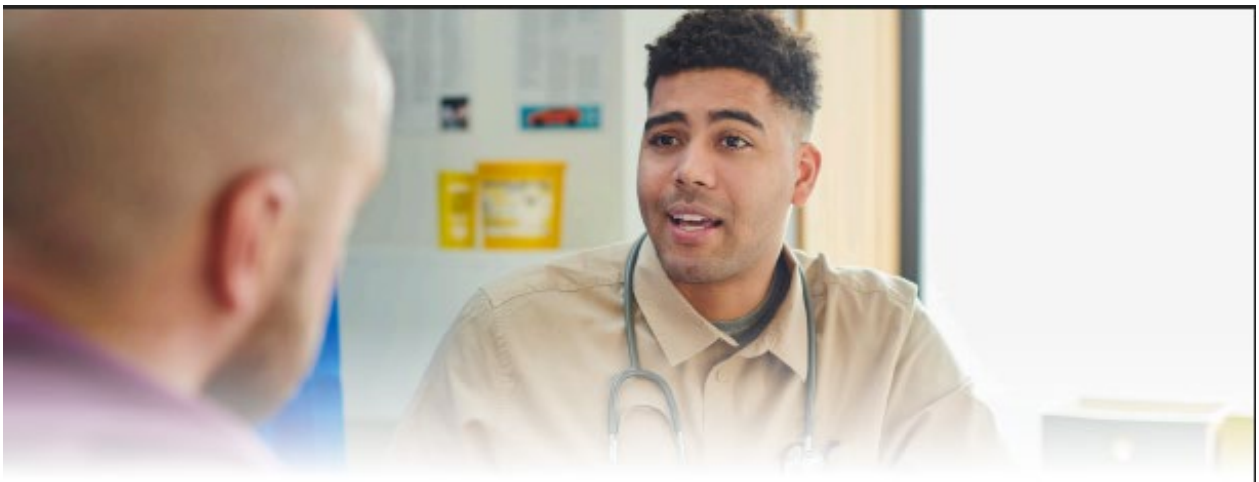
PrEP

Where Can I Learn More About Prescribing and Managing Patients on PrEP?

The Centers for Disease Control and Prevention (CDC) has published comprehensive guidelines in their *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2021 Update*, which consists of two parts:

- The *Clinical Practice Guideline for PrEP* describes CDC guidelines for prescribing PrEP, required baseline and ongoing assessments, information about how patients can pay for PrEP and related services, and evidence of PrEP's safety and efficacy. Access the guideline at: cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf.
- The *Clinical Providers' Supplement for PrEP* contains additional tools, such as a patient/provider checklist, patient and provider information sheets, a risk incidence assessment, supplemental counseling information, billing codes, and practice quality measures. Access the supplement at: cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2021.pdf.

CDC also offers additional *Clinicians' Quick Guides* on PrEP, as well as other materials for providers, patients, and practices. To download these materials, visit: cdc.gov/hiv/clinicians/materials/prevention.html.



What PrEP Options Are Available?

Various PrEP medication and dosing options are available to meet patients' needs:

Oral PrEP

Daily oral PrEP. Two medications are US Food and Drug Administration (FDA) approved to be used as daily oral PrEP by adults and adolescents weighing at least 35 kg (77 lb):

- Emtricitabine (F) 200 mg in combination with tenofovir disoproxil fumarate (TDF) 300 mg (F/TDF—brand name **Truvada®** or generic equivalent).
- Emtricitabine (F) 200 mg in combination with tenofovir alafenamide (TAF) 25 mg (F/TAF—brand name **Descovy®**).

Only F/TDF is approved for use by people who are at risk through vaginal sex. F/TAF has not yet been studied in women and other people who could get HIV through receptive vaginal sex.

Off-label 2-1-1 dosing of oral PrEP. Health care providers can prescribe F/TDF off-label using 2-1-1 dosing for adult gay, bisexual, and other men who have sex with men. This is also known as event-driven, intermittent, on-demand, or coitally timed PrEP. When using 2-1-1 dosing, the patient takes F/TDF doses based on when they plan to have sex.

Patients who could benefit from 2-1-1 dosing are those who:

- Request non-daily dosing.
- Have sex less often than once per week.
- Can anticipate or delay sex to permit the first two-pill dose at least 2 hours before sex.

Note that 2-1-1 dosing is not approved by the FDA and is not recommended by CDC.

Injectable PrEP

Cabotegravir (CAB) 600 mg injection (brand name **Apretude®**) is FDA approved to prevent HIV infection in adults and adolescents weighing at least 35 kg (77 lb). It is recommended for patients at risk for HIV through sex and may be especially useful for patients who:

- Are not oral PrEP candidates.
- Have problems taking oral medication as prescribed.
- Prefer getting an injection every 2 months instead of taking oral PrEP.

CDC | Let's Stop HIV Together | Ending the HIV Epidemic

PubNo. 301168
August 2022

Enhancing Community Connections: Partnership Opportunity with 211

Providers who prescribe pre-exposure prophylaxis (PrEP) are encouraged to apply for inclusion in Michigan 2-1-1, a free, confidential service connecting people with local and statewide resources. Trained specialists are available 24/7 via phone, text, or online to help individuals with housing, food, healthcare, and crisis support.

Benefits of listing with 2-1-1:

- Increased Visibility and Referrals: 211 is a central hub, acting as a referral point for services.
- Reduced Burden on Staff: 211 helps to pre-screen individuals, ensuring referrals align with eligibility requirements. This allows staff to focus on direct service delivery.
- Better Understanding of Community Needs: Participating in 211 helps to understand community needs and service gaps.
- Partnership Opportunities: Collaborating with 211 opens doors for potential partnerships and funding opportunities.

More information about partnering with 211 can be found on the website at mi211.org/providers. To search 2-1-1 resources by agency, visit mi211.org/providers/search. To apply to be part of Michigan 2-1-1's statewide resource database, visit mi211.org and review participation criteria. Then, contact the resource manager in your area.

Syphilis Screening

All pregnant persons should be screened for Syphilis in the first trimester at the first prenatal visit and again during third trimester (between 28-32 weeks). Pregnant persons with risk factors should be screened at any stage of pregnancy and at 36 weeks. Pregnant persons with no prenatal care should be screened with rapid testing upon presentation at any medical facility (including the ED and L&D Department).

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.

Hepatitis C

The Michigan Department of Health and Human Services (MDHHS) 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.

Blood Pressure Monitoring – Pregnancy and Postpartum

MDHHS is proposing effective 10/1/2025 revisions to the blood pressure monitoring policy by expanding coverage of blood pressure monitors to any Medicaid beneficiary who is pregnant or who is within the 12-month postpartum period. To align with PA 244, The MDHHS is removing from the standards of coverage the requirement of having a hypertensive disorder (e.g., preeclampsia) or uncontrolled blood pressure to receive a blood pressure monitor. The ordering practitioner must report a pregnancy or postpartum related diagnosis code on the order/prescription. Prior authorization is not required if the standards of coverage are met. All other blood pressure monitoring policy standards of coverage, documentation, and prior authorization requirements remain unchanged. [1]

[1] Michigan Department of Health and Human Services, (2025, August 29 proposed). Revisions to Blood Pressure Monitoring Policy. Notice of Proposed Policy, 1-2.

Children's Health: Lead Testing Guidelines

All children should be tested for lead twice: Once at the age of 1 and again by age 2.

Are your 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 built 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

Tips & Best Practices

- Avoid missed opportunities by taking advantage of every office visit to provide lead testing
- 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/hedisinformation

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.

Michigan Medicaid Mental Health Framework

The Michigan Department of Health and Human Services (MDHHS) is shifting to a more person-centered approach to serving Medicaid enrollees with mental health needs. As part of MIHealthyLife, an initiative to strengthen the Comprehensive Health Care Program (CHCP) that began in 2022, MDHHS is partnering with Medicaid Health Plans (MHPs), including McLaren Health Plan, Prepaid Inpatient Health Plans (PIHPs), and providers to improve access to and coordination of mental health care statewide.

Under the Mental Health Framework, an enrollee's level of mental health need, as determined through a State-identified standardized assessment tool, will more clearly determine which payer—the enrollee's health plan or PIHP—is responsible for their mental health coverage and care.

Also, MHPs will begin covering some additional mental health services for enrollees with lower levels of mental health need, so MHPs are accountable for more of these enrollees' continuum of care.

Beginning in October 2026:

- MHPs will cover most mental health services for CHCP enrollees with lower levels of mental health need, and
- PIHPs will cover all mental health services for CHCP enrollees with higher levels of mental health need

Referrals for mental health care, including those across MHP and PIHP systems, will be standardized to facilitate enrollee access to care.

What Does this Mean for Mental Health Providers?

Beginning October 2025, all qualified mental health providers[1] participating in Michigan's Medicaid program and contracted with an MHP and/or PIHP will need to incorporate into their practice:

- Use of standardized tools for assessing the level of mental health need of CHCP enrollees seeking mental health. MDHHS' designated assessment tools are:
    - Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener for children and youth (enrollees under age 21)
    - Level of Care Utilization System (LOCUS) for adults (enrollees aged 21 and older)

MDHHS will provide more information and access to trainings on these tools in the coming months. This is only a requirement for CHCP enrollees (enrolled in a Medicaid Health Plan). Information regarding the assessment frequency requirement, billing, and instructions for accessing the tools will be included in an upcoming policy guide.

- Adoption of a standardized referral process for mental health services, including use of a new referral platform accessible to mental health providers, primary care providers, Community Mental Health Services Programs (CMHSPs), MHPs and PIHPs.

Beginning in October 2026, MHPs will begin covering additional mental health services—including inpatient psychiatric care, crisis residential services, partial hospitalization services, and targeted case management for enrollees with lower levels of mental health need. Providers of these services should prepare to contract with MHPs, as well as PIHPs, for coverage effective October 1, 2026. In the coming months, MDHHS will provide more detailed guidance to facilitate these efforts.

MDHHS encourages all mental health providers to send any questions or comments to: MDHHS-MentalHlthFramework@michigan.gov.

Training for Standardized Assessments

Standardized assessment training will be free for providers and eligible for CME/CEU credit (details vary between each training).

- LOCUS: The LOCUS Training will be an online, self-paced training. Once available, there will be a link provided on MDHHS' webpage, and communications will be sent out from MDHHS.
- MichiCANS: Please utilize these instructions to register for the MichiCANS training. Providers must complete the TCOM Training prior to taking the Overview Training.

MDHHS Webinars and Meetings:

- Mental Health Framework 101
  - Recording: https://somdhhs.adobeconnect.com/pjm8km93ykdy/
  - Presentation: MHF 101
- MichiCANS Screener and LOCUS All Provider Draft Rate Meeting
  - Recording: https://somdhhs.adobeconnect.com/pfxrnsu70vyr/
  - Presentation: Mental Health Framework SFY 2026 All Provider 8/6/25

The feedback process related to the Mental Health Framework MichiCANS Screener and LOCUS All Provider Draft Rate Meeting is now closed. Feedback received earlier will be reviewed and considered.

SortPak Helps Medicaid Patients with Medication Adherence

McLaren Health Plan is offering eligible Medicaid members new ways to stay compliant with their maintenance medication regimens. This is particularly helpful to members taking maintenance medicine for asthma, diabetes, high cholesterol, or high blood pressure.

McLaren has partnered with SortPak - a presorting packaging pharmacy, to help our Medicaid members by organizing patient medication refills to support compliance, medication adherence and

medical safety. SortPak's Preferred Home Delivery program incentivizes members to obtain up to a 30-day supply of a maintenance medication through SortPak Mail Order Pharmacy.

With SortPak Pharmacy Home Delivery, members receive:

- Free home delivery of the member's medication.
- Ability to choose between SortPak Pharmacy's packaging systems in SyncPak or SortPak pouches.
- Have all medications sorted for the member with the exact time and day they need to take them.
- 24-hour access to a pharmacist.

Medication adherence is not only critical for your patients' health, but can also improve your performance rate for the following Quality measures:

- Medication adherence for asthma, diabetes, cholesterol and hypertension
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Transitions of care – medication reconciliation post discharge

If you have a McLaren Health Plan Medicaid patient who could benefit from this type of service, contact SortPak Pharmacy at 877-570-7787. A representative will begin the process and obtain all necessary information to get started with their Preferred Home Delivery Program. Providers can submit prescriptions to SortPak via fax to 877-475-2382, calling 877-570-7787 or online at: www.sortpak.com.

SortPak information for prescribers:

- NCPDP/NABP: 0524733
- NPI: 1063407252
- Address: 655 N Central Ave. 22nd Foor. Glendale, Ca 91203

Quality Quick Tips

August: Child & Adolescent Immunizations

Staying up to date for preventative care and well-child visits is essential to obtaining on-time vaccinations. Vaccines provide immunity to potentially life-threatening diseases. The following immunizations are recommended for children and adolescents based on their age:

Childhood Immunizations
(Children who turn 2 during the measurement year)-on or before the 2nd birthday

Expectation:

- 3 HepB
- 2/3 Rotavirus Series
- 4 DTap
- 1 HepA
- 3 HIB
- 4 PCV
- 3 IPV
- 2 Influenza
- 1 MMR
- 1 VZV

Adolescent Immunizations
(Children who turn 13 during the measurement year)-on or before the 13th birthday
Expectation:

- 1 Td or Tdap
- 1 Meningococcal
- 2 or 3 HPV

2025 Healthy Child Immunization Incentive for Medicaid Members:

Immunization Combo	Immunizations Included	MHP Incentive
Childhood Immunization Combo 10	DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, Influenza	$100
Adolescent Immunization Combo 2	Meningococcal, Tdap, HPV	$50

This incentive is for completion of Childhood Immunization Combo 10 by the Member's 2nd birthday and Adolescent Immunization Combo 2 by the Member's 13th birthday.

To receive the incentive for each of your eligible members, providers must bill for administration of these immunizations and report immunizations through MCIR. Providers are eligible to receive ***one completed immunization incentive per child*** which is paid in the spring of the following year.

How are We Doing?

HEDIS Measure		NCQA 75%	MY2024	MY2025
CIS-E	Childhood Immunization Status- Combo 3	68.86%	58.88%	55.11%
CIS-E	Childhood Immunization Status- Combo 10	34.79%	19.95%	17.96%

IMA-E	Immunizations for Adolescents- Combo 1	85.16%	76.16%	71.09%
IMA-E	Immunizations for Adolescents- Combo 2	41.61%	31.39%	24.86%

Tips & Best Practices

- Utilize MCIR to run reports, make sure series vaccines are complete, and uploaded.
- Review a child's immunization record before every visit and recommend all immunizations to parents.
- Schedule appointment for next the child's next vaccine at current visit to stay on track for completion
- Use your *Gaps in Care* lists to identify patients who are missing or due for immunizations
- If a member had immunizations outside of Michigan, submit medical records to **MHPQuality@Mclaren.org**.
- Find more immunization tools on the McLaren Physician Partners (MPP) website: **https://www.mclaren.org/mclaren-physician-partners/immunization-resources-mpp**

If you would like additional information regarding these quality measures or your *Gaps in Care* report, please email MHPQuality@Mclaren.org.

September: Respiratory Conditions

NCQA has developed HEDIS® standards around respiratory conditions including asthma, upper respiratory infections, COPD, pharyngitis and bronchitis. Some of these respiratory illnesses are viral while others are bacterial. Your testing and treatment of these illnesses is vital to appropriate care. To assist in your understanding of the quality measures surrounding certain respiratory illness, see the key respiratory HEDIS measures with a brief description.

Asthma Medication Ratio (AMR)

(Patients 5-64 years of age)

Expectation: Ensure patients with persistent asthma have a ratio of controller medications to total asthma medications of 50% or greater during the year.

NCQA 75th Percentile: **72.22%** HEDIS Rate MY2024: **42.41%** Current: **48.10%**

Appropriate Treatment for Upper Respiratory Infection (URI)

(Children or Adult Ages 3 months and older)

Expectation: Members with a diagnosis of URI (only) are **NOT** dispensed an antibiotic.

NCQA 75th Percentile: **92.47%** HEDIS Rate MY2024: **86.8%** Current: **87.57%**

Appropriate Testing for Pharyngitis (CWP)

(Children or Adult Ages 3 years and older)

Expectation: Members with a diagnosis of Pharyngitis (only) who were dispensed an antibiotic received a strep test for the episode of care.

NCQA 75th Percentile: **86.26%** HEDIS Rate MY2024: **80.09%** Current: **80.46%**

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

(Children or Adult Ages 3 months and older)

Expectation: Members with a diagnosis of acute bronchitis (only) are **NOT** dispensed an antibiotic.

NCQA 75th Percentile: **69.28%** HEDIS Rate MY2024: **53.69%** Current: **55.95%**

Educate patients on comfort measures such as acetaminophen for fever, rest and extra fluids. Also, provide education that antibiotics are not necessary for a viral infection. Ensure co-morbid diagnosis codes are billed when appropriate. Ensure patients with asthma are compliant with their medications throughout the year.

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.

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

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.

October: Women's Health - Postpartum Care Needs

Timely Postpartum Care

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease.

Reminder: Medicaid coverage includes essential sexual and reproductive health services like birth control, wellness exams, prenatal and maternity care, breast and cervical cancer screenings, and STI testing and treatment, and HIV treatment and prevention.

Measure	McLaren Medicaid MY2024	Goal
Postpartum Care: Measured by the percentage of women who delivered a live birth who received a postpartum visit on or between 7 and 84 days after delivery within the measurement period	**76.69%**	NCQA 75% 83.33%
Contraceptive Care: Postpartum Measured by the percentage of women between the ages of 15-44 who had a live birth, that were provided a most effective or moderately effective method of contraception within 3 and 90 days of delivery within the measurement period • Ages 15-20: Most or moderately effective contraception- 3 days • Ages 15-20: Most or moderately effective contraception- 90 days • Ages 21-44: Most or moderately effective contraception- 3 days • Ages 21-44: Most or moderately effective contraception- 90 days	**10%** **47.69%** **12.38%** **39.71%**	>=7% >=43% >=12% >=43%
Postpartum Depression Screening: Measures women who had a delivery and were screened for clinical depression with a standardized tool during the postpartum period, and if screened positive, received follow-up care with 30 days of a positive finding. Two rates are reported: • Screening • Follow-Up	**1.28%** **84.62%**	>=5% >=71%

Resources for Providers: We look forward to working in partnership with you to assist our members in achieving optimal health. If you would have questions or would like more information, please email us at MHPQuality@mclaren.org. For more information and tips on all HEDIS measures, check out our HEDIS Quality Toolkit/HEDIS Manual on our website at **https://www.mclarenhealthplan.org/mclaren-health-plan/hedis-information**.

October: Women's Health

October is Breast Cancer Awareness Month. This is a great time to check in with your female members who have not already obtained their mammogram. McLaren Health Plan (MHP) is committed to the health of our members. In addition to this important screening, there are other preventive screenings your female patients should be obtaining such as screening for Cervical Cancer and Chlamydia. Please **join us** in this effort by providing the following preventive screenings for women.

- **Mammograms** are recommended every two years for women 50 - 74 years of age.
- **Cervical cancer screening** is recommended every 1-5 years for women 21 - 64 years of age. Thi3s can be one of the following services:
  - Cervical cytology (Age 21-64 every 1-3 years) or
  - Cervical high-risk HPV testing (Age 30-64 every 1-5 years) or
  - Cervical cytology and high-risk HPV co-testing (Ages 30-64, every 1-5 years)
- **Chlamydia testing** is recommended for all women 16 - 24 years of age (and males 16 - 18 years of age.)

For providers in the Wayne, Oakland, Macomb, Livingston, and Washtenaw Counties, please consider referring to the Tri-County Breast and Cervical Cancer Control Program (BCCCP). They offer **FREE** mammograms, breast screenings, cervical cancer screening and follow-up testing to eligible uninsured women or insured women who face high out-of-pocket costs due to their insurance deductible. (For more information on BCCCP, go to http://www.bcccp.org)

Health Screening Measure	Medicaid MY24 Rates	Medicaid YTD25 Rates	NCQA 75%	NCQA 90%
Breast Cancer Screening (BCS-E)	55.94%	49.57%	59.51%	63.48%
Cervical Cancer Screening (CCS)	59.06%	46.29%	61.56%	67.46%
Chlamydia Testing (CHL)	56.88%	36.36%	64.37%	69.07%

McLaren Incentivizes these important screenings as well as other preventive services, please check out all our PCP Incentive Opportunities at McLaren's website **www.McLarenHealthPlan.org**.

Health Screening Measure	Medicaid PCP Incentives
Breast Cancer Screening	$50 per Eligible Member Screened
Cervical Cancer Screening	$50 per Eligible Member Screened PAP and HPV test completed meet the NCQA 75% ($25 Achievement Award) OR PAP & HPV completed meet the 90th% ($50 High Achiever Award)
Chlamydia Testing	$25 per Eligible Member Screened

We look forward to working in partnership with you to assist our members in achieving optimal health. If you would have questions or would like more information, please email us at MHPQuality@mclaren.org. For more information and tips on all HEDIS measures, check out our HEDIS Quality Toolkit/HEDIS Manual on our website at **https://www.mclarenhealthplan.org/mclaren-health-plan/hedis-information.**

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, and Medicaid/Healthy Michigan Plan 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%

Type of Service	Standard
Urgently needed or emergency services	Immediately
Non-Urgent Symptomatic Care	Within 7 business days
Routine/Regular Care including preventive services (physicals)	Within 30 business days

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.

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

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 departicipation.

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

Benefits of Patient-Centered Medical Home Certification

McLaren Health Plan recognizes the importance of Patient Center Medical Home (PCHM) principles being incorporated into provider practices.

Benefits to a provider practice becoming and maintaining PCMH designation 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 this status with members in Provider Directories to assist those looking for a PCMH practice.

Measurement Year 2024 HEDIS® Results and Trends - Measuring the Quality of Care

MEASURE	COMMERCIAL		MEDICAID	
	RATE	TREND	RATE	TREND
Living with Illness				
Diabetes Care- HbA1c testing <8	64%	↑	49%	↑
Kidney Health, Evaluating for Patients with Diabetes	42%	↑	36%	↑
Diabetes Care, Eye Exam	55%	↑	57%	↑
Controlling High Blood Pressure	63%	↑	53%	↑
Taking Care of Women				
Breast Cancer Screening	78%	=	55%	=
Cervical Cancer Screening	81%	↑	57%	↑
Chlamydia Screening	44%	↓	58%	=
Timeliness of Prenatal Care	80%	↑	78%	↑
Postpartum Care	90%	↑	78%	↑
Keeping Kids Healthy				
Childhood Immunizations Combo 3	86%	↑	59%	↑
Childhood Immunizations Combo 10	40%	↓	22%	↓
Well-Child Visits in First 15 months 6+ Visits	84%	↓	66%	↑
Well-Child Visits 15-30 months, 2 visits	85%	↑	66%	↑
Child and Adolescent Well-Care Visit	55%	=	50%	↑
Blood Lead Level (on or before age 2)			52%	↑
Access to Care				
Adult Access (ages 20-44)	94%	=	71%	↑
Adult Access (ages 45-64)	96%	=	81%	=

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

Eligibility & Claim Inquiries

- Prior to rendering services, always verify eligibility and coverage using the McLaren Connect Provider Portal. Eligibility can be verified on the McLaren Connect Provider Portal with just the Member ID.
- For questions regarding the status of a claim, login to the McLaren Connect Provider Portal, to view the status of a claim, if you have additional questions, please initiate a request on the McLaren Connect Provider Portal.
- Maintain your tracking number from your portal request in the event you need to reach to Customer Service for further information.
- Direct all claims inquiries to MHP Customer Service to investigate any issues by calling MHP Customer Service at (888)-327-0671 or initiating a request on the McLaren Connect Provider Portal.
- To dispute a claim denial, providers **must** submit an Appeal within 90 calendar days of the action and include supporting documentation.
    - Submit corrected claims within 90 days.
    - Visit the MHP Appeals information page online and the Provider Administrative Appeal Form.
- Provider Relations Representatives can assist with claims issues after a provider has already contacted MHP Customer Service and is unable to achieve resolution though established

channels. Provider Relations intervention is limited to exclusive situations when denials occur due to complex configuration, contracting or enrollment issues following Customer Service involvement.

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 MQIC | Michigan Association of Health Plans | Michigan Association of Health Plans 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.

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
- 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 review our website periodically for interim changes and to view upcoming authorization changes please visit the website here: Upcoming-Authorization-Changes.pdf

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

Thank you for the quality care you deliver!

Member Language Needs and Resources

McLaren Health Plan uses census data to track and monitor the language needs of its enrolled members – as well as the language of the population in its geographical area – to ensure appropriate language assistance.

The top languages spoken by MHP members:

- English
- Spanish
- Arabic
- Swahili

MHP offers providers detailed reports on service area language needs and the language needs of assigned members. Language assistance resources are made available to providers and staff, along with training to identify needs and services available.

Please contact Customer Service at 888-327- 0671 (TTY: 711) to obtain a list of language needs of assigned members in your practice or to request training about language services.

Medicare STARS

Helping Patients Understand the Medicare Annual Wellness Visit

The Medicare Annual Wellness Visit (AWV) is an important opportunity for you to support preventive care and strengthen your patient relationships. Unlike a hands-on physical exam, the AWV is designed to assess a patient's overall health risks, identify gaps in preventive services, and create a personalized plan to keep them healthy. This distinction can sometimes lead to frustration in your patients who use the terms "wellness exam" and "physical exam" interchangeably. Setting the expectation for the AWV ahead of time during scheduling can help alleviate this frustration.

What patients should know:

1. **It's covered by Medicare:** The AWV is available once every 12 months at no cost to patients when they see a provider who accepts Medicare.
2. **It's not a "head-to-toe" physical:** The AWV focuses on health history, risk factors, and preventive care needs. Patients may need a separate appointment for new or existing medical concerns.
3. **It includes preventive screenings:** The visit reviews needed immunizations, screenings (such as cancer or diabetes), and other preventive services.
4. **It's personalized:** Patients receive a written plan for their preventive health, including recommendations for healthy lifestyle changes, referrals, and community resources.

How you can help:

Remind patients of the value of their AWV, set clear expectations, and emphasize that it is a chance to talk about being and staying well and be proactive about their health. Many patients may not realize that this visit is available at no cost and provides a roadmap for staying healthy and independent as they get older.

By guiding patients through what to expect, you can increase their engagement, close preventive care gaps, and build trust with your Medicare population. Remind scheduling staff to review their Medicare patients for the need of an AWV and provide staff with education and scripting to factually communicate the purpose and expectations for the AWV versus a Physical Exam. Use Care gap reports to identify your patients turning 65 with Medicare to schedule their AWV. By addressing preventive care and health maintenance and assessing for conditions or issues early in the AWV, the risk for complications can be reduced while enhancing your patient health outcomes and quality of life.

Contact Customer at 888-327-0671 (TTY: 711) for further information or questions.

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

Member Rights and Responsibilities

McLaren Health Plan Members have the right to:

- Confidentiality
- Be treated with respect and recognition of their dignity and the right to privacy, including to be free from restraint and seclusion
- Have access to a primary care provider or provider designee 24 hours a day, 365 days a year for urgent care
- Receive culturally and linguistically appropriate services
- The right to receive covered benefits consistent with your contract and State and Federal regulations
- Obtain a current provider directory of participating providers and access to a choice of specialists within the network who are experienced in treatment of chronic disabilities, with a referral

- Obtain OB-GYN and pediatric services from network providers without a referral request
- Continue receiving services from a provider who has been terminated from the Plan's network, through the episode of care, as long as it remains medically necessary to continue treatment with this provider, including female members who are pregnant have the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to 6 weeks after delivery
- Have no "gag rules" from the Plan. Doctors are free to discuss all medical treatment options, even if they are not covered services
- Participate in decision-making regarding his/her health care, including the right to refuse treatment, to obtain a second opinion, and express preferences about treatment options
- Receive a copy of their medical record upon request, and request those to be amended or corrected
- Know how the Plan pays its doctors, allowing Members to know if there are financial incentives or disincentives tied to medical decisions; and the right to be provided with a telephone number and address to obtain additional information about compensation methods, if desired
- Voice complaints or appeals about McLaren Health Plan, the care provided or a decision to deny or limit coverage, including that a member or provider cannot be penalized for filing a complaint or appeal in compliance with federal and state laws
- Receive information about McLaren Health Plan, including the services provided, the practitioners and providers, and the members' rights and responsibilities
- Make recommendations regarding McLaren Health Plan's member's rights and responsibilities
- Be free from other discrimination prohibited by State and Federal regulations
- Having the member's medical record be kept confidential by McLaren Health Plan and the PCP

McLaren Health Plan Members have the responsibility to:

- Schedule appointments in advance and be on time; and cancel an appointment with the doctor's office as soon as possible
- Use the hospital emergency room only for acute or emergency care, not for routine care - this means following the protocol and using the emergency room only when medically necessary, and contacting the PCP prior to a visit to the emergency room
- Become a partner with the PCP in planning individual health care and completing treatments, including supplying the information (to the extent possible), to practitioners, providers, and the health plan that is needed to deliver the services needed
- Follow plans and instructions for care that the member has agreed on with all their treating health care providers and practitioners
- Understanding their health problems and participate in developing treatment goals to the degree possible
- Notify McLaren Health Plan's Customer Service immediately for any change in address or telephone number
- Allow McLaren Health Plan to assist with health care and services to which a member is entitled and of notifying the Plan of any problem related to health care, benefits, etc.

- Forward suggestions to McLaren Health Plan in writing or contacting Customer Service for assistance
- Carry the McLaren Health Plan Member ID card at all times