Member Rights and Responsibilities
Medical care is based on scientific principles and on partnerships among the member, doctor, MDwise and other health care staff. MDwise is committed to developing these partnerships and recognizes that there are certain member rights and responsibilities that are critical to the success of this partnership and the provision of appropriate medical care. Please review the MDwise member rights and responsibilities statements:

Hoosier Healthwise and HIP member rights and responsibilities
MDwise Marketplace member rights and responsibilities

WE APPRECIATE YOU!
MDwise appreciates your hard work and dedication as part of our provider network. MDwise values your participation as you provide quality care to our MDwise members throughout 2017 and for years to come.

Visit MDwise.org/providers for additional information and tools for providers.

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Patient Safety: Health Literacy

Health Literacy is defined in the Institute of Medicine report, *Health Literacy: A Prescription to End Confusion*, as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." According to the 2008 National Assessment of Adult Literacy (NAAL), 38 percent of adults living in the United States (representing 81 million adults) either had “limited” health literacy or were unable to be measured because language barriers prevented participation in the assessment. According to the most recent studies the United States average score was significantly higher than on the 2003-2008 studies but was not significantly different from the 1994-1998 scores. Adults living at or below 125 percent of the federal poverty level (FPL) had a much lower average health literacy score than adults with higher income levels.

Health literacy impacts an individual’s ability to successfully manage their health and health care. Research shows literacy is a stronger predictor of health status than age, income, employment status, education level or racial and ethnic group. Unfortunately, evidence shows that patients often misinterpret or do not understand much of the information given to them by clinicians.

Communication barriers caused by poor health literacy can lead to misunderstood health care instructions, prescriptions and appointment slips (no-shows), poor health outcomes and medical errors. For example, patients who must self-manage chronic diseases such as asthma or diabetes will have poorer outcomes if they cannot understand written instructions for using metered-dose inhalers or for monitoring and recording their own blood sugar levels; an infant with an ear infection will not benefit from treatment if her mother cannot understand that the antibiotic the clinic prescribed is to be given orally, not put in the child’s ear.

Some tips to improve interpersonal communication with patients:

1. Slow down.
2. Use plain, non-medical language.
3. Show or draw pictures.
4. Limit the amount of information provided and repeat it.
5. Use the teach-back or show-me technique.
6. Create a shame-free environment and use patient friendly and culturally appropriate materials.

Additional information can be found in these health literacy resources:

- Reducing the Disparities in Health Care
- Joint Commission "What Did the Doctor Say?"
- AHRQ Health Literacy Universal Precautions Toolkit
- CDC Plain Language Thesaurus
Prior Authorization Requests for Hoosier Healthwise and Healthy Indiana Plan

We are here to partner with you in providing the best care to our members. In order to provide prompt response times for inpatient and outpatient prior authorization (PA) requests, please use the IHCP Universal Prior Authorization Form when faxing requests to MDwise. Be sure that the form is filled out completely to include ICD and CPT codes, and place of service and that any needed clinical supporting documentation is attached. Once MDwise has received a complete authorization request, the following time frames apply to our response.

Turnaround Time for Prior Authorizations
Please do not delay care needed to emergently treat or stabilize our members while requesting authorization.

Emergent requests: Include symptoms suggesting an imminent life-threatening condition. Prior authorization is not required for emergency services. Notification of services must occur within two business days of the date of service.

Urgent concurrent (emergent inpatient admissions) determinations will be completed within 24 hours of receipt of request.

Pre-service urgent: A determination will be made within three business days as the member’s condition warrants.

An urgent request is for services where the situation warrants an expedited response, e.g., a member is scheduled for discharge unexpectedly, treatment following stabilization of an emergency condition, the member is in extreme pain or delay in treatment may cause deterioration of the member’s condition.

Urgent requests that are consistent with the examples above should be marked URGENT on the PA form.

Note: Providers will be informed if the request does not meet the definition of urgent, explaining that either additional information must be submitted to meet the urgent definition or that the request will be processed as non-urgent.

Pre-service non-urgent (e.g., elective procedure): A determination will be made within seven calendar days.

Tips for Submitting Prior Authorization Requests
✓ For pre-service non-urgent requests, request a date span rather than a specific date.
✓ Repeat phone calls or faxes to check the status of a requested PA or to ask for an expedited PA slow down the rate at which PAs can be completed. Please note our turnaround times above.

Note: Requesting to speak to a supervisor or manager will not result in an expedited review.
✓ Please submit complete clinical information at the time of the request.
✓ Please include a contact name and number for us to request additional clinical information if needed.
✓ Please be sure to provide your fax number and a secure voice mailbox number, so we can communicate with you in a timely manner and be in compliance with HIPAA regulations.
✓ If you have faxed your request, please ensure that your prior authorization request was faxed to the correct fax number and that you received a confirmation.

Services that Require Prior Authorization
Check our website to determine which procedures require prior authorization and where to fax the request.

Delivery System Contact Information for Prior Authorization
Please reference the MDwise delivery system prior authorization contact guide for a list of prior authorization contact numbers for all MDwise delivery systems and IHCP programs.
Quick reference guides and specific lists of services requiring prior authorization for medical review are distributed to the contracted providers by delivery system medical management staff and can also be found on the MDwise website. For the 2016 and 2017 Prior Authorization List and Quick Reference Guide for MDwise Marketplace, click here.

The list of services requiring prior authorization is reviewed at least annually and updated as needed. For the most up-to-date and comprehensive list of services requiring prior authorization providers should contact their delivery system medical management department. See the MDwise Marketplace quick contact guide for contact information for each delivery system or call the MDwise provider relations department at 317.822.7300 ext. 5800.

Authorizations can be obtained from each delivery system by phone, fax, mail or delivery system online authorization tool (if available). Delivery system medical management contact information can be found on the MDwise Marketplace quick contact guide.

Valid Prior Authorization Requests
A valid prior authorization request is defined as one where:
✓ The request is initiated by the primary care provider (PCP/PMP), treating specialist, the treating provider or member.
✓ The member is enrolled with MDwise Marketplace at the time of the service.
✓ The appropriate authorization form is completed for service requests.
✓ A physician prescription is included with a request for enteral formulas, infusion therapy and DME that requires authorization accompanies the request.
✓ Clinical documentation to support medical necessity is included in the request.

Authorization Submission
For specific service requirements, see the MDwise prior authorization guidelines.

For faxed or mailed submission physical health providers should use the MDwise Marketplace prior authorization form. There will be a separate MDwise Marketplace outpatient treatment request form for behavioral health providers. See the MDwise Marketplace quick contact guide for medical management phone and fax numbers.

Information submitted with a service request should include:
✓ Demographic information.
✓ Type of care.
✓ Frequency and duration (if applicable).
✓ Facility or provider.
✓ Diagnosis.
✓ Procedure.
✓ Date of service or onset date of services.
✓ Other pertinent clinical information to benefit coverage determinations.

Confirmation of Requested Authorizations
Network providers will obtain confirmation of received authorization requests and an authorization letter via fax or mail. Information provided will include the authorization identification number, authorization decision, number of days/visits and the duration approved or denied.

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider. All requests are assigned an authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing.

A provider may request a copy of the criteria or guideline used to make a prior authorization denial decision by calling the telephone number indicated on the denial letter and asking the delivery system medical management staff for a copy of the criteria.
Important Announcement Regarding Behavioral Health Intensive Outpatient Treatment and Prior Authorization

As of February 1, 2017, MDwise Hoosier Healthwise (HHW)/Healthy Indiana Plan (HIP) will begin covering Intensive Outpatient Services as noted below. These services will require Prior Authorization for in-network providers as of April 1, 2017:

Out of Network providers are required to obtain Prior Authorization for all services.

If you have any questions, please contact MDwise, Inc., Holli Mahoney, LMHC at 317.983.7768.

Behavioral Health Member Satisfaction Survey

The behavioral health department contracted with SPH Analytics (SPHA) to complete a member satisfaction survey in the fourth quarter of 2016. The Experience of Care and Health Outcomes (ECHO) survey was used to measure MDwise members’ experience with behavioral health services they had received.

A two-wave mail with phone follows up survey methodology to administer the ECHO® Behavioral Satisfaction Survey:

- First questionnaire was sent to each member: September 13, 2016.
- A reminder letter was sent to non-respondents: October 4, 2016.
- Telephone calls were conducted for non-respondents: October 10, 2016.

Of the members that were surveyed, only 313 members responded indicating that they had received counseling, treatment or medicine for the reasons listed on the survey tool. The response rate was 28.8 percent.

The results of this year’s survey indicate that there is room for improvement. Key questions that have a strong relationship with overall satisfaction with behavioral health services are related to the provider’s delivery of services and timely access to care. The results of these 6 questions all fell just above or below 25th percentile of the SPHA overall book of business. By focusing improvement efforts in the areas related to these 6 questions, member satisfaction with MDwise behavioral health services should improve. The goal for 2017 is to meet 50th percentile.

The table below shows the 6 questions as well as the survey results for 2016:

| Goal |
|------------------------|------------------------|------------------------|------------------------|
| Q5. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted? | Current Year Performance | 25th Percentile | 50th Percentile Goal |
| 65.5% | 61.4% | 68.3% |
| Q13. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you? | 84.1% | 84% | 91.5% |
| Q14. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand? | 84.3% | 82.8% | 91.0% |
| Q15. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say? | 85.9% | 87.6% | 94.0% |
| Q16. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you? | 80.6% | 82.9% | 90.9% |
| Q19. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment? | 81.1% | 79.4% | 89.0% |
Interpretation Services

MDwise members are eligible to receive interpretation services at no cost. This includes all foreign languages as well as sign language services. The legal foundation for language access lies in Title VI of the 1964 Civil Rights Act. The Health and Human Services (HHS) Office for Civil Rights has responsibility for enforcing the Civil Rights Act and the Americans with Disabilities Act. They have issued guidance for providers to help clarify responsibilities. They suggest that given the nature and importance of health care services, health care providers have a special obligation to ensure language access for their patients. Once a health care provider accepts any federal funds (e.g., Medicare or Medicaid payments), the provider is responsible for providing language access to all of their patients.

There are several ways that appropriate language access can be provided. Interpretation services can occur:

- Face-to-face by hiring an interpreter from a local or state organization that provides these services in-person at the provider office.
- Telephonically through language line options, many of which may be available through provider groups or hospital affiliations.

These language options all have varied per hour (in-person) or per minute (phone) costs. If you do not have this resource or do not know how to obtain interpretation services for your patients, please contact your MDwise provider relations representative for assistance.

The use of family members and friends as interpreters is not recommended! It raises quality and confidentiality concerns. Here are a few examples:

- Breach of confidentiality.
- Patients may be reluctant to disclose information critical to their situation/condition.
- Greater likelihood of medical errors.
- Mistaken naming of body parts.
- Family shame and other issues that may interfere.
- Inaccurate history collection can result in inadequate treatment recommendations.

The use of professional, trained interpreters is critical. If you need additional information about accessing or use of interpretation services, please access the MDwise Provider Toolkit on Culturally and Linguistically Appropriate Services.