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Provider Access Guidelines

An integral part of patient care is making sure patients have access to needed medical care. In accordance with Office of Medicaid Policy and Planning (OMPP) policy and NCQA standards, MDwise establishes standards and performance monitors to help ensure MDwise members receive timely and clinically appropriate access to providers and covered services. For example, an initial appointment for a member, who is not a pregnant adult, should be within three months from the date the member requests the appointment.

MDwise also follows the OMPP-outlined timeframes for provider follow up to members. For emergencies and urgent situations, members must be able to reach their PMP or designee by phone within 30 minutes, 24 hours a day, 7 days a week. The designee can be a person, or instructions for the member to call 911 if they believe they are experiencing a medical emergency. For non-urgent routine telephone messages, a return call must be made to the member within one working day.

For more information on these access requirements, visit our quality page.

As 2019 is entering the fourth quarter, we want to thank you for providing the best care to our members. Your hard work and dedication to MDwise members is greatly appreciated!
Provider Portal

With the implementation of our new claims vendor Evolent (formerly Valence), MDwise created an additional provider portal with a more in depth look at submitted provider claims. By accessing this claim specific portal, you can view member claims, print EOB’s, check eligibility and verify other insurance, and access the Member Health Profile (MHP). To access the Provider Portals, go to MDwise.org/for-providers, and click on the myMDwise Provider Login link on the right under "Quick Links."

The MHP allows the PMP/Behavioral Health provider to view their members’ medical and pharmacy claims for all doctors the member sees. This information can assist in coordination of care by showing the member’s benefit service limitations and usage for the last 12 months. For example, if a member got a new pair of glasses in January from Dr. Jones, this will show in the MHP under the Member Medical Claims section. PMPs can use this information to identify the gaps in care and better manage the member’s overall care plan.

To access the MHP, providers can request access by completing the request form on the Provider Portal.

For additional questions on access to the Provider Portal and the MHP, please contact the MDwise Provider Relations department at 317-822-7300 ext. 5800.

Availability of UM Criteria

MDwise is an NCQA accredited organization and complies with all NCQA UM standards including UM 2 regarding criteria availability. Please remember that if you receive notification of an adverse decision, which includes the determination to deny, modify or reduce the services for which you requested authorization, you may request the clinical guideline or criteria that was applied to make the decision by calling the Medical Management Department. The Medical Management Department will work with you to provide you with the guideline or criteria in the method that is most acceptable via fax, email, phone or mail.

Claim Dispute Process

All in-and out-of-network providers have the right to dispute a claim decision or action. The initial claim dispute must be filed within 60 days of the explanation of payment (EOP). When submitting a dispute, the dispute form, explanation of payment, and an explanation of the reason for disputing the claim should be submitted by email (preferred) to cdticket@mdwise.org or by mail to:

MDwise
PO Box 44123
Indianapolis, IN 46244-1423
Attention: Dispute Department

Reminder: The following items are not considered a claim dispute and should not be sent via the dispute process: new claims, corrected claims, a MDwise request for medical records or attachments, or a provider recoupment request.

For more information on the dispute process and to locate the Claims Dispute Form, go to MDwise.org/claims. You can also call 1-800-356-1204 to speak to a claims dispute representative.

Population Health Management Practitioner/Provider Support

Our behavioral health providers are also held to a similar access standard. Behavioral health care services include both mental health and substance abuse services for the MDwise Hoosier Healthwise and Healthy Indiana Plan. Behavioral health providers should adhere to the following time frames:

- Non-life threatening Emergency Care 6 hours.
- Urgent Care 48 hours.
- Routine Office Visits 10 working days.
- Provisional Access 24 hour availability/after hours care.

MDwise performs audits each year per the guidelines established by the State of Indiana, CMS and NCQA. Steps are taken to work with any provider that does not meet access and performance improvement plans are implemented. If you have questions regarding behavioral health access standards, reach out to the MDwise Behavioral Health Specialist.
Well-Child and Adolescent Immunizations

The Benefits of Preventive Care Well-Child Visits Steer Children to Better Health; 2019 Immunization Schedule for Children

Universal vaccination is a crucial part of quality health care and should be accomplished through routine and catch-up vaccinations. Early childhood immunization rates are still suboptimal. Although some types of vaccine-preventable diseases are at an all-time low some are resurging like pertussis. Other recommendations have been expanded, like influenza and HPV vaccination in adolescents, but there are still gaps in sustainable immunization rates. Diseases such as measles, mumps and pertussis can be more severe and can result in social, economic and physical costs.

MDwise values its ongoing partnership with our network Primary Medical Providers (PMP). Our quality improvement program is focused on monitoring and improving high-quality care, including well-child and adolescent visits as well as immunizations.

Physicians and other pediatric providers have an important role in ensuring that all patients keep their vaccinations current. Providers can do a lot to maintain and increase the rates among their patients by providing immunizations at the earliest possible.

The full recommended schedule of childhood and adolescent immunizations can be found at the Centers for Disease Control and Prevention (CDC) website. It includes recommendations for a catch-up schedule.
The MDwise Pay for Outcomes (P4O) Program

MDwise made payments to provider groups in 2018. This was for their performance in 2017.

The awards for 2017 performance recognized provider groups who performed well on these key measures:

• Well Child (0-15 months; 3-6 years and 12-21 years).
• Postpartum timeliness.
• Adult preventive care.
• 7-day follow-up after behavioral health inpatient stay.

Member profiles:

MDwise has a Member Health Profile portal that both PMPs and behavioral health providers can log into to view any appointments that members have had with other providers, as well as prescriptions that have been filled. This profile is designed to improve the coordination of care between medical and behavioral health care. Contact your MDwise Provider Relations Representative if you do not currently have access to this resource.

Provider portal:

MDwise has a provider portal that providers can log into to view their individual quality scores as well as member-specific information such as non-compliant member lists, members using the ER and member rosters. Contact your MDwise Provider Relations Representative if you do not currently have access to this resource.

MTM:

MDwise has contracted with a Medication Therapy Management (MTM) service provider through our Pharmacy Benefit Manager (PBM). Following a therapeutic medication review, potential issues around adherence, cost, treatment guidelines, safety and interactions were identified. Attempts were then made to contact members to discuss the findings and complete a Comprehensive Medication Review in which questions and concerns were addressed and resolved. The pharmacists then reached out to prescribers regarding interventions for change in medication therapy.

Medically Frail

Medically Frail is a program that may qualify HIP members for enhanced State Plan benefits if they meet specific criteria established by the state involving:

• Complex medical conditions.
• Disabling behavioral health disorders.
• Chronic substance abuse diagnoses.
• Social Security Disability.
• Impairment of specific activities of daily living.

Most members who qualify as Medically Frail are identified automatically through claims processing. Others are qualified by a designated team that examines medical and pharmacy records and interviews members in addition to reviewing claims. State Plan benefits of a Medically Frail designation include

• Expanded therapy limits.
• MRO services.
• Non-emergency transportation.
• Vision and dental coverage.

Providers may refer members to the MDwise Medically Frail program for assessment or members can self-refer by contacting MDwise customer service.
MDwise Q1 Program

Areas in which MDwise improved (2018):

• Weight assessment and counseling for children and teens.
• Lead screening in children.
• Medication management for people with asthma.
• Cervical cancer screenings for Healthy Indiana Plan (HIP) females.
• Eye exams for HIP members with diabetes.
• Annual dental visits.

For children, MDwise is still working to make improvements in 2019:

• Babies getting six well-child visits by 15 months of age.
• Babies getting all recommended immunizations by age two.
• All babies having a test for lead poisoning at 12 months of age and again at 24 months.
• Teens getting a well exam each year and the immunizations they need.
• Children having an annual dental visit.

For adults, MDwise is also working to improve in the following areas in 2019:

• After delivery of a baby, women getting in for their postpartum exam within 21–56 days (3-8 weeks).
• All members, especially pregnant women, quitting tobacco use.
• Getting adults in for well care and the health screenings they need every year.
• Getting HIP adult members in for a follow-up appointment within 7 days of a mental health inpatient hospital stay.
• Members using the emergency room wisely.
• Diabetic members getting the tests they need and keeping healthy sugar levels and blood pressure.
• Improving early identification of pregnancy to ensure adequate prenatal care.
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 certain member rights and responsibilities are critical to the success of this partnership and the provision of appropriate medical care.

The MDwise Member Rights and Responsibilities Statement:
MDwise provides access to medical care for all its members. We do not discriminate based on religion, race, national origin, color, ancestry, handicap, sex, sexual preference or age.

MDwise members have the right to:
• Be treated with dignity and respect.
• Personal privacy. We keep medical records confidential as required by law.
• Be provided with information about MDwise, its services, its doctors and other health care providers and members’ rights and responsibilities.
• A clear explanation of their medical condition. The member has a right to be part of all treatment decisions. Options should be discussed with the member no matter what they cost or whether they are covered as a benefit.

In addition, members have the right to:
• Change their doctor by calling the MDwise customer service department.
• Timely access to covered services.
• Appeal any decisions we make about their health care. The member can also complain about personal treatment they received.
• Get copies of their medical records or limit access to these records, according to state and federal law.
• Amend their medical records.
• Get information about their doctor.
• Request information about the MDwise organization and operations.
• Refuse care from any doctor.
• Ask for a second opinion, at no cost.
• Make complaints about MDwise, its services, doctors and policies.

• Get timely answers to grievances or appeals.
• Take part in member satisfaction surveys.
• Prepare an advance directive.
• Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits or complaints.
• Get complete benefit information. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions and limits on covered services.
• Request information about the MDwise physician incentive plan.
• Be told about changes to benefits and doctors.
• Be told how to choose a different health plan.
• Health care that makes the member comfortable based on their culture.
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with Federal regulations.
• When a member exercises these rights, the member will not be treated differently.
• Provide input on MDwise member rights and responsibilities.
• Participate in all treatment decisions that affect the member’s care.
• If MDwise closes or becomes insolvent, members are not responsible for MDwise debts. Also, members would not be responsible for services that were given to a member because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally, in the case of insolvency, members do not have to pay any more for covered services than what they would pay if MDwise provided the services directly. Through the MDwise member handbook and member newsletter, each MDwise member is advised of his or her rights and responsibilities. When the MDwise member is a child, the above list of rights and responsibilities apply both to the child and the child’s parent or guardian. All of the above rights also apply to the designated personal representative of the member.
Rethinking Primary Care – The Patient-Centered Medical Home (PCMH)

What does PCMH really mean? According to the Agency for Healthcare Research and Quality (AHRQ), the medical home is not just a place, but a model of the organization of primary care that implements the core functions of primary health care (2018). PCMH embraces a new, evidence-based model of care that is built to obtain quality, accessible and efficient care for all patients.

5 Attributes of a PCMH:
1. Comprehensive Care.
2. Patient-Centered.
3. Coordinated Care.
4. Accessible Services.
5. Quality and Safety.

Shifting your practice toward a PCMH may seem daunting, but help is available! AHRQ’s PCMH Resource Center includes free tools, white papers and resource guides about implementing PCMH.

The American Academy of Family Physicians has created Practice Improvement Checklists to assist providers and office groups no matter where you are on your PCMH journey.

Want to do a deep dive into implementing PCMH? Check out AHRQ’s comprehensive Primary Care Practice Facilitation (PCPF) Curriculum.

References:
Agency for Healthcare Research and Quality (2018). Defining the PCMH.

Best Practices Learned from HEDIS 2019

The Healthcare Effectiveness Data and Information Set (HEDIS) 2019 project has officially come to an end. Thank you to all of our providers and office staff that sent in requested medical records. The HEDIS project would not be a success without your help!

After reviewing thousands of medical records, we want to share a handful of best practices gleaned from our reviews:

• Utilize every interaction for postpartum care. Life gets busy for mom after baby arrives. During medical record review, we saw acute visits 21 to 56 days after delivery, but postpartum care was not performed. It is a challenge for new moms to make their health a priority after delivery, so providers must take advantage of every opportunity that a new mom is in their office and offer postpartum care. You never know if you’ll see her back in your office. A simple notation of “postpartum care” or “PP check” meets documentation requirements for HEDIS purposes.

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Best Practices Learned from HEDIS 2019 – Continued

- Use a template for well-child visits. This ensures all 5 HEDIS-required components are captured. HEDIS requires the following 5 components be present to constitute a well-child visit.
  - Health history.
  - Physical development.
  - Mental development.
  - Physical exam.
  - Anticipatory guidance. Medical records must include evidence of a discussion. Only documenting that a handout was given will no longer meet the criteria.

*Remember: The above are basic documentation requirements per HEDIS guidelines and must be considered in addition to EPSDT guidelines on required age-specific screenings and services.

- Take a second blood pressure reading if the patient’s initial reading is elevated. Medical record review showed the second blood pressure reading was often controlled and ‘compliant’ for HEDIS purposes.

Maximize all HEDIS opportunities by engaging your members in well care. While you have the member present in the office take advantage of this opportunity to turn a visit into a well-care visit. Some suggestions are below:

- Include a physical exam at contraceptive management visits.
- Convert a sick, acute or reoccurring follow up (i.e. medication follow up) visit into a well visit by covering all 5 components.
- Combine the initial comprehensive prenatal visit or the comprehensive postpartum visit with a preventive care visit that meet all the HEDIS requirements, including age-appropriate health and developmental history (both mental and physical), physical exam and health education/anticipatory guidance. The appropriate Z00.129, Z00.121 or Z00.00 can be submitted as a secondary diagnosis code and count towards the AWC measure.