news**flash**

MHS™
Managed Health Services

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›› Behavioral Health Follow-Up

Managed Health Services can help your patients schedule appropriate after-care to improve the follow-up rates for members who have been hospitalized for a behavioral health condition.

Outpatient follow-up within seven days of discharge is vital to members' recovery. It is an opportunity to support their transition back into the community and to ensure they are taking prescribed medications correctly.

Please contact Managed Health Services if you have a patient who recently has been hospitalized for a behavioral health condition and who is having difficulty arranging a post-discharge appointment. We will work with your staff to make these arrangements.

We will continue to work diligently with our facilities, outpatient providers and members to schedule these valuable appointments. Here are some ways we can help:

▸ Scheduling assistance to obtain follow-up appointments within the seven-day time frame.
▸ Appointment reminder calls to members.
▸ Member transportation assistance.

Learn more. Call **1-800-222-9831** or visit **www.mhswi.com**.

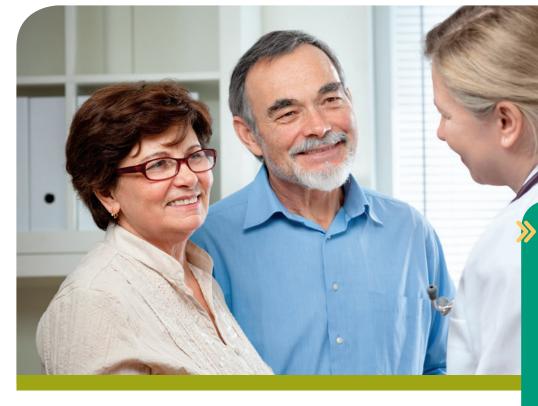## Could Case Management Benefit Your Patients?

Medical case management is a collaborative process that assesses, plans, implements, coordinates and evaluates options and services to meet an individual's health needs. It relies on communication and resources to promote quality and cost-effective outcomes.

Managed Health Services' case management is intended for high-risk, complex or catastrophic conditions—including transplant candidates and members with special healthcare needs and chronic conditions such as asthma, diabetes, HIV/AIDS and congestive heart failure.

Case managers do not offer hands-on medical care or treatment. They do not diagnose conditions or prescribe medication. A case manager can help a patient understand the benefits of following a treatment plan and the consequences of not following the plan outlined by the physician. In this way, they become a resource for the healthcare team, the member as well as the member's family.

Our case management team is here to support your team for such events as non-adherence, new diagnosis and complex multiple comorbidities.

Providers can directly refer members to our case management program at any time. Call **1-800-222-9831** for additional information about the case management services offered or to initiate a referral. Learn more about our case management services at **www.mhswi.com**.

Member Rights and Responsibilities: A Shared Agreement

Managed Health Services' member rights and responsibilities address members' treatment, privacy and access to information. We have highlighted a few below. There are many more and we encourage you to consult your provider manual to review them. You can find the complete provider manual online at **www.mhswi.com**, or get a printed copy by calling **1-800-222-9831.**

Member rights include, but are not limited to:

- Receiving all services that Managed Health Services must provide.
- Assurance that member medical record information will be kept private.

- Being able to ask for, and get, a copy of medical records, and being able to ask that the records be changed/corrected if needed.

Member responsibilities include:

- Asking questions if they don't understand their rights.
- Keeping scheduled appointments.
- Having an ID card with them.
- Always contacting their primary care physician (PCP) first for non-emergency medical needs.
- Notifying their PCP of emergency room treatment.

COUNTDOWN TO ICD-10

Recent legislative developments have occurred which affect the adoption of the ICD-10 Code set, originally planned for adoption in October of 2014.

On March 27, 2014, the Protecting Access to Medicare Act (H.R. 4302) passed the House of Representatives. On March 31, the bill passed the U.S. Senate, and on April 1, President Barack Obama signed the bill into law. The law includes a delay in the adoption of ICD-10 codes, which are now expected to be adopted on October 1, 2015.

We will provide updates as more details are released by HHS.

The Goals of Disease Management

As part of our medical management and quality improvement efforts, we offer members disease management programs.

The goals of disease management programs include:

- Promote coordination among the medical, social and educational communities
- Ensure that referrals are made to the proper providers.

- Encourage family participation.
- Provide education regarding a member's condition to encourage adherence and understanding.
- Support the member's and caregiver's ability to self-manage chronic conditions.
- Identify modes of delivering coordinated care services, including home visits.

These programs are intended for patients with conditions such as asthma, diabetes, heart failure, COPD and high-risk pregnancies.

Learn more about our disease management services at **www.mhswi.com** or by calling **1-800-222-9831.**

Pregnant Patient? Let Us Know

With your help, Managed Health Services can identify pregnant members early, and direct them to the services they need to support a healthy pregnancy and infant.

Notify us about a pregnant member by submitting a Notification of Pregnancy (NOP) form. When you send in an NOP, you're helping us reach women early in their pregnancy so those who are considered high risk can be referred to our case managers.

We also offer members the Start Smart for Your Baby® program, which helps women who are pregnant or who have just had a baby. Your staff and patients can learn more at **www.startsmartforyourbaby.com** or by calling Managed Health Services at **1-800-222-9831.**

ARE YOU AVAILABLE?

We define "availability" as the extent to which Managed Health Services contracts with the appropriate type and number of PCPs necessary to meet the needs of its members within defined geographic areas. The availability of our network practitioners is essential to member care and treatment outcomes.

Managed Health Services evaluates its performance in meeting these standards and appreciates providers working with us. Summary information is reported to the Quality Improvement Committee for review and recommendation and is incorporated into our annual assessment of quality improvement activities. The Quality Improvement Committee reviews the information for opportunities for improvement and provides recommendations.

Take note of our current accessibility standards:

PCP APPOINTMENT AVAILABLE	
Type of Service	**Appointment Availability**
Emergency Visit	Immediately upon request of appointment
Urgent Visit	Within 24 hours of request of appointment
Non-Urgent, Symptomatic Care	Within 7 calendar days of request of appointment
Foster Care Physicals	Within 48 hours of request of appointment
Routine Physical Exam/HealthCheck	Within 30 calendar days of request of appointment
High-Risk Prenatal Care	Within 2 weeks of request of appointment Within 3 weeks if the request is for a specific provider
Physical or Sexual Abuse Assessment	Immediately upon request of appointment
SPECIALIST APPOINTMENT ACCESS STANDARDS	
Type of Service	**Access Standard**
Routine Referral Visits	Within 60 calendar days
After-Hours Coverage	24 hours per day, 7 days per week
Office Wait Times	Within 30 minutes of scheduled appointment
HOSPITAL RESPONSIBILITIES	
Notification Timelines Are:*	
Emergent and Urgent Admissions	Within 2 business days following admission
Maternity Admissions	At admission
All Other Admissions	By close of the next business day

Failure to notify within the timeframes above may result in denial of payment for lack of timely notification.

HEDIS Physician Measurement

Below is a summary of HEDIS measurements related to ADHD, asthma and mental health.

ADHD: Children ages 6 to 12 with newly prescribed ADHD medication should receive at least three follow-up visits within a 10-month period, the first of which should occur within 30 days of when the first ADHD medication was dispensed. During these follow-up visits, physicians will review that:

- the prescription is being taken appropriately
- the patient is not abusing the medication
- the patient is not combining medications dangerously
- side effects are not discouraging regular and proper use of the prescription

ASTHMA: Members ages 5 to 50 with persistent asthma are being prescribed medications that are acceptable as primary therapy for long-term asthma control.

Ask your patients to bring their medications to appointments, and confirm that they know when and how to use them properly.

MENTAL ILLNESS: Patients age 6 and older who have been discharged from an inpatient mental health admission should receive one follow-up visit with a mental health provider within seven days after discharge and one follow-up visit with a mental health provider within 30 days after discharge.

A HEDIS Primer

WHAT: HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. Through HEDIS, NCQA holds Managed Health Services accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse membership.

WHY: As both state and federal governments move toward a healthcare industry driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. State purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its members. Physician-specific scores are used as evidence of preventive care from primary care office practices. These rates then serve as a basis for physician profiling and incentive programs.

HOW: HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include:

- annual mammogram
- annual chlamydia screening
- treatment of pharyngitis
- treatment of URI
- appropriate treatment of asthma
- antidepressant medication management
- access to PCP services
- utilization of acute and mental health services

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include:

- comprehensive diabetes care
- control of high-blood pressure
- immunizations
- prenatal care
- well-child care
- annual Pap test
- cholesterol management

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