newsflash

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A NEWSLETTER FOR MHS PLAN PHYSICIANS ... WE TAKE HEALTHCARE PERSONALLY

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We Are Here to Help

You can contact us at the following numbers:

- **PROVIDER SERVICES: 1-800-222-9831**
- **MEDICAL MANAGEMENT: 1-800-222-9831**
- **UTILIZATION MANAGEMENT STAFF: 1-800-222-9831**

To learn more about our provider services and processes, please check our provider manual, available at **www.mhswi.com**.

If you or one of our members would like a paper copy of anything found on our site, please contact **1-800-222-9831**.

How You Can Support HEDIS Scores

HEDIS measurements are an important part of measuring and reporting on healthcare quality. They give consumers and employers a way to make informed decisions as they choose care.

Below is a summary of key HEDIS measurements related to children's health.

WELL-CHILD EXAMS

- Ages 0 to 15 months: Six well-care visits (at least two weeks apart) with a PCP, to include health and development history, physical exam and health education/anticipatory guidance.
- Ages 3 to 6 years: Annual well-care visit with a PCP, to include health and development history, physical exam and health education/anticipatory guidance.
- Ages 12 to 21 years: Annual well-care visit with a PCP or ob/gyn, to include health and development history, physical exam and health education/anticipatory guidance.

LEAD SCREENING

For children in the Medicaid population, at least one capillary or venous lead screening test on or before their second birthday.

DENTAL VISIT

For Medicaid enrollees ages 2 to 21, at least one dental visit annually.

Helping Parents: Immunizations

A critical part of children's healthcare, immunizations can also be confusing to parents. Help parents understand and follow the recommended schedule for immunizations by sharing a simply formatted and customizable chart, like the one provided on this page. Distribute it to new patients and new parents along with appointment information. You may also direct members to reliable online resources like **www.cdc.gov/vaccines**.

Your Child's Immunization Schedule

Child's Name: Date of Birth:

VACCINE	PROTECTS AGAINST	RECOMMENDED VACCINATION TIMING	DATE(S) RECEIVED	NOTES
HepB	Hepatitis B virus (chronic inflammation of the liver)	At birth; between 1 and 4 months; 6 to 18 months		
RV	Rotavirus (virus causing severe diarrhea and vomiting)	2 months; 4 months; 6 months		
DTaP	Diphtheria (thick covering in the back of the throat); Tetanus (painful muscle stiffness); Pertussis (whooping cough)	2 months; 4 months; 6 months; 15 to 18 months; 4 to 6 years		
Hib	Meningitis (infection of the covering of the brain and spinal cord); Epiglottitis (severe throat infection)	2 months; 4 months; 6 months; 12 to 15 months		
PCV	Pneumococcal disease (bacterial infection that can lead to pneumonia, blood infections and meningitis)	2 months; 4 months; 6 months; 12 to 15 months		
IPV	Polio (virus which can lead to paralysis)	2 months; 4 months; 6 to 18 months; 4 to 6 years		
Influenza	Influenza (virus causing fever, chills, sore throat, muscle aches, fatigue, cough, headache and runny/stuffy nose)	Annually, starting at 6 months		
MMR	Measles (virus that can lead to pneumonia, seizures, brain damage and death); Mumps (virus that can lead to deafness, meningitis, swelling of testicles/ovaries and sterility); Rubella (virus causing rash, arthritis, fever and potential miscarriage or birth defects in pregnant women)	12 to 15 months		
Varicella	Varicella (chickenpox caused by varicella-zoster virus)	12 to 15 months		
Hep A	Hepatitis A (virus that causes a liver disease)	12 to 23 months		

+ Tdap: You can protect your baby from whooping cough by getting a Tdap shot when you are pregnant, during the third trimester.

Medicare Pharmacy Star Measures

The Five Star Quality Rating System for Medicare Advantage Plans is run by the Centers for Medicare and Medicaid Services (CMS), and was put in place as part of an effort to help educate consumers on quality and make quality data more transparent.

The ratings consist of more than 50 measures from five rating systems:

1. HEDIS (Healthcare Effectiveness Data and Information Set)
2. CAHPS (Consumer Assessment of Healthcare Providers and Systems)
3. CMS (Centers for Medicare and Medicaid Services)
4. HOS (Health Outcomes Survey)
5. IRE (Independent Review Entity)

These systems rate Medicare Advantage plans according to five domains:

1. Staying healthy via preventive services such as screenings and vaccines
2. Managing chronic conditions
3. Ratings of plan responsiveness and care
4. Complaints, appeals and voluntary disenrollment
5. Telephone customer service

Data to support these star ratings come from surveys, empirical observation, administrative (claims) data and medical records. Based on criteria provided in technical specs outlined by CMS, rates and scores are calculated and stars are awarded on a contract level. CMS stars ratings are published annually and are available for viewing by all Medicare members prior to open enrollment.

All Medicare Advantage plans are rated on a 1 to 5 star scale, with 1 star for poor and 5 stars for excellent performance.

Medicare Part D ratings are heavily influenced by five medication-related measures:

1. Adherence to oral diabetes medications
2. Adherence to statins
3. Adherence to angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
4. Avoiding high-risk medications in the elderly
5. The use of ACEIs or ARBs for diabetes patients with hypertension

MEDICATION ADHERENCE

CMS measures non-adherence as the percent of plan members who do not fill their prescription often enough to cover 80 percent or more of the time that they are supposed to be taking the medication.

CMS is currently focusing on three medication categories for medication adherence: oral diabetes medications, hypertension medications and cholesterol medications.

There are many issues that can lead to medication non-adherence. Some examples include perceived burden of taking medication, concern about side effects and failure to understand why the medication is needed. Other barriers to adherence may include difficulty getting to the pharmacy, as well as simply forgetting to take the medication.

Managed Health Services, through its pharmacy team, currently does outreach through letters and phone calls by a pharmacy coordinator to help members address barriers to adherence that they may be experiencing. **Providers can assist with this Star measure by discussing the importance of medication adherence, specifically by reviewing with the member why they are prescribing a particular medication and what can happen if they do not take their medication as prescribed. During follow-up visits, providers can also help with adherence by discussing with the member any side-effects and addressing any concerns that the member may have with taking their medications and, of course, encouraging their patients to take their medications exactly as prescribed.**

THE USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY

CMS measures this by looking at the percentage of members 65 years and older who receive two or more prescription fills for a high-risk medication during the calendar year. The use of high-risk medications in the elderly can put some patients at increased risk for serious side effects from their medications.

Multiple factors contribute to the increased risk of adverse drug events in older individuals. Aging and chronic conditions commonly seen in older adults produce physiologic changes that alter the pharmacokinetics and pharmacodynamics of medications. Such changes often affect the choice, dose and dosing frequency of many medications. Furthermore, as patients develop more chronic conditions, the likelihood increases that a medication used to treat one condition will exacerbate another condition. It is also important to keep in mind that as patients get older they may have a decrease in renal and liver function which can lead to increased risk for toxicities for certain high-risk medications. Some therapies that were once needed may no longer be appropriate or needed in the elderly patient.

Current outreach by Managed Health Services is conducted by fax and follow-up phone calls to providers by a clinical pharmacist to discuss the use of high-risk medications in the elderly Medicare members that it serves. **Providers can assist with this Star measure by understanding the importance of evaluating both the current and future use of high-risk medications and prescribing safer alternatives when appropriate for their elderly Medicare patients.**

THE USE OF ACEIS OR ARBS FOR DIABETES PATIENTS WITH HYPERTENSION

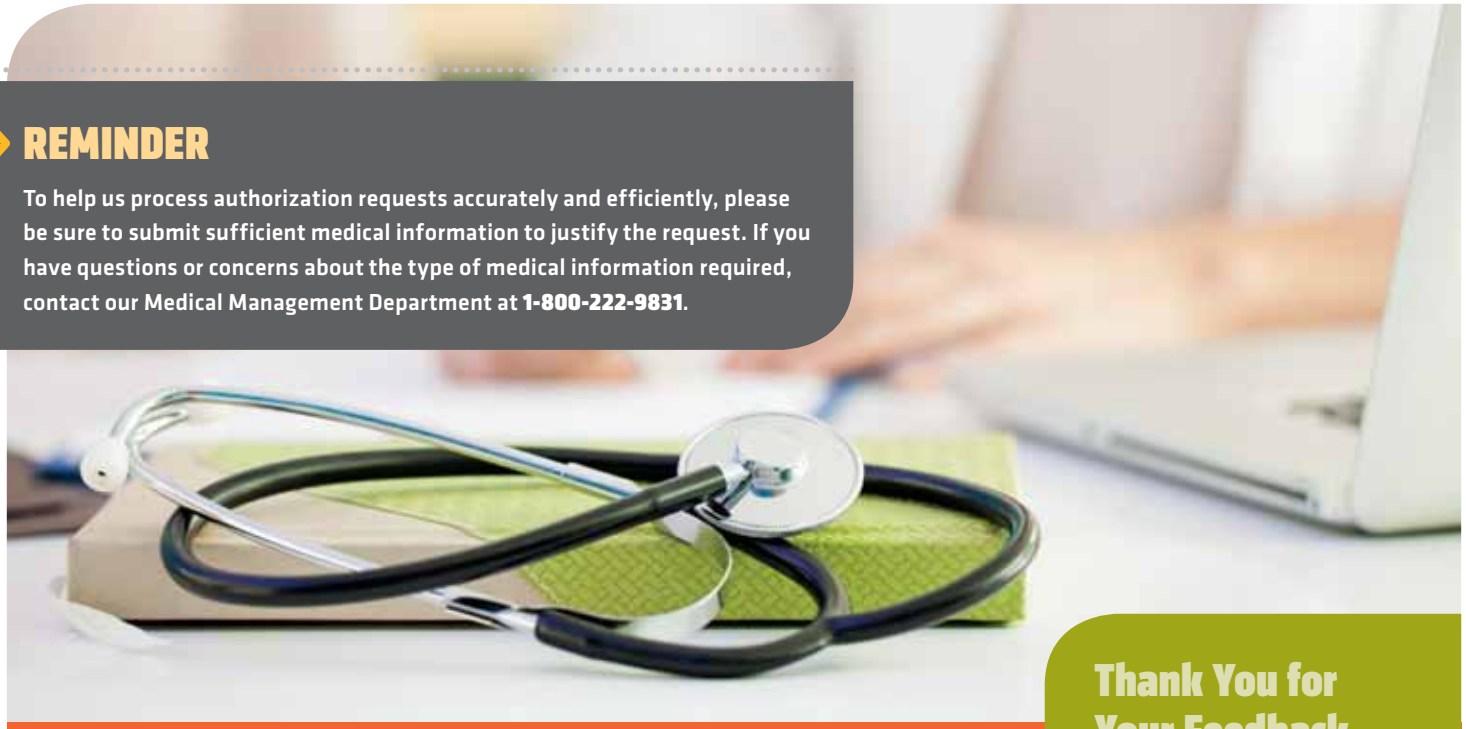
CMS measures this diabetes initiative by the percent of plan members that have both a diagnosis of diabetes and hypertension and are being treated with either an ACEI or an ARB. A higher percentage correlates to a higher Star rating. Recent reporting shows that Managed Health Services has done well on this measure and will continue to monitor and conduct outreach to providers when appropriate.

Current outreach by Managed Health Services is conducted by letters, and when necessary, phone calls to providers by a clinical pharmacist. **Providers can assist with this Star measure by continuing to evaluate diabetic members with hypertension to determine if ACEI or ARB therapy is appropriate for the patient.**

Managed Health Services takes great pride in providing the best possible service to all of our Medicare members. We take the CMS Stars ratings very seriously and will continue to work hard to achieve the highest Star rating possible. We appreciate all that our providers do to care for our members, and the attention our providers give to all Stars measures.

REMINDER

To help us process authorization requests accurately and efficiently, please be sure to submit sufficient medical information to justify the request. If you have questions or concerns about the type of medical information required, contact our Medical Management Department at 1-800-222-9831.



The Appropriate Use of Resources

Managed Health Services and its delegated partners have utilization and claims management systems in place to identify, track and monitor care provided and to ensure appropriate care is provided to members.

Managed Health Services does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities for issuing denials of coverage or care. Utilization management (UM) decision-making is based only on appropriateness of care, service and existence of coverage. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization. Utilization denials are based on lack of medical necessity or lack of covered benefit.

Utilization review criteria have been developed to cover medical and surgical admissions, outpatient procedures, referrals to specialists and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physician members of the Managed Health Services' UM Committee.

Providers may obtain the criteria used to make a specific decision by contacting the Medical Management Department at **1-800-222-9831**. Practitioners also have the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination.

LEARN MORE: Our UM staff is available 8 a.m. to 5 p.m. at **1-800-222-9831**.

Thank You for Your Feedback

Managed Health Services recently conducted our annual Provider Satisfaction Survey. If you participated, thank you.

Survey questions covered a range of topics, including provider relations, coordination of care, utilization, finance and overall satisfaction. Your feedback will guide our improvement efforts in the upcoming year.

Specifically, we plan to focus on the following areas for improvement:

- **Claims operations**
- **Network improvements**
- **Provider communication**
- **Customer service**

Please look for the next Provider Satisfaction Survey this fall.

MHS Managed Health Services

ADVANTAGE by Managed Health Services HMO SNP

1-800-222-9831
WWW.MHSWI.COM

MHS/NHP REFERS TO THE BADGERCARE PLUS AND MEDICAID SSI MEMBERS OF MANAGED HEALTH SERVICES AND NETWORK HEALTH PLAN.