MDwise
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- Hoosier Healthwise
- Healthy Indiana Plan

ProviderLink

Winter 2020

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HEDIS Housekeeping – It's That Time of Year Again

MDwise is well under way preparing for our annual HEDIS® (Healthcare Effectiveness Data and Information Set) audit. The State of Indiana requires the collection of data and reporting of HEDIS® rates by all participating Medicaid managed care plans. **Every medical record we receive makes a difference!** As a participating MDwise provider, one or more of your patients may be randomly selected for the audit. To make this process as efficient and hassle-free as possible, the MDwise Quality Team will send communication out to providers regarding medical record retrieval early next year.

Reminder – as outlined in the MDwise provider contact, MDwise does not pay for medical records. If your office utilizes a medical record vendor, then please let them know they cannot bill and hold those medical records. Please contact your Provider Relations Representative if you have any questions or call **317-822-7300** ext. 5800.

MDwise sincerely thanks you for your assistance with our HEDIS® medical record reviews and your help making this vital project a success!

Hours of Operation Parity

MDwise requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members. **Medicaid law requires the organization to ensure that network practitioners offer hours of operation that are no less, in number or scope, than the hours of operation offered to non-Medicaid members.** If the provider serves only Medicaid recipients, hours offered to Medicaid managed care enrollees must be comparable to those for Medicaid fee-for-service members. NCQA reviews MDwise's (e.g., practitioner contract templates, practitioner manual, practitioner newsletters) for language that the practitioner's hours of operation are not less for Medicaid patients than for non-Medicaid patients.

Comprehensive Well-Child Care

EPSDT services are required for all Medicaid members up to age 21.

Early Periodic Screening Diagnosis and Treatment (EPSDT), also known as HealthWatch in Indiana, is a federal program in place to ensure all children receive comprehensive and timely screenings and services. EPSDT requirements focus on preventive services and early detection to catch potential problems before they develop into a more serious and more costly issue. Further, EPSDT requirements are evidence based and follow the **American Academy of Pediatrics' Bright Futures™** guidelines.

Bright Futures™ is considered the gold standard of all-encompassing pediatric care. Please refer to the Bright Futures™ Periodicity Schedule to determine which services and screenings are recommended and at which time intervals. IHCP also offers an EPSDT/HealthWatch Provider Reference Module further detailing EPSDT screening services, exam components, billing guidelines and available community resources.

A crucial piece of the EPSDT/HealthWatch program is screening and evaluating children on a routine basis. Partner with MDwise to engage members in their health care and make establishing a medical home a priority.

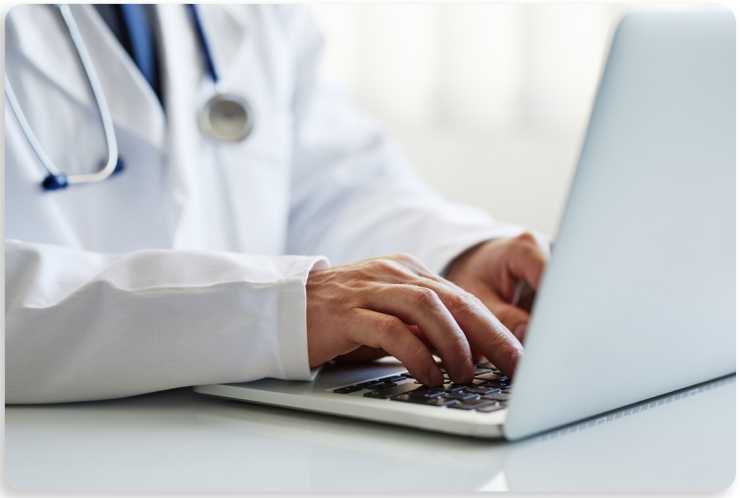
Looking for ideas on how to get members to schedule and keep routine preventive care visits?

- Host a health fair featuring well-child check-ups and screenings (i.e. vision, hearing, lead testing).
- Partner with the MDwise Outreach Team and inquire about possible collaboration opportunities.
- Utilize monthly Progress Reports posted to the Quality Reports section on the **MDwise Provider Portal** and outreach to your assigned members in need of services.
- Promote the **MDwiseREWARDS** program – members can earn points for well-child visits.
- Contact your **Provider Relations Representative** for additional ideas and questions.

Poor Documentation Does Affect Patient Care

Insufficient documentation can lead to adverse patient care. Per the National Committee for Quality Assurance (NCQA), "consistent, current and complete documentation in the medical record is an essential component of quality patient care."

With a fast-paced and complex health care delivery system, practitioners must thoroughly document examination findings, treatment plans, referrals and more to facilitate quality continuity of care for patients. NCQA has established **21 accepted standards for medical record documentation**.



Some practical, yet sometimes forgotten, standards include:

1. Patient name or ID number is on each page.
2. Every entry is dated.
3. Each entry includes author's identification and credentials.
4. Problem List(s) and Histories are up to date.
5. Record is legible.

MDwise also outlines medical record requirements in the MDwise **Provider Manual**.

As we head into HEDIS season, please remember individual authorization is not required for MDwise to perform medical record review. Privacy regulations permit the sharing of information between health plans and providers for purposes of health plan operations, which includes quality improvement activities.

Source: Guidelines for Medical Record Documentation. July 2018. National Committee for Quality Assurance. https://www.ncqa.org/wp-content/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf

Affirmative Statement about Incentives

MDwise medical management makes prior authorization decisions based on appropriateness of care and coverage rules. MDwise medical management does not receive incentives or rewards, financial or otherwise, for making denial decisions and are not rewarded for making UM decisions that decrease utilization of services by MDwise members.

CAHPS Member Satisfaction Summary

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for Hoosier Healthwise and Healthy Indiana Plan

MDwise contracts with an approved CAHPS® vendor, SPH Analytics, to conduct an annual survey with its Hoosier Healthwise and Healthy Indiana Plan (HIP) members. The overall objective of the CAHPS® survey is to capture information on members' experiences with health care. The survey measures how well we are meeting our members' expectations and goals, which areas of service have the greatest effect on our members' overall satisfaction and identifies opportunities for improvement. Many of the ratings involve member feedback on their interaction with MDwise providers.

SPH Analytics surveyed eligible members for Hoosier Healthwise and HIP from February through May 2020. The mixed survey administration included mail, telephone and a link that allowed members to complete the survey online.

Once the survey was complete, SPH generated reports to compare MDwise to prior years and other health plans. NCQA utilizes CAHPS® scores in determining health plan accreditation status and rating.

Overall Scoring

In 2020, the scores across all programs, compared to previous year's scores and to other health plans, indicated opportunities in:

- Getting Needed Quickly (getting care/tests/treatments needed).
- Coordination of Care.

The chart below displays some of our scores for 2020 with the benchmarks from other Medicaid health plans across the country inserted for comparison.

Category	MDwise Child Hoosier Healthwise 2020	Benchmarks from Child Medicaid Health Plans	Healthwise 2020	MDwise Adult HIP 2020	Benchmarks from Adult Medicaid Health Plans
Getting Needed Care	88.3%	85.6%	84.5%	88.2%	83.5%
Getting Care Quickly	93.6%	90.5%	83.8%	80.3%	82.7%
Coordination of Care	87.3%	85.0%	80.0%	86.7%	85.9%
How Well Doctors Communicate	95.4%	95.1%	98.1%	90.4%	93.2%
Rating of Personal Doctor (rated 8, 9 or 10)	91.3%	91.2%	87.5%	81.2%	84.2%
Rating of Specialist (rated 8, 9 or 10)	84.5%	75.0%	96.6%	83.8%	84.7%
Rating of Health Care (rated 8, 9 or 10)	90.6%	88.7%	91.7%	77.1%	76.9%

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On the 2020 survey, MDwise members had the following responses:

Category	Adult Hoosier Healthwise 2020 (current year results)	Adult HIP 2020 (current year results)
Advising Smokers and Tobacco Users to Quit	81.8%	85.4%
Discussing Cessation Medications	50.0%	62.8%
Discussing Cessation Strategies	40.0%	58.6%

The Summary Rate for the **Advising Smokers and Tobacco Users to Quit** measures is the percentage of members who indicated that they "Sometimes," "Usually," or "Always" received counsel to quit smoking or using tobacco from a doctor or other health provider. The Summary Rates for the **Discussing Cessation Medications** and **Discussing Cessation Strategies** measures are the percentage of members who indicated that their doctor or health provider "Sometimes," "Usually," or "Always" recommended cessation medications or provided cessation methods or strategies. The above data supports the need for tobacco cessation counseling. Providers can directly refer a patient to the Indiana Tobacco **Quitline** where you can get additional information. **Fax forms** can be found on the **MDwise website**.

HEDIS Tips

We will be sharing HEDIS tips in quarterly ProviderLink newsletters to help you maximize your efforts. **This edition focusses on general tips and those for girls and women.**

- Schedule prenatal visits starting in the first trimester, or as early as possible, when a patient contacts you for an appointment. If possible, ask front office staff to **prioritize scheduling newly pregnant patients to ensure prompt appointments in their first trimesters**.
- If you use global billing/bundling, your claims may not routinely include the specific date information that counts toward the prenatal or postpartum HEDIS measures. Check to see if you have an opportunity to **include specific dates of prenatal and postpartum visits on claims**.
- Educate new moms on the need for a postpartum visit 7-84 days after delivery and schedule the visit. **Remember that a day too early or a day too late makes the patient noncompliant with the HEDIS measure;** ensure scheduling staff are aware of the importance of timely appointments.
- Request copies of mammography results be sent to your office. **Consider scheduling mammograms so that they occur before the patient's appointment** with your office, so that you have the results available to review during the appointment.
- **Annual urine screenings for chlamydia are compliant with the HEDIS chlamydia measure.** Consider using any visit opportunity to screen for chlamydia in those patients who are sexually active. Ask your clinical staff whether chlamydia screening should be more routine. The HEDIS measure for chlamydia screenings applies to females ages 16 to 24. If your office does not perform chlamydia screenings or pap tests, refer members to an obstetrician or gynecologist (OB/GYN) or other appropriate provider and have copies of the results sent to you. Pap tests are not always done at OB/GYN visits, so please ask specifically whether a pap test has been done and request the result.
- Make sure records of cervical cancer screenings reflect both the date the test was performed and results or findings.
- Document any applicable surgical history of complete/total/radical abdominal or vaginal hysterectomy and make sure to include the year the surgery was performed.
- To boost the rates of cervical cancer and breast cancer screenings, consider what tools staff could use to educate patients. Examples might include **handheld cards, charts, EMR flags and brochures.** Patients' confusion over how the screenings apply to them is a common reason why they do not follow up on screenings.

Coordination of Care with Additional Providers through Electronic Health Records

Electronic Health Records (EHR) are becoming more and more common for medical providers, however, many EHR systems do not communicate with each other making it difficult to coordinate care between PMPs and other ancillary providers and specialists. Coordinating care can be a very time-consuming task for a PMP due to the various EHR systems and whether the PMP has access to a particular system. Additionally, some PMPs, ancillary providers and specialists do not have access to EHR and still use paper for documentation of clinical notes. Even if a PMP has access to EHRs to view their patient's clinical records from other providers, it can be difficult to review all clinical notes from other health care providers. **Without timely and effective communication between health care providers, the quality of care and patient satisfaction can suffer, as well as, increase risk for adverse events.**

How can communication between all providers be easier and more effective?

- Encourage your patients to have a "medical home" where all clinical notes and documentation from all involved health care providers can be sent to be kept in one central location.
- If a patient is being seen by their PMP and the PMP is aware of a recent visit to a specialist and/or ancillary provider, utilize medical assistants or nurses in the PMP office to perform first level reviews of information (i.e. lab results, updated medication list) and highlight that information to be communicated with the PMP.
- Define the most important information regarding the care of a patient that must be shared between providers. Document information of note in a summary that is easy to access between all medical providers involved in caring for the patient. **If possible, document this information in a way that it can be displayed at the beginning of clinical notes and easily found.** It will assist other health care providers in seeing the "whole picture."
- Encourage patients to see specialists that you already have a working relationship with. When health care providers have an established relationship, each feel more comfortable communicating critical patient information with each other.
- In urgent situations, even if EHR access is available between different providers who are coordinating care, contacting a provider directly may be more valuable. Electronic communication has many benefits, but **in critical situations direct communication can be crucial** at preventing an adverse event.

1-800-356-1204
Hoosier Healthwise and HIP

MDwise.org/providers

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

HIP HEALTHY INDIANA PLAN

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