

The Communicator



2009 SCORES ARE IN

The final scores are now available for Managed Health Services' 2009 Consumer Assessment of Healthplan Providers and Systems (CAHPS) member survey. Members rated MHS and its providers on 14 areas:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making
- Health Promotion and Education
- Coordination of Care
- Rating of Healthcare
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan
- Advising Smokers to Quit
- Smoking Cessation—Medication
- Smoking Cessation—Strategies

For the adult survey, scores for all measures except Getting Needed Care, Smoking Cessation Medication and Smoking Cessation Strategies improved for 2009 compared to 2008. To meet benchmarks set by the National Committee on Quality Assurance, improvement is needed regarding how members perceive Getting Needed Care (77.7% favorable rating), How Well Doctors Communicate (87.3% favorable, but below benchmarks), Customer Service (73.7% favorable), Rating of Personal Doctor (75.9% favorable), Rating of Specialist (76.0% favorable), Rating of Health Plan (70.1% favorable), Advising Smokers to Quit, and Smoking Cessation Medication.

For the child survey, scores improved for 2009 compared to 2008 for all measures except How Well Doctors Communicate, Rating of Specialists and Rating of Healthcare. Customer Service saw a significant change, increasing from 63.5% to 82.5% for 2009.

MHS is currently examining opportunities for improvement in 2010. We thank all of you who helped achieve the commendable 2009 scores. We look forward to achieving greater success for our 2010 CAHPS survey, and welcome your ideas about what can be done to improve members' perceptions of their healthcare experiences.

Ready for The Flu?

Tips to help with this challenging season.



This year's flu season is complicated by having the traditional seasonal flu along with the novel H1N1 (swine) influenza. A vaccine for H1N1 is in production and will likely be of a type that is most effective if given two times about three weeks apart. The seasonal and H1N1 vaccines are intended to be used together to fight different influenza viruses and can be given on the same day.

ACOG and the CDC both recommend the seasonal and H1N1 flu shots for almost all pregnant women. Pregnant women are much more likely to get sick if infected with the H1N1 virus—even if they are healthy. At any one time, one percent of the population in our country is pregnant, but already 13 percent of the deaths from H1N1 infection have been in pregnant women.

Additionally, the CDC recommends both the seasonal and H1N1 flu vaccination for children ages six months to 18 years, caregivers of those younger than six months old and non-elderly adults with certain chronic conditions. H1N1 flu vaccine alone is recommended for adults age 19 to 24. Seasonal flu vaccine continues to be recommended for people with certain chronic conditions and all adults age 50 and older.

With two types of influenza and two different immunizations, education is even more important this flu season. Managed Health Services is sending out educational information to its members, including pregnant women, encouraging them to get the flu vaccines. We will also be updating our website and sending out additional provider mailings as updated CDC information becomes available.

Providers: Remember to ask your patients, "Do you smoke?" and "Can I help you quit?" Indiana Medicaid programs cover tobacco cessation counseling and prescription cessation aids! Read the full bulletin from Indiana Medicaid at www.managedhealthservices.com/Providers/Resources/Guides.

2 Tips for Antidepressant Medication Compliance

3 Our Members' Rights And Responsibilities

4 How We Can Help With Chronic Disease Care

Effective Antidepressant Medication Management

We're stepping up efforts to ensure patient compliance.

The National Committee for Quality Assurance reports that the consequences of untreated or inadequately treated depression are significant; therefore, improving compliance of your patients taking antidepressant medications is very important. Pharmacotherapy has been shown to be critical to the effective treatment of depression. Coupled with appropriate forms of psychological therapy, most patients experience good outcomes with antidepressants taken for at least a six-month duration. Clinicians should monitor patients very carefully during the acute phase (the first three months) and the initial continuation phase (the first six months) of treatment so that adjustments to the dosage or type of medication can be made, if necessary.

Depression as a diagnosis represented 22.5 percent of total diagnoses within the MHS member population in 2008. MHS providers prescribing antidepressant medication in the acute phase of treatment did very well in relationship to the national HEDIS® measures. The acute phase measures those members who had a follow-up appointment with their provider within 30 days of the initial start. MHS prescribers did not do so well in the maintenance phase. This is defined as those members from the acute phase

cohort that remain on the antidepressant for at least 180 days after initial start.

To improve this measurement, MHS advocates the following interventions:

- 1 Education about the medication at the beginning of treatment, including the benefits, side effects, how to cope with side effects, and how it works with symptoms.

- 2 Regularly scheduled appointments for follow-up to assess symptoms, side effects, etc.

- 3 Referral to a therapist or counselor. Research has shown that there is an increase in efficacy if medication is coupled with therapy (Arnow, B.A. and Constantino, MJ, *Journal of Clinical Psychology*, 2003, Aug., pp. 893–905).

- 4 For more information, go to the provider section of www.cenpatco.com or the National Institute of Mental Health website at www.nimh.nih.gov.

New Resources on Our Website

The Provider/Hospital Directory (Find a Doctor) has recently been updated to include more information for each listing and new search criteria options.

You can request printed copies of all items, including all items on the MHS website, by calling Provider Services at 1-877-647-4848.

About Our Process

A toll-free number, 1-877-647-4848, is available to accept calls regarding utilization management (UM) related questions and/or issues 24 hours a day, seven days a week. From 8 a.m. to 5 p.m., Monday through Friday (excluding state holidays), calls are directed to the UM Department. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. After operating hours, the department operates a call-recording system capable of providing instructions and recording messages. All messages left on this call system will be returned within two business days.

Appropriately licensed, qualified professionals make all medical necessity decisions, based only on appropriateness of care, service and existence of coverage. The Indiana Department of Insurance, Office of Medicaid Policy and Planning and MHS Medicaid providers are notified in writing prior to implementing any significant changes that affect provider processes or procedures. MHS does not provide financial incentives for UM decision makers that encourage decisions that result in underutilization, nor do we reward practitioners or other individuals for issuing denials of coverage or care.

Utilization Management Affirmative Statement About Incentives

MHS conducts its UM activities in a manner that encourages appropriate utilization of, and discourages underutilization of, care and services. In addition, MHS does not use incentives to encourage barriers to care and service.

Utilization Management Criteria

MHS has adopted nationally recognized utilization review criteria developed by Milliman Care Guidelines to assist in determining the appropriateness of medical services. Milliman criteria cover medical and surgical admissions, outpatient procedures and ancillary services. Criteria are established, periodically evaluated and updated with appropriate involvement from physician members of the MHS Utilization Management Committee. Practitioners may obtain a copy of the criteria guiding the recommendation of the medical director to deny or modify a service request by contacting MHS' Medical Management Department at 1-877-647-4848.

Get to Know Managed Health Services Members' Rights and Responsibilities

MHS MEMBERS HAVE THE RIGHT TO:

- Courteous and considerate treatment from MHS staff, practitioners and office staff.
- Be treated with respect and dignity, including recognition of a need for privacy.
- Choose a PMP and be told which hospitals they can access.
- Change their health plan anytime during the first 90 days of enrollment, once a year on their enrollment anniversary date, move with their PMP to another health plan, and anytime during the year if there is "just cause."
- Know how to receive referrals for specialty care and other services.
- Review our practice guidelines—the criteria used to approve or deny medical requests.
- Information about their rights and responsibilities, MHS, its practitioners, providers and services. MHS sends a Member Handbook to all newly enrolled members and a newsletter to all members quarterly. In addition, information can be found on our website at www.managedhealthservices.com or by calling Member Services at 1-877-647-4848.
- Confidentiality regarding medical records and all personal information and the opportunity to approve or refuse the release of personal information, except when required by law.
- Be involved in decisions about their healthcare and be given information about alternative treatment options, and the option to refuse treatment.
- Personalized help from MHS staff, especially in cases where there is a

"special healthcare need" such as a long-term disease or severe medical condition. We make sure members get access to all needed care and will help coordinate care with all practitioners involved.

- A discussion regarding appropriate or medically necessary treatment options and alternatives, regardless of cost or benefit coverage, in a clear manner.
- Be free from any actions used to punish, isolate, convince or persuade them for any reason.
- Get a second opinion from a qualified healthcare professional.
- Access to family planning and OB services for annual tests without approval from MHS or a PMP, including birth control, HPV tests and annual Pap smears.
- Be informed of denied authorizations as quickly as needed so that their medical needs are met and treatment is not delayed. We will not jeopardize any medical condition waiting for approval of services. Authorizations are reviewed based on medical needs and made in compliance with state time frames.
- Receive written notice of a denied authorization, partial denial or limitation of a service—including decisions that limit the number of visits, date range, or decisions about other treatment options.
- Request and receive copies of medical records and to request changes to their records without affecting how the plan, providers or the State treats them.
- Be given a full range of advice and

counseling from healthcare providers as appropriate.

- Know how to file a complaint, how to use the grievance procedure, and how to be protected from any negative actions resulting from use of the complaint or grievance procedure.
- File an appeal with the FSSA Office of Hearing and Appeals if they are not satisfied with the final decision after using the grievance procedure.
- Be given complete information in order to give informed, voluntary permission to participate in medical research even though experimental/investigational procedures are not covered services.
- Complete benefit information, including how to get: services during regular hours of operation, emergency care after hours, out-of-area care, and what exclusions and limits are present on covered services.
- Be told about a change in any benefit, termination of services, and availability of any provider. The State will notify members if their doctor is no longer available through Hoosier Healthwise. Members should have at least 30 days to choose another doctor before being assigned
- Have MHS or contracted providers arrange for interpreter services at no charge if needed.
- Make recommendations about our Member Rights and Responsibilities policy.
- Free medical care for covered services unless copayments are required. This includes:

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About Members' Rights and Responsibilities *Continued from page 3*

- Free covered services already received, even if MHS closes.
- Free covered services already received, even if the State does not pay MHS.
- Free covered services already received, even if MHS does not pay for it under our contract, but services are covered through HHW State coverage.
- Not have to pay extra payments for covered services, even if MHS could have provided the service for less.

MHS MEMBERS HAVE THE RESPONSIBILITY TO:

- Establish a relationship with their MHS PMP within the first 90 days of enrollment.
- Read all notices MHS sends to members regarding health plan benefits.
- Update their case worker, MHS and their PMP when they change their

address or telephone number so that MHS can continue to send benefit updates.

- Provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly give care.
- Keep all scheduled appointments; be on time for those appointments, and to cancel 24 hours in advance if unable to keep an appointment.

■ Understand their health problems as best they can and work with their doctors to develop treatment goals.

- Follow plans and instructions for care that they have agreed to with their MHS doctor, and to get all care from their PMP, except for referrals made by the PMP and self-referral services.
- Show their HHW card every time they get care.

HELP FOR PATIENTS WITH CHRONIC DISEASES

MHS offers disease management programs to empower members to achieve the highest level of wellness, functioning and quality of life when diagnosed with asthma, high-risk pregnancy and diabetes. Additionally, MHS provides education and follow-up for members at risk of lead poisoning. Our programs and interventions are stratified to address the various needs of members. Outreach includes mailed educational items, screening assessments, resource assistance and telephone clinical coaching by registered nurses or respiratory therapists. Providers who have newly diagnosed or noncompliant members who wish to make a referral for disease management may do so by calling 1-877-647-4848.

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