ProviderReport

home state health™

Reviewing the appropriate use of resources

Home State Health has utilization management and claims management systems to identify, track and monitor care provided to our members. Utilization management (UM) care criteria cover preventive care, emergency care, primary care, specialty care, acute care, short-term care, maternity care and ancillary care services. Home State Health uses nationally recognized criteria (such as InterQual) if available for the specific service; other criteria are developed internally through a process that includes the review of scientific evidence and input from relevant specialists.

UM decision-making is based only on appropriateness of care and service and the existence of coverage. Home State Health does not reward providers, practitioners or other individuals for issuing denials of coverage or care. Denials are based on lack of medical necessity or lack of covered benefit. Financial incentives for UM staff do not encourage decisions resulting in underutilization of services.

To help us make appropriate UM decisions, providers should submit complete clinical information with the initial request for a service or treatment. If a denial of coverage or care is issued, providers have the opportunity to discuss the denial decision with a physician or another appropriate reviewer at the time of notification of an adverse determination.

Providers may request UM criteria pertinent to a specific authorization, or speak to a UM representative, at any time by contacting the UM Department at **1-855-694-HOME (4663).**

How we measure quality

Home State Health strives to provide quality healthcare to our members as measured through HEDIS quality metrics.

HEDIS, the Healthcare Effectiveness Data and Information Set, is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allow direct, objective comparison of quality across health plans. NCQA develops the HEDIS measures through a committee composed of purchasers, consumers, health plans, healthcare providers and policymakers.

HEDIS allows for standardized measurement and reporting and accurate, objective side-by-side comparisons. Learn more at **ncqa.org**.

Please note the HEDIS measures highlighted on the next pages regarding child and adolescent health visits and lead screening.

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HEDIS for well-child visits

Several HEDIS measures cover issues related to well-child visits. These include:

- **Well-Child Visits in the First 15 Months of Life:** Assesses children who had up to six well-child visits with a primary care practitioner (PCP) during their first 15 months of life.
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life:** Assesses children ages 3 to 6 who received one or more well-child visits with a PCP in a year.
- **Adolescent Well-Care Visits:** Assesses adolescents and young adults ages 12 to 21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN in a year.
- **Children and Adolescents' Access to Primary Care Practitioners:** Assesses children and young adults ages 12 months to 19 years who had a visit with a PCP.

Guidelines for well-child care

Home State Health reminds parents that children should have a well-child visit every year and that routine health screenings and needed immunizations can help ensure children are healthy and developing normally.

For children under age 21 who are enrolled in Medicaid, services are provided through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which requires preventive, dental, behavioral health, developmental and specialty care.

The American Academy of Pediatrics offers guidelines for caring for infants, children and adolescents through **Bright Futures**, a health promotion and prevention initiative. These guidelines include health promotion and anticipatory guidance, disease prevention and early detection of disease, and development and behavioral health screenings.

Under Medicaid rules, states must develop a periodicity schedule for recommended care. States may elect to use the **Recommendations for Preventive Pediatric Health Care periodicity schedule** developed by Bright Futures or a different periodicity schedule developed by a recognized medical organization.

In October 2018, Bright Futures released the second edition of its Bright Futures Tool and Resource Kit, a compilation of current forms and materials related to preventive health supervision and health screening for infants, children and adolescents. The toolkit is designed to accompany the organization's guidelines.

Our members' satisfaction matters

To provide the best care, Home State Health surveys our members annually about their healthcare experiences. Because you and your staff are such an integral part of our members' healthcare experiences, we share the results with you. The survey results show how members feel about care they receive from our providers and service they receive from the health plan.

Areas where we scored well in this year's survey include:

- Getting care quickly, 81st percentile
- How well doctors communicate, 86th percentile

Areas we are working to improve include:

- Getting care needed, 68th percentile. The goal is 75th percentile
- Customer service, 66th percentile. The goal is 75th percentile

Home State Health uses the results to help improve care. With your assistance, providers can improve survey results by focusing on customer service year-round, improving communication and helping members feel connected to their providers and the health plan.

Results were gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. In addition, Home State Health submits survey results to the NCQA to meet accreditation requirements.

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Health checks for teens

Just like younger children, teenagers need annual checkups. As children reach adolescence, providers should be aware that their health needs will change. According to the **American Academy of Pediatrics** (AAP), adolescents and young adults may engage in high-risk behaviors such as:

- Alcohol use, which plays a role in a high number of unintentional injuries, the leading cause of death for this age group
- Use of electronics while driving
- Sexual activity

Many teens also engage in behaviors that can affect their long-term health, including smoking, poor eating habits and a lack of exercise.

To offer complete care to adolescents, providers will need to address not just physical and mental health, but also sexual and social development and risk-taking behaviors. Bright Futures, a health promotion and prevention initiative from the AAP, offers **guidance for providers** with adolescent patients. The guide offers detailed information on changes and challenges faced at different stages of development, breaking teens into three groups: ages 11-14, ages 15-17 and ages 18-21. An annual tobacco, alcohol and drug use risk assessment should begin at age 11, for instance, and screening for depression should begin at age 12.

You can find adolescent preventive care guidelines, along with guidelines for adult and child preventive care and for chronic diseases, at **HomeStateHealth.com**. Or call **1-855-694-HOME (4663)** for more information. A copy of the guidelines may be mailed to your office as part of disease management or other quality improvement initiatives. Members also have access to these guidelines.

Adolescent immunization needs

As teen members head off to college, it's important for providers to review necessary immunizations. That's because, as **Consumer Reports** notes, the close quarters of dorm living make diseases much more likely to spread.

Though vaccine requirements differ by college and state, Consumer Reports says young adults entering college especially need vaccines for:

- Bacterial meningitis (meningococcal)
- Human papillomavirus (HPV)
- Influenza
- Tetanus, diphtheria and pertussis (Tdap)

Many young adults entering college may have received the necessary vaccinations during childhood. Go to the **Centers for Disease Control and Prevention** website to review an immunization schedule for those ages 18 and younger.

HEDIS

The HEDIS measure **Immunizations for Adolescents** assesses 13-year-olds who had one dose of meningococcal vaccine, one Tdap vaccine and the complete HPV series.

Screening for lead

Lead poisoning can cause intellectual, developmental and physical problems. Yet because it doesn't have obvious symptoms, it may be easily overlooked.

The Centers for Disease Control and Prevention reports that children living in 4 million U.S. households are being exposed to lead. High lead levels can damage the brain and nervous system. They can also cause developmental and growth delays, learning and behavioral problems and hearing and speech problems.

Home State Health reminds providers that all children enrolled in Medicaid are required to have a blood lead screening test at ages 12 and 24 months. Children ages 24 months to 6 years who haven't been screened in the past should also have a blood lead screening.

HEDIS

The HEDIS measure **Lead Screening in Children** measures the percentage of 2-year-olds who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

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Meeting appointment accessibility standards

Are your patients able to obtain services when they are needed? Home State Health monitors the availability of our network practitioners. Availability is key to member care and treatment outcomes.

Home State Health follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. We monitor compliance with these standards annually and use the results of monitoring to ensure adequate appointment availability and reduce the unnecessary use of emergency rooms.

Home State Health network providers are required to meet and/or exceed the following appointment accessibility standards in accordance with the appointment standards outlined in the contract and in the provider manual:

Wait Times:

Home State Health shall ensure that waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment.

Appointment Accessibility Standards:

All provider types shall adhere to appointment standards. The time elapsed between the request for an appointment and the scheduled appointment should not exceed the following:

Type of Appointment	Scheduling Time Frame for Appointment
Urgent Care – appointments for illness or injuries that require care immediately but do not constitute emergencies (e.g., high temperature, persistent vomiting or diarrhea, symptoms that are of sudden or severe onset but that do not require emergency room services)	Within 24 hours
Routine care with symptoms - (e.g., persistent rash, recurring high-grade temperature, nonspecific pain, fever)	Within one week or five business days; whichever is earlier
Routine care without symptoms - (e.g., well-child exams, routine physical exams	Within 30 calendar days
Behavioral health and substance abuse services Behavioral health and substance abuse emergent services	Aftercare appointments within seven calendar days of hospital discharge Immediately (non-life-threatening within six hours)
Maternity Care – Obstetric providers shall provide initial prenatal care appointments for enrolled pregnant members as follows.	
First trimester appointments must be available...	Within seven calendar days of first request
Second trimester appointments must be available...	Within seven calendar days of first request
Third trimester appointments must be available...	Within three calendar days of first request
Appointments for high-risk pregnancies must be available...	Within three calendar days of identification of high risk to Home State or maternity care provider or immediately if an emergency exists

After-hours requirements

Members need to know who to contact after business hours. Providers are required to offer arrangements for access to a covering physician after business hours, or they must have an answering service, triage service or voice message that explains to members how to access urgent and emergency care. This helps ensure our members get the best possible healthcare.

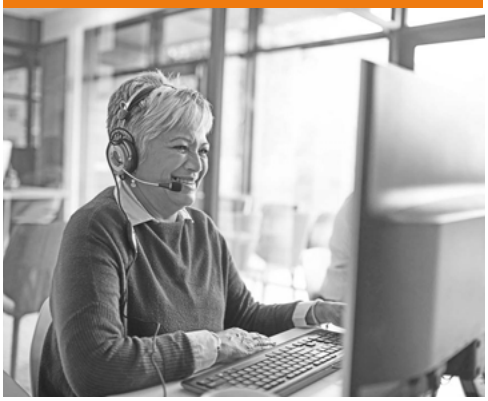
The requirements below ensure that our members have adequate access to needed healthcare services and can access their providers after normal business hours and on weekends.

Offices using an answering machine must:

- Provide a message directing members to call **911** or go to the nearest emergency room if they think it is too urgent to wait for a doctor to call back.
- Provide instructions on how to contact the doctor if the situation is urgent.

Offices using an answering service must:

- Direct members to call **911** or go to the nearest emergency room if they think it is too urgent to wait for a doctor to call back.
- Provide an option to contact the provider on call with the member's contact information. When possible, the provider must return the call within 30 minutes.



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