2021 End of Year Wrap Up & Hot Topics

1221.PR.P.PP 6/22

Agenda

- MHS Overview
- Ambetter
- Allwell
- MHS Secure Portal
- Pay for Performance (P4P) Overview
- Continuity of Care Overview
- MHS Partnership
- Member Resources
- MHS Network Team
- Questions

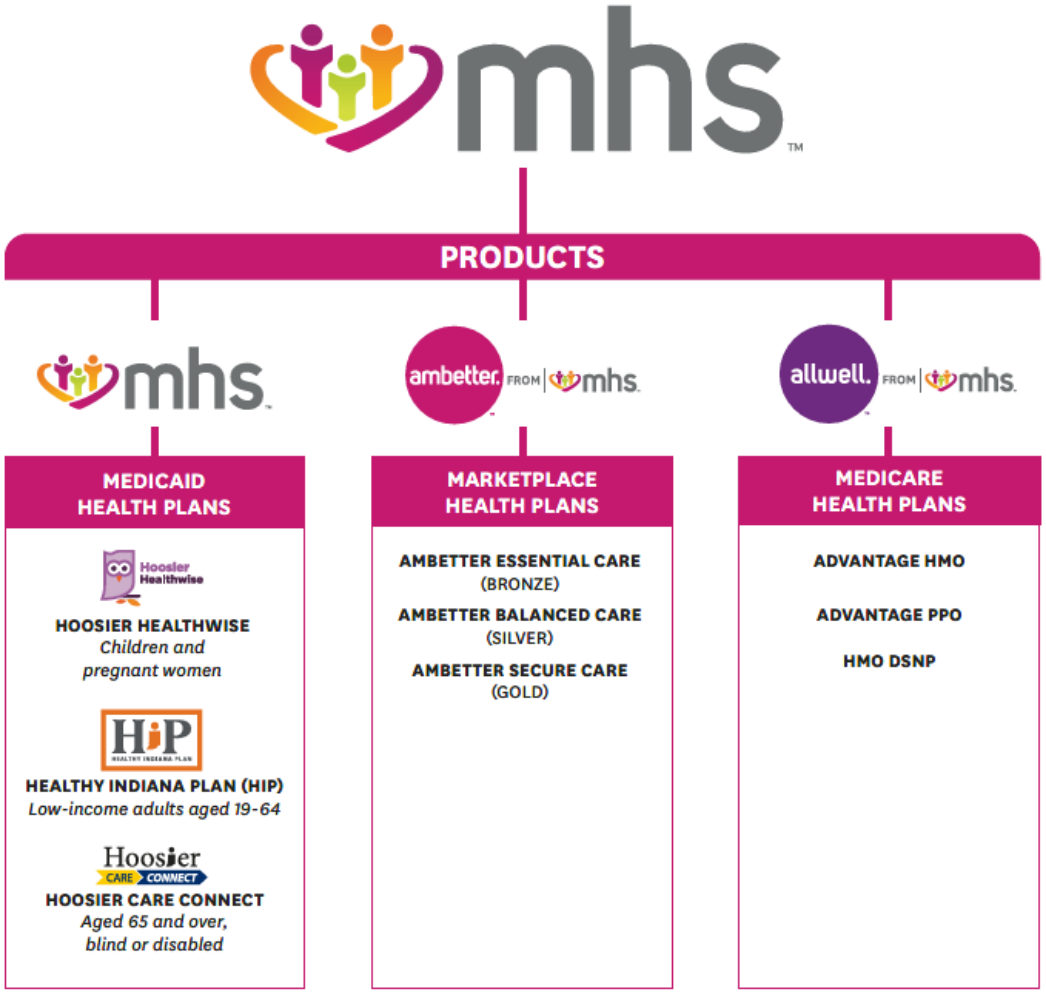
Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 25 years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.

- MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS and a Medicare Advantage product called Allwell from MHS. All of our plans include quality, comprehensive coverage with a provider network you can trust.

- **MHS is your choice for better healthcare**

MHS Products



Ambetter

Statewide Coverage
2022

Member Open Enrollment
1/1/21 to 1/15/22

Allwell from MHS name change

- Effective 1/1/21

Wellcare by Allwell

Meet Wellcare

- Welcome to the new Wellcare!
- We have changed our name, we've combined multiple national Medicare brands under the Wellcare name to offer a better range of plans that provide members with affordable access to doctors, nurses, and specialists
- This change makes things easier for members, brokers, and providers
- Our goal remains the same: **ensuring your patients receive the best care**

Who We Are

- Wellcare by Allwell is a Medicare Advantage plan
- We provide quality healthcare you'd expect from a big company, but delivered on a local level
- Our members benefit from strategic care coordination and programs through strong and collaborative relationships built with local healthcare providers and community organizations

Who We Are

Wellcare by Allwell is designed to give members:

- Affordable healthcare coverage
- Benefits they need to take good care of themselves
- Access to doctors, nurses and specialists who work together to help them feel their best
- Coverage for prescription drugs
- Extra benefits that aren't covered by Medicare Part A or Part B (Original Medicare)

Key Contact Information

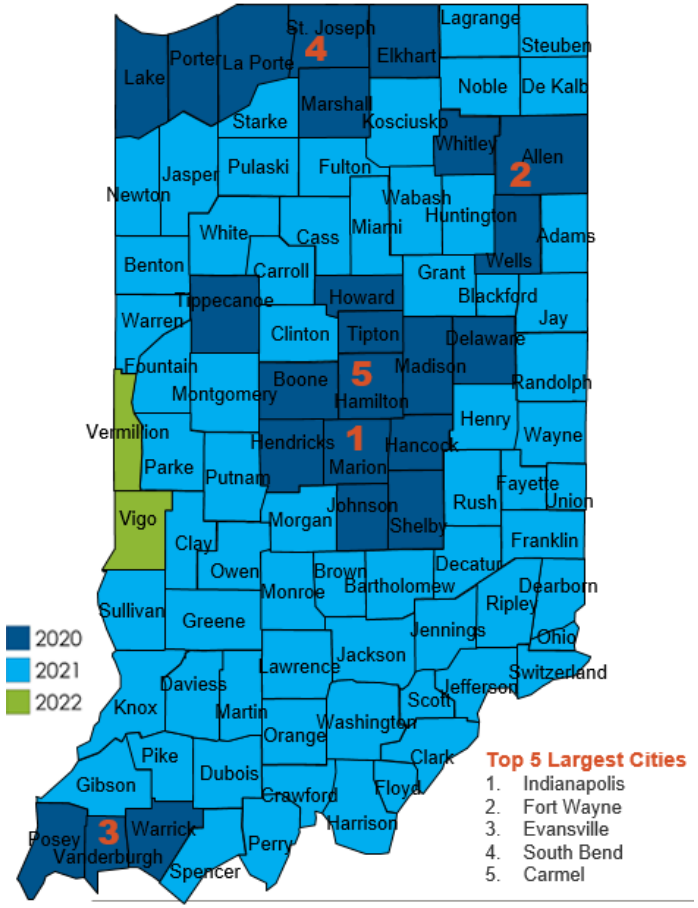
PHONE

- **HMO & PPO 1-855-766-1541,**
- **HMO D-SNP 1-833-202-4704**

TTY/TDD
TTY:711

Wellcare.mhsindiana.com

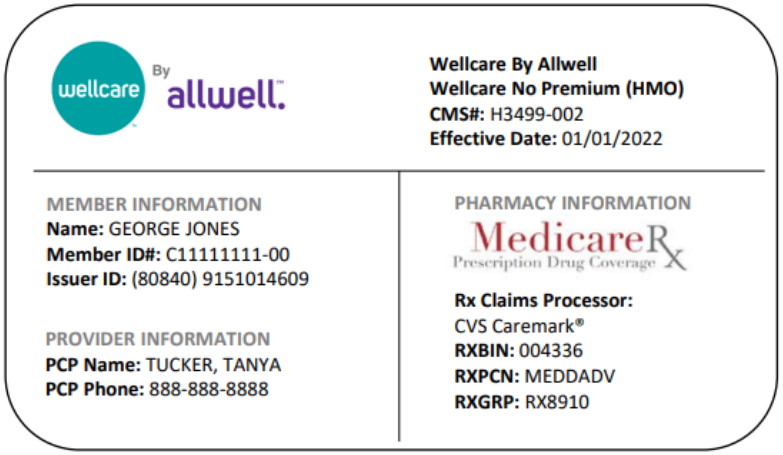
2021 MA Indiana Service Area



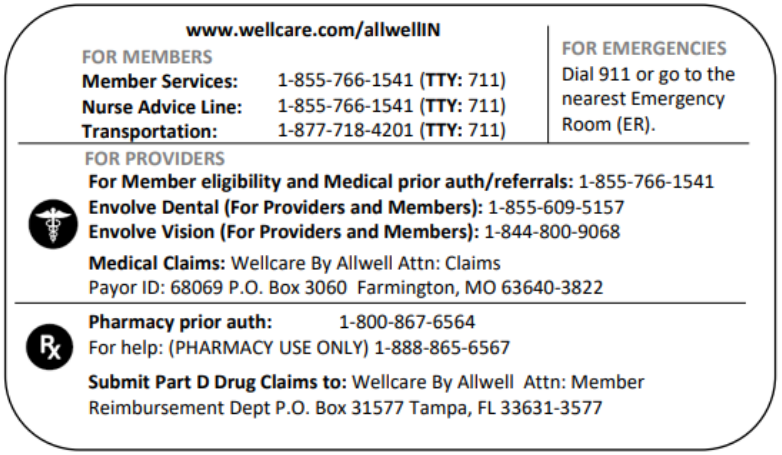
Allwell

Allwell 2021 Membership Cards

FRONT PANEL



BACK PANEL



Portal Functionality

mhs

mhs

Home | Find a Provider | Portal Login | Events | Careers | Contact Us | search

Contrast On Off | a a a | language

Select Your Plan Below *Which plan do I have?*

FOR MEMBERS | **FOR PROVIDERS** | **GET INSURED**

- Allwell From MHS
- Ambetter From MHS
- Healthy Indiana Plan
- Hoosier Care Connect
- Hoosier Healthwise

Find a Provider

Finding a doctor is quick and easy. Search for Primary Medical Providers, hospitals, pharmacies and more.

Opioid Resource Center

Opioid use disorder is a disease. Recovery is possible – find support and resources here.

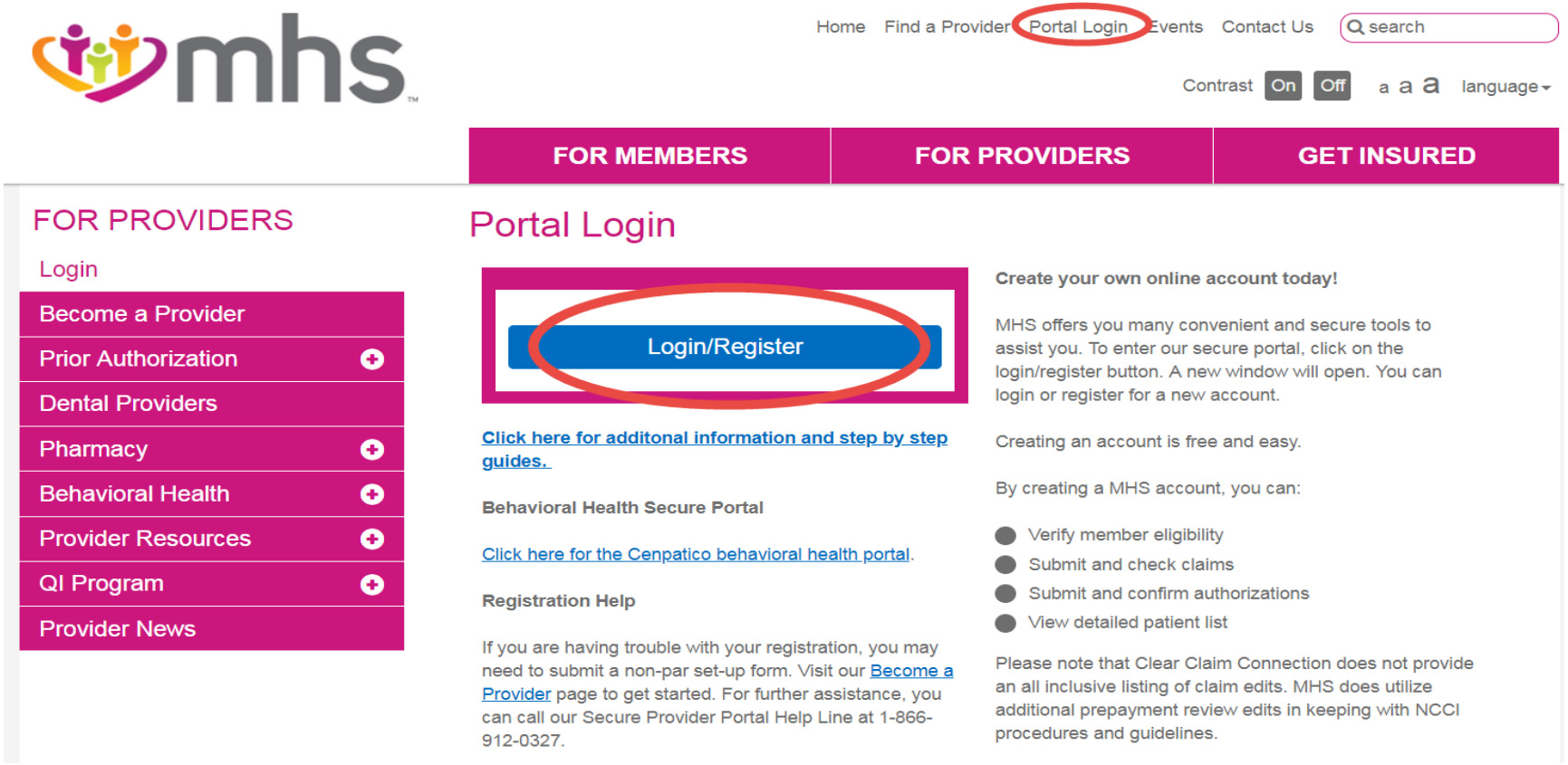
Complete Your HNS

Take the Health Needs Screening (HNS) and start earning CentAccount rewards today!

Allwell from MHS | Ambetter from MHS | Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

Secure Web Portal Login or Registration

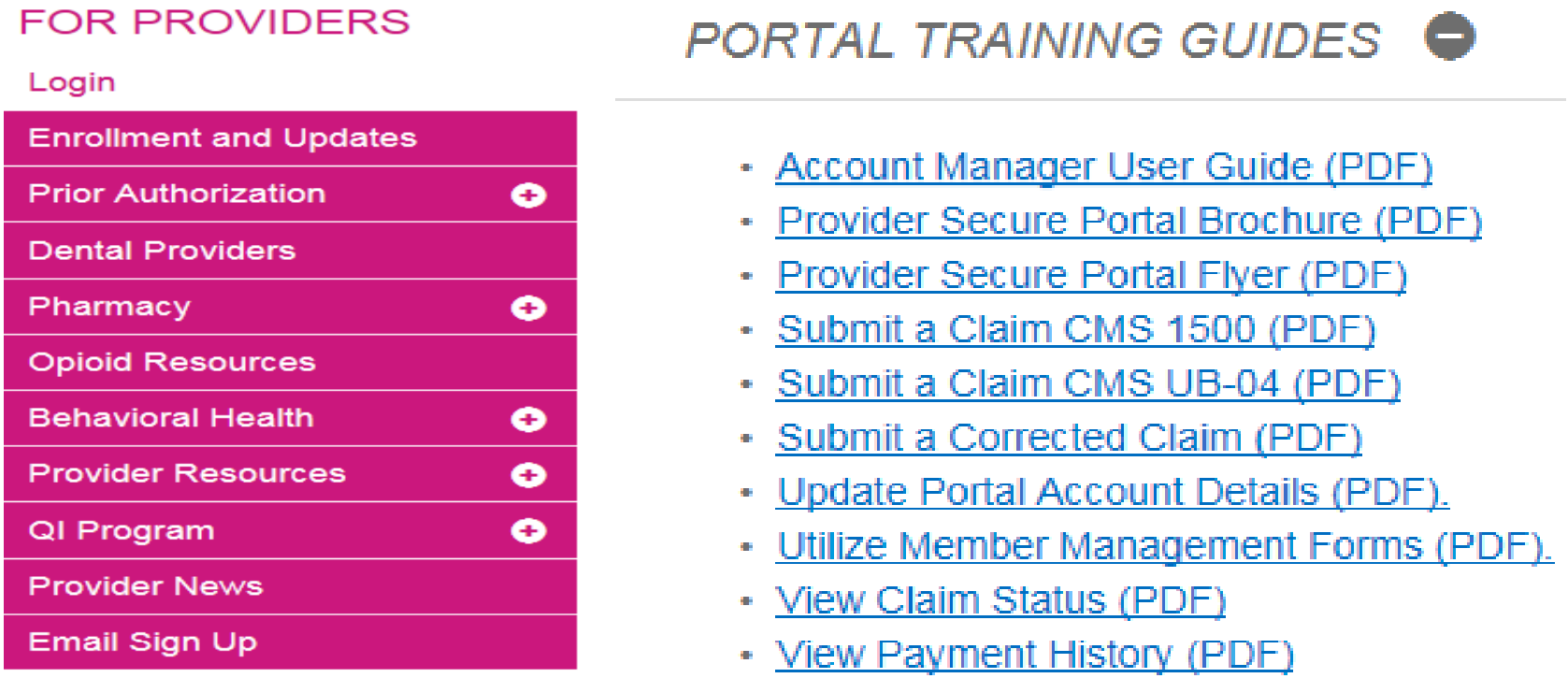
- Login/Register is the same for **MHS**, **Ambetter from MHS, Allwell from MHS** and **Behavioral Health** Providers



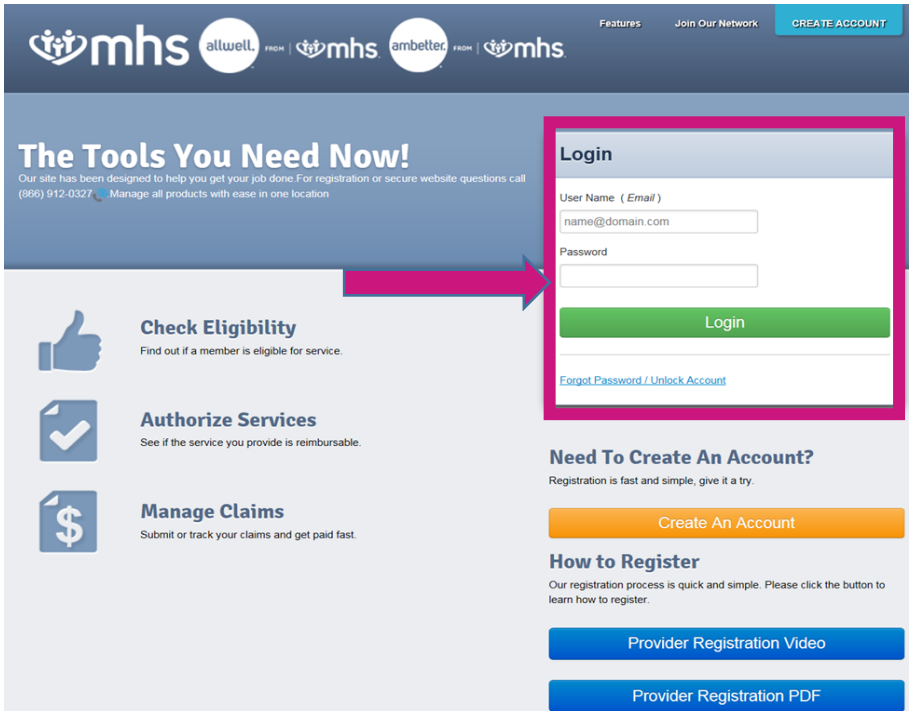
Web Portal Training Documents

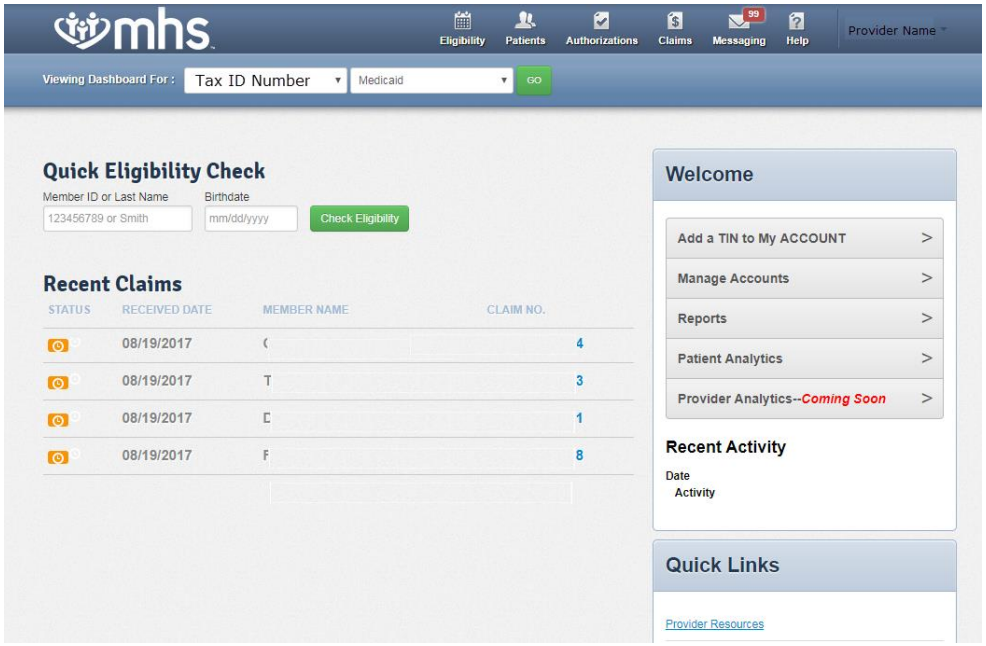
Documents Include:

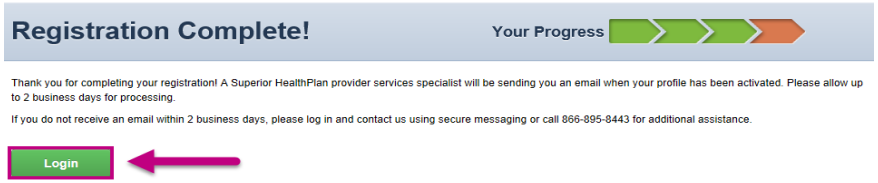
- Registration Guide
- MHS Web Portal User Guides
- How To Complete Specific Tasks on the MHS Web Portal



Complete Registration or Login



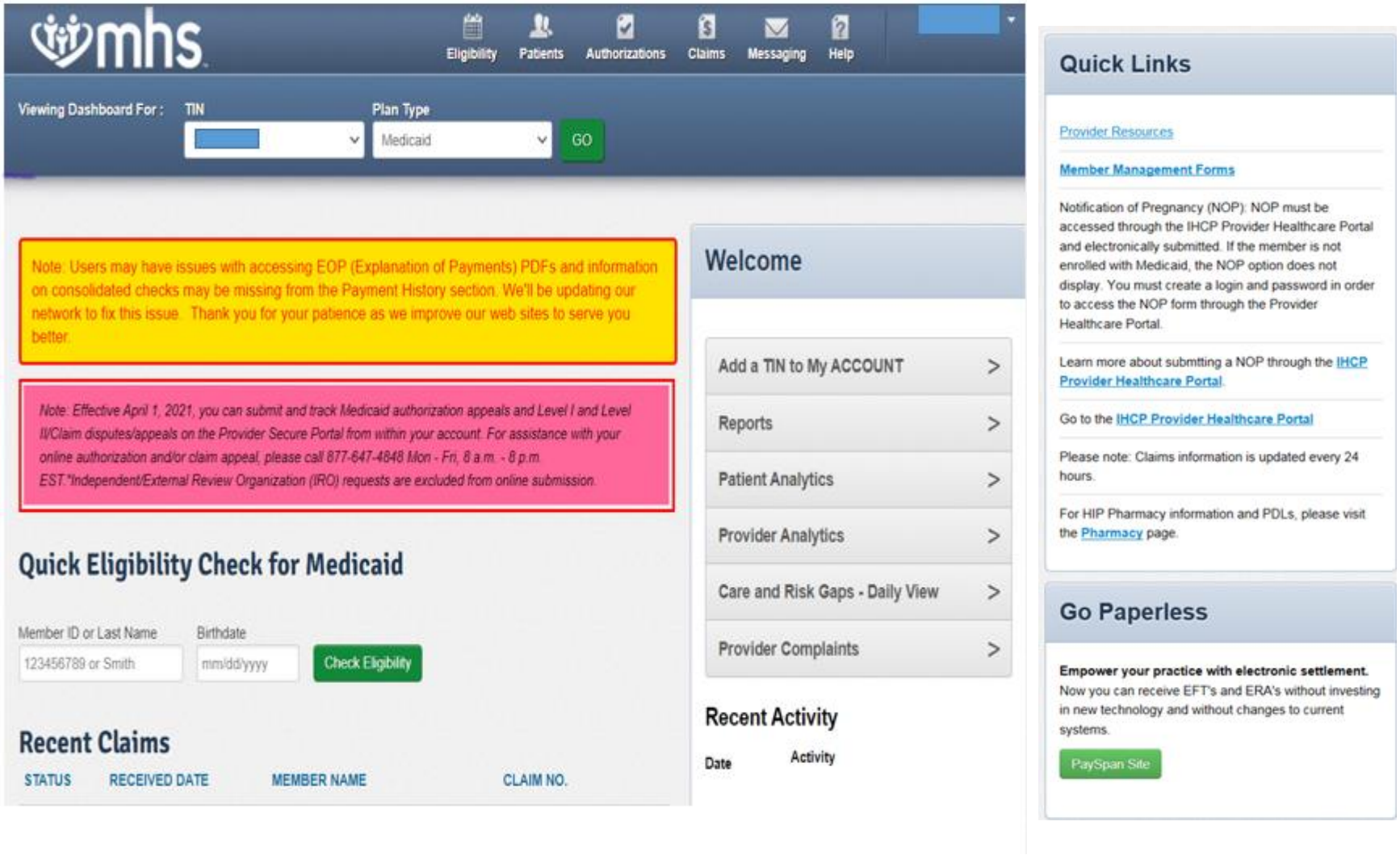




- An email will be sent to the provider when they have access to specific tools.

- The Registration is complete and the Secure Portal homepage will be visible!

Homepage – MHS (Medicaid)



Claim Submission Process

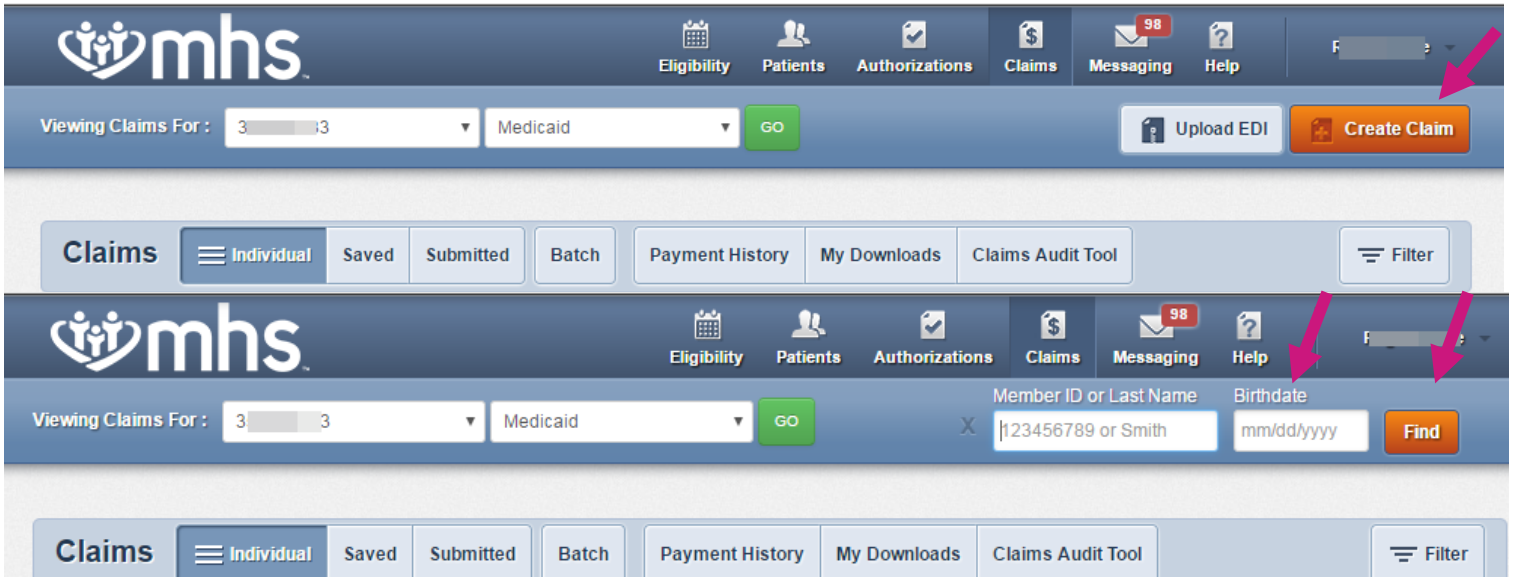
Claims

Web Portal Claims Functionalities:

- **Submit** new claim.
- **Review claims** information on file for a patient.
- **Correct** claims.
- **View payment history.**

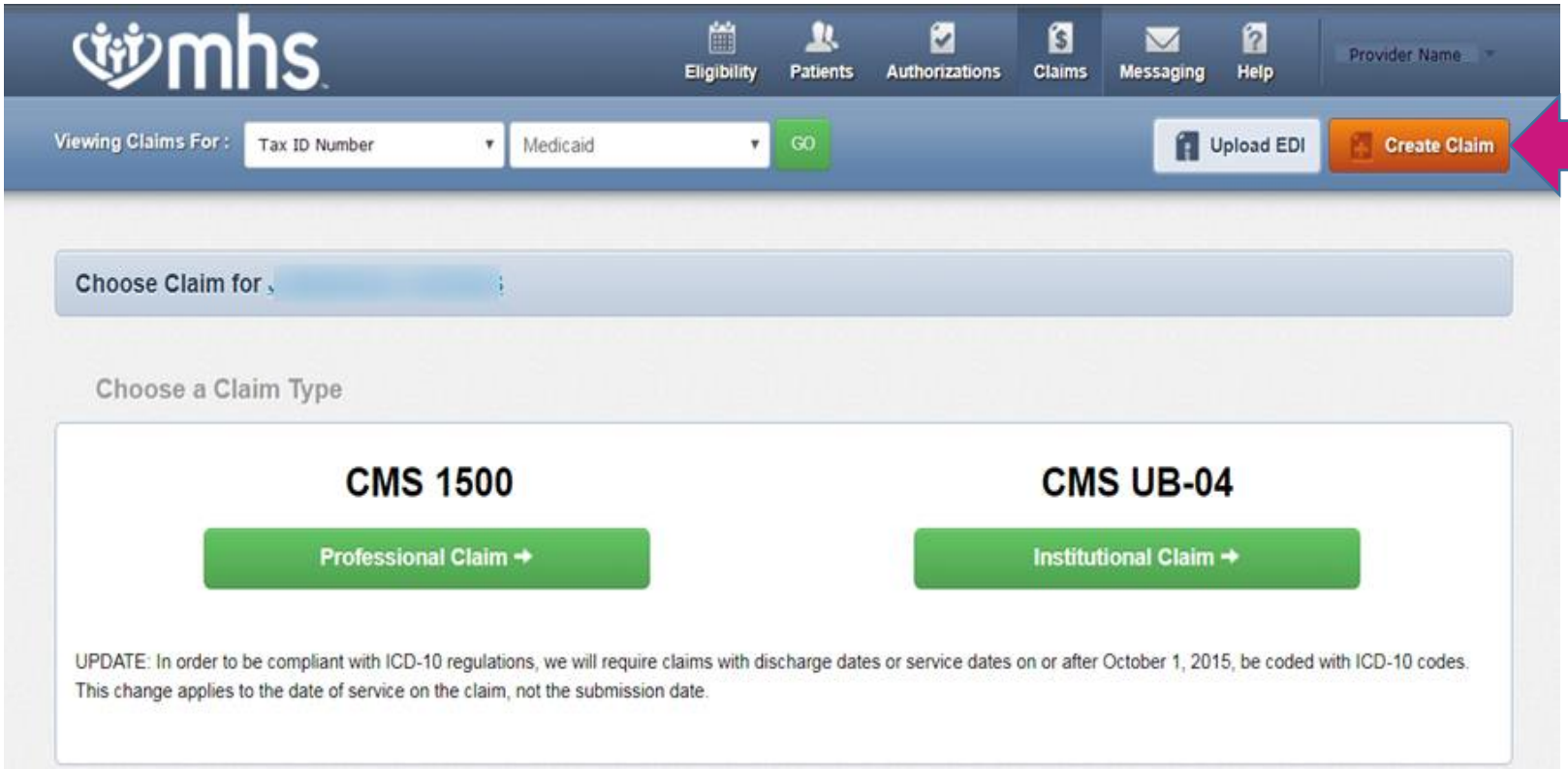
Submit a New Claim:

- Click **Create Claim** and enter **Member ID** and **Birthdate**



Claim Submission

- Choose the **Claim Type**
  - **Professional** or **Institutional** claim submission



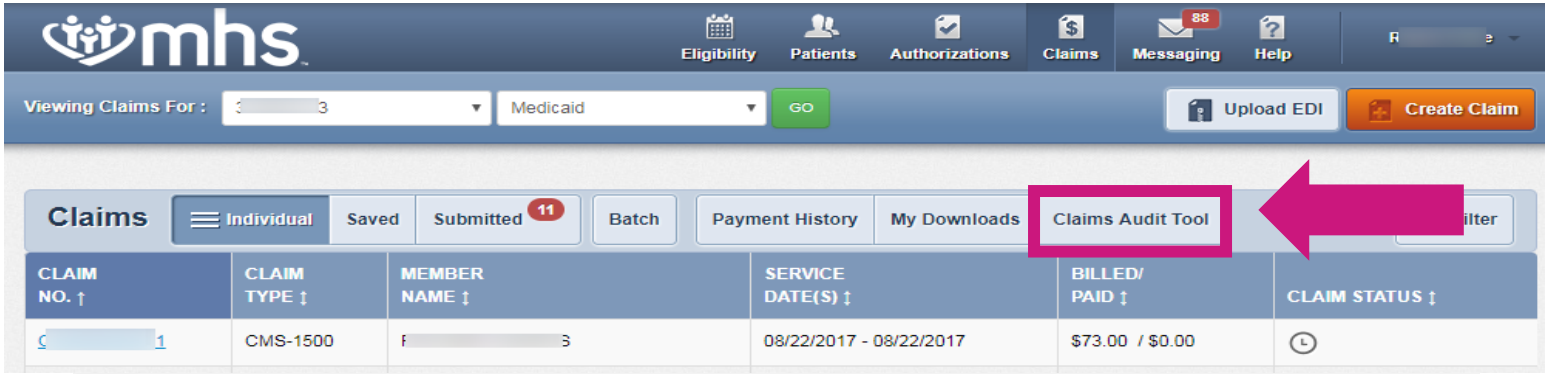
Claim Submission

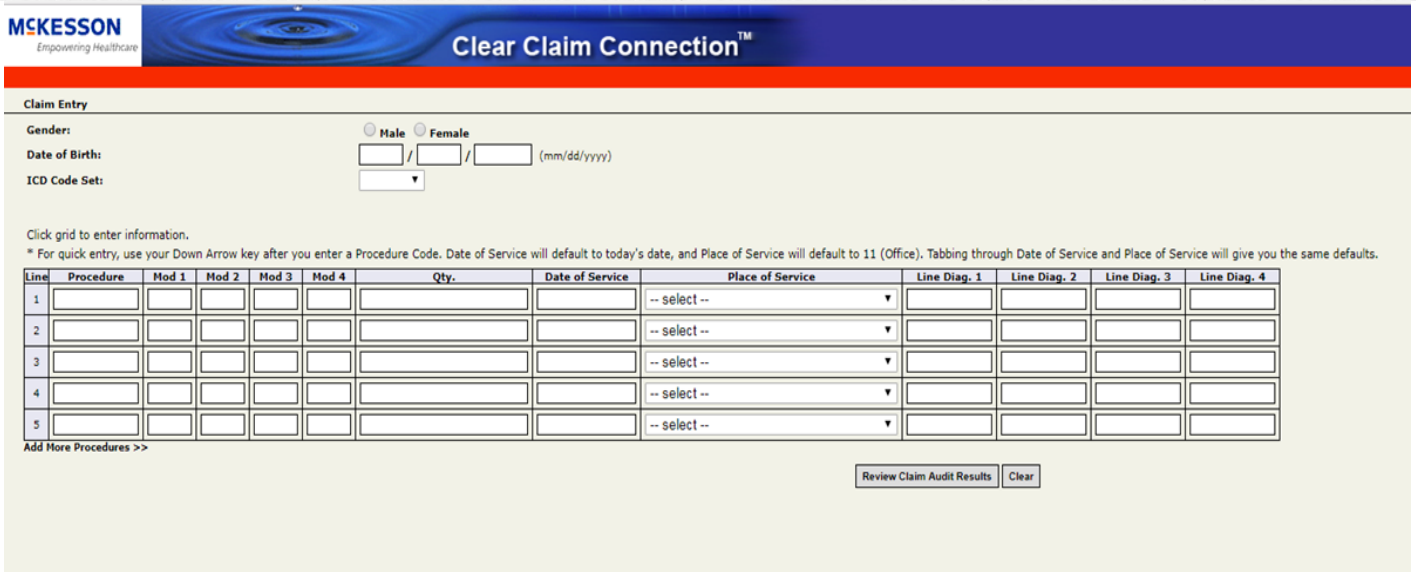
Claim Acceptance & Adjudication

- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.
- National Provider Identifier (NPI) common rejection/denial; provider information on claim **must** match record at IHCP enrollment – a State requirement.

Claims Audit Tool

- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.





Claim Submission

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Exceptions:
  - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's Medicaid Identification number.
  - TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits. If primary EOB is received after the 365 days, providers have *60 days* from date of primary EOB to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Paper Claim Corrections

- A corrected claim can be submitted following IHCP claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
  - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.
  - Example: Frequency 7 used as the last digit for the bill type on a UB-04 form (i.e. 1x7)
- The original claim number must also be listed on the corrected claim.
  - Box 22 on the CMS-1500 and box 64 on the UB-04.
  - Remember a rejection, must be submitted as 1st time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

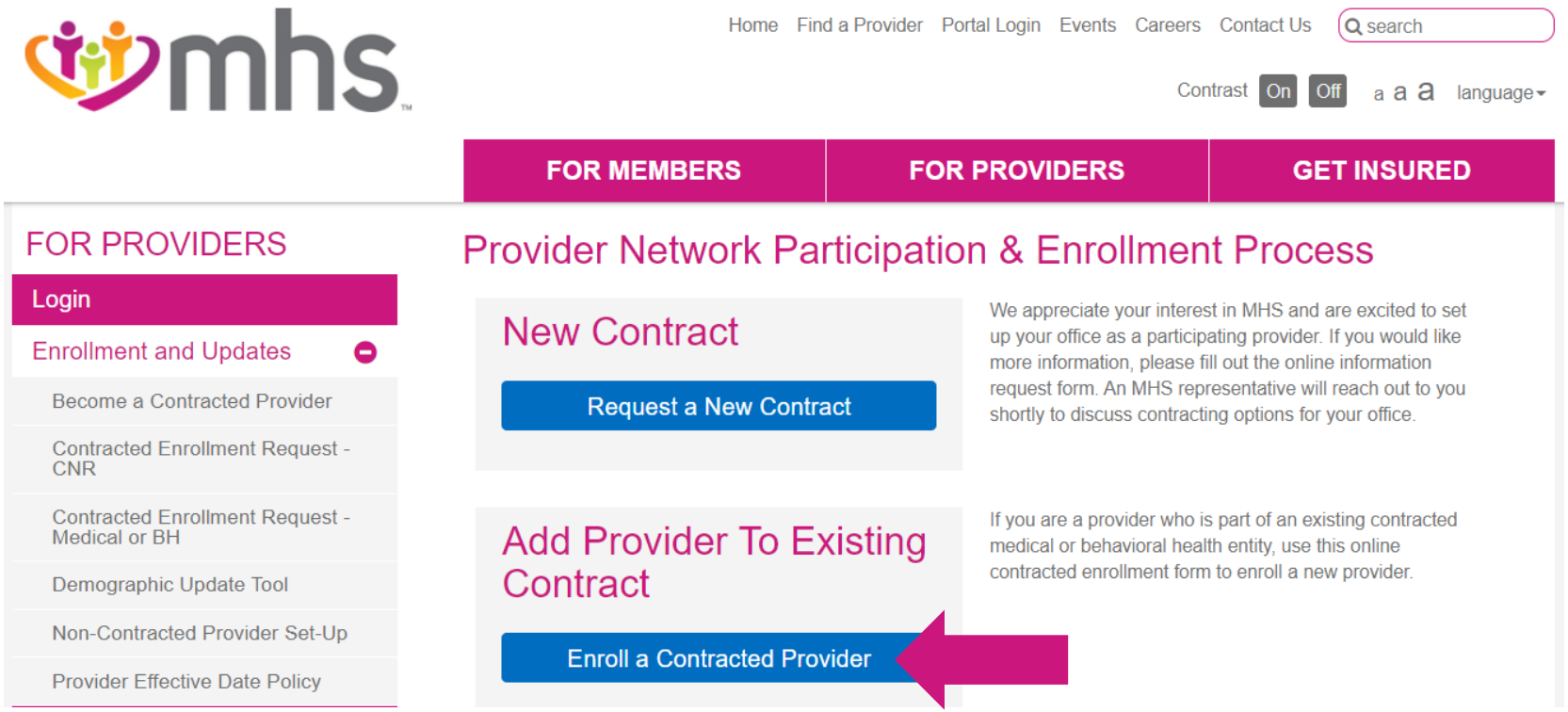
Claims Submission

- For detailed electronic claim submission:

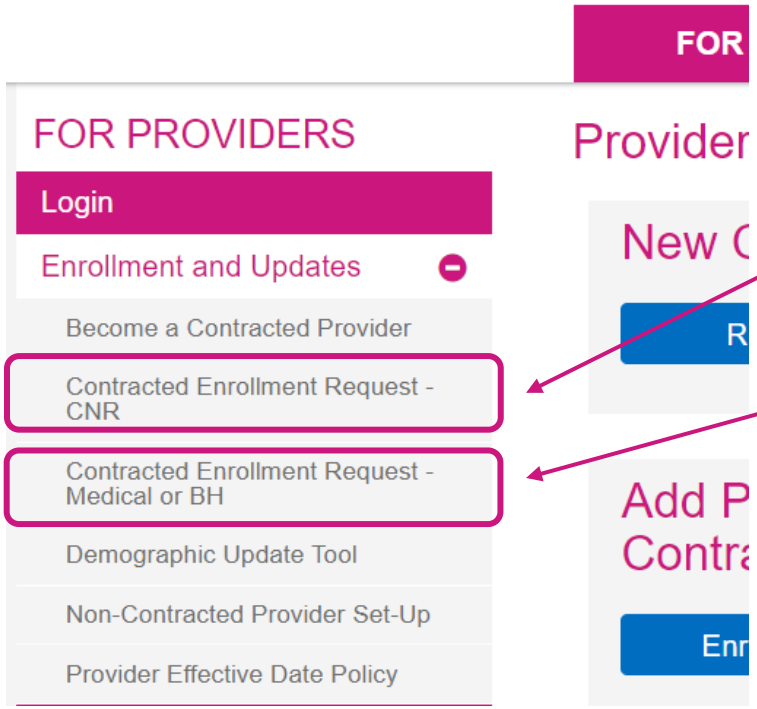
- https://www.mhsindiana.com/providers/login.html
- For Providers
- Login
- Provider Training Guides

Provider Enrollment

Provider Enrollment



Provider Enrollment

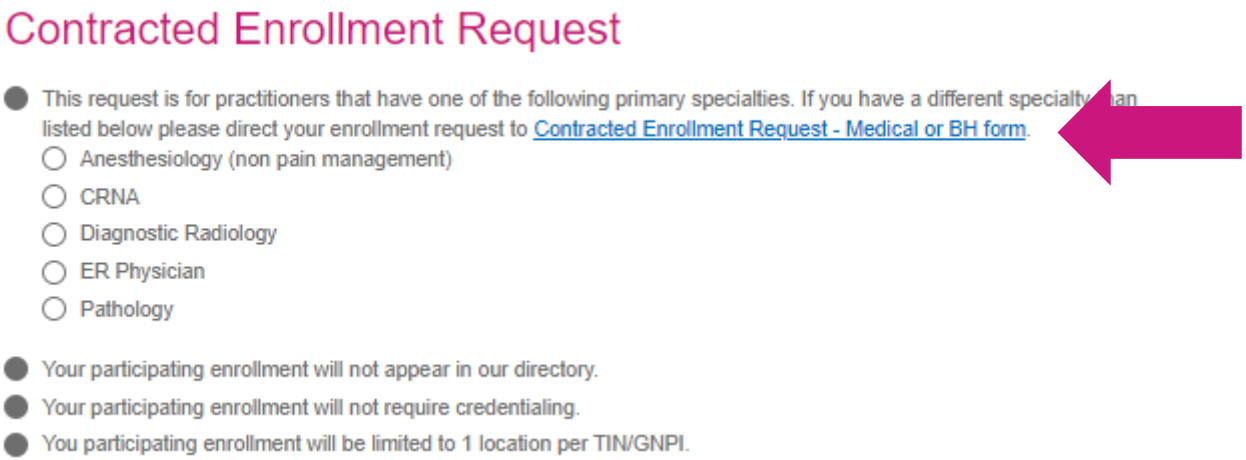


- Enrollment requests are broken down by:
  - Credentialing not Required (CNR)
  - Medical or BH (Credentialing may be required)

Provider Enrollment

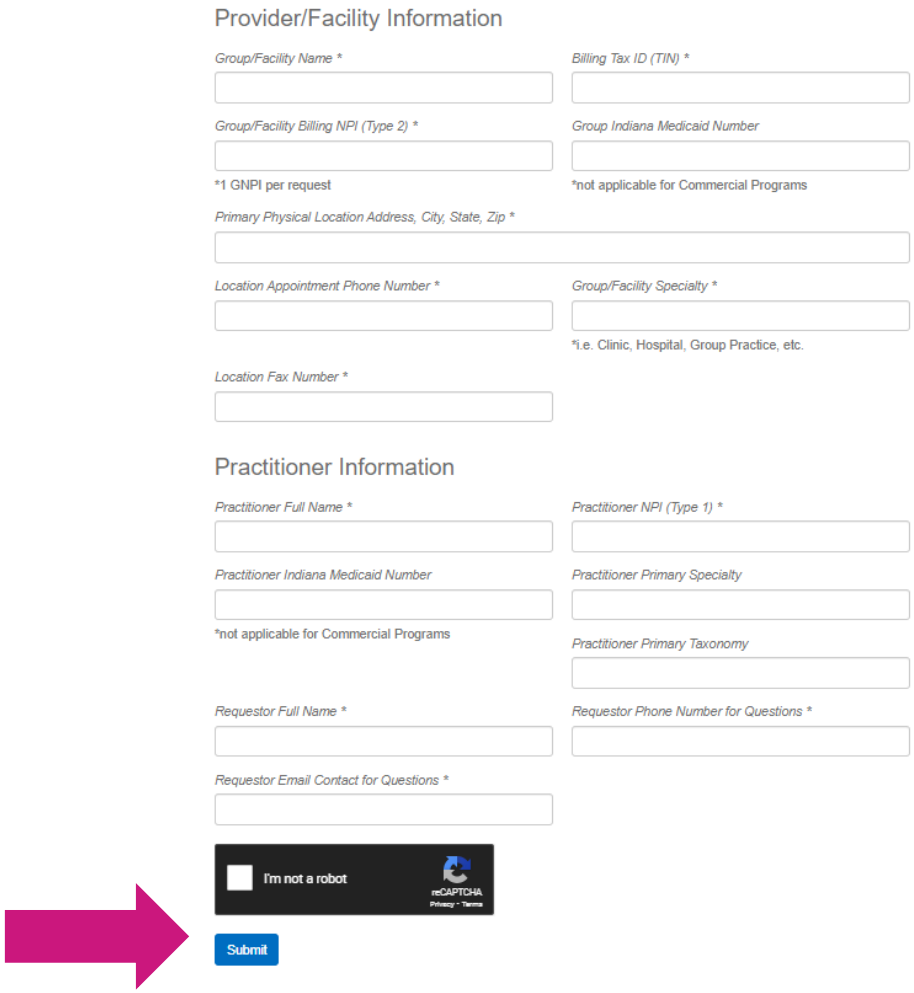
- Provider Network Participation & Enrollment Process
  - Definition of Enrollment, Credentialing, and Contracting/Negotiating
  - Network Participation Request documents required to enroll with MHS as a Participating Provider and/or Practitioner
  - MHS' Credentialing Team Verification Criteria
  - Helpful Tips to making sure your enrollments are processed successfully
  - New Effective Date Policy

Provider Enrollment - CNR



- CNR page outlines specialties that do not require credentialing
- Link goes to Medical or BH enrollment page (providers may require credentialing)

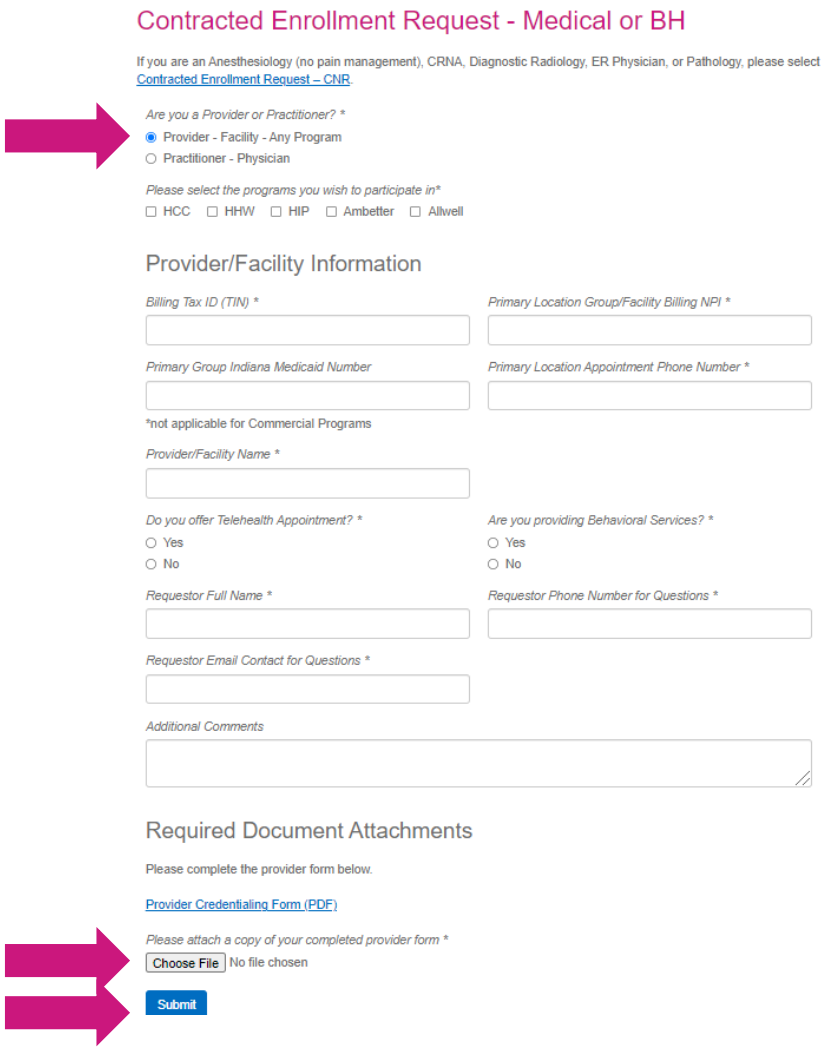
Provider Enrollment - CNR



Provider Enrollment – Medical or BH

- Medical or BH Enrollments
  - Ancillary-Facility-Any Product
  - Practitioner-Physician

Provider Enrollment – Medical or BH



Contracted Enrollment Request - Medical or BH

If you are an Anesthesiology (no pain management), CRNA, Diagnostic Radiology, ER Physician, or Pathology, please select Contracted Enrollment Request – CNR.

*Are you a Provider or Practitioner? **

- (•) Provider - Facility - Any Program
- ( ) Practitioner - Physician

*Please select the programs you wish to participate in**

☐ HCC ☐ HHW ☐ HIP ☐ Ambetter ☐ Allwell

Provider/Facility Information

*Billing Tax ID (TIN) **

*Primary Location Group/Facility Billing NPI **

Primary Group Indiana Medicaid Number

*Primary Location Appointment Phone Number **

**not applicable for Commercial Programs*

*Provider/Facility Name **

*Do you offer Telehealth Appointment? **

( ) Yes
( ) No

*Are you providing Behavioral Services? **

( ) Yes
( ) No

*Requestor Full Name **

*Requestor Phone Number for Questions **

*Requestor Email Contact for Questions **

Additional Comments

Required Document Attachments

Please complete the provider form below.

Provider Credentialing Form (PDF)

*Please attach a copy of your completed provider form **

Choose File No file chosen

Submit

Provider Enrollment – Medical or BH

Contracted Enrollment Request - Medical or BH

If you are an Anesthesiology (no pain management), CRNA, Diagnostic Radiology, ER Physician, or Pathology, please select Contracted Enrollment Request – CNR.

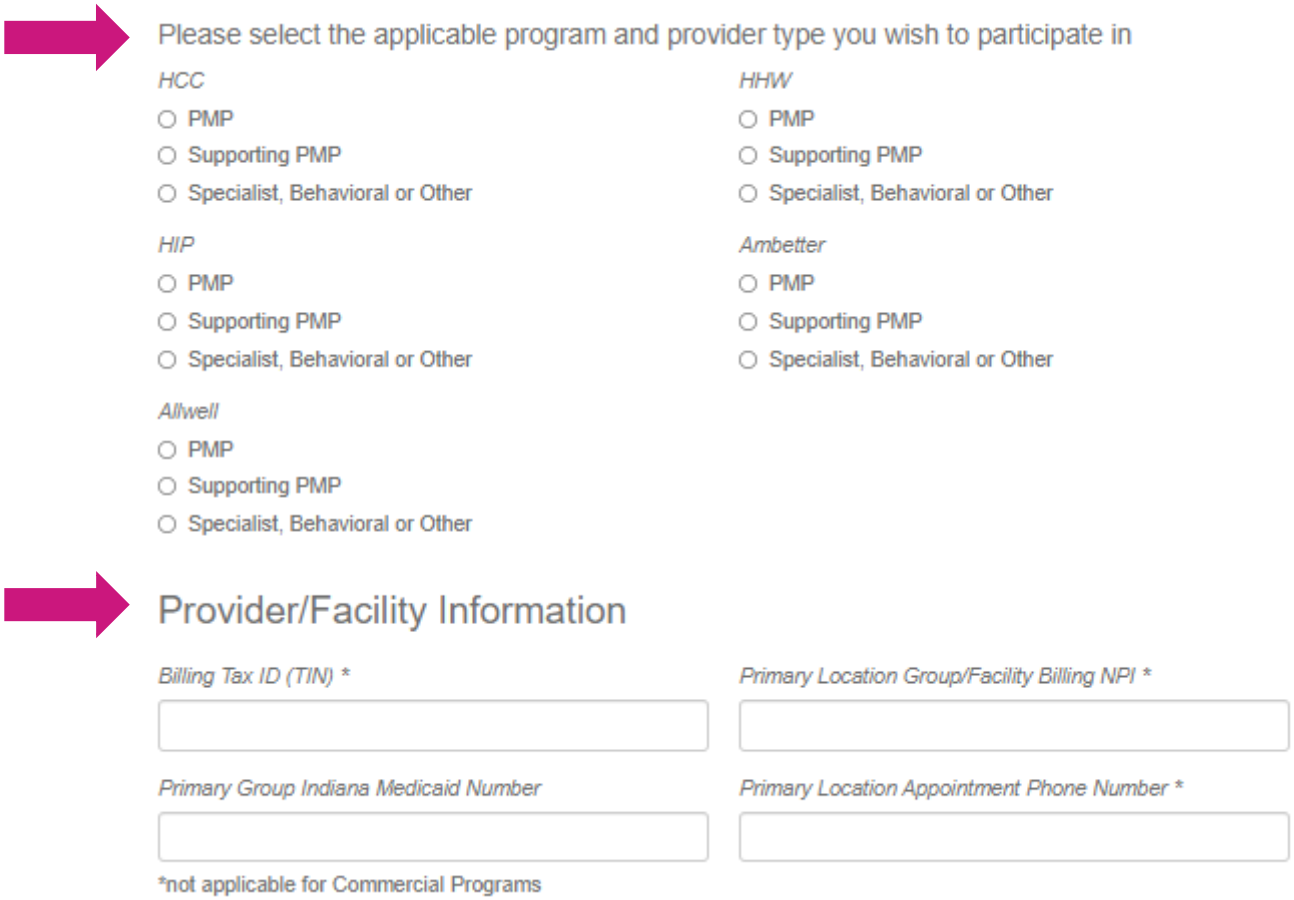
*Are you a Provider or Practitioner? **

- ○ Provider - Facility - Any Program
- ◉ Practitioner - Physician

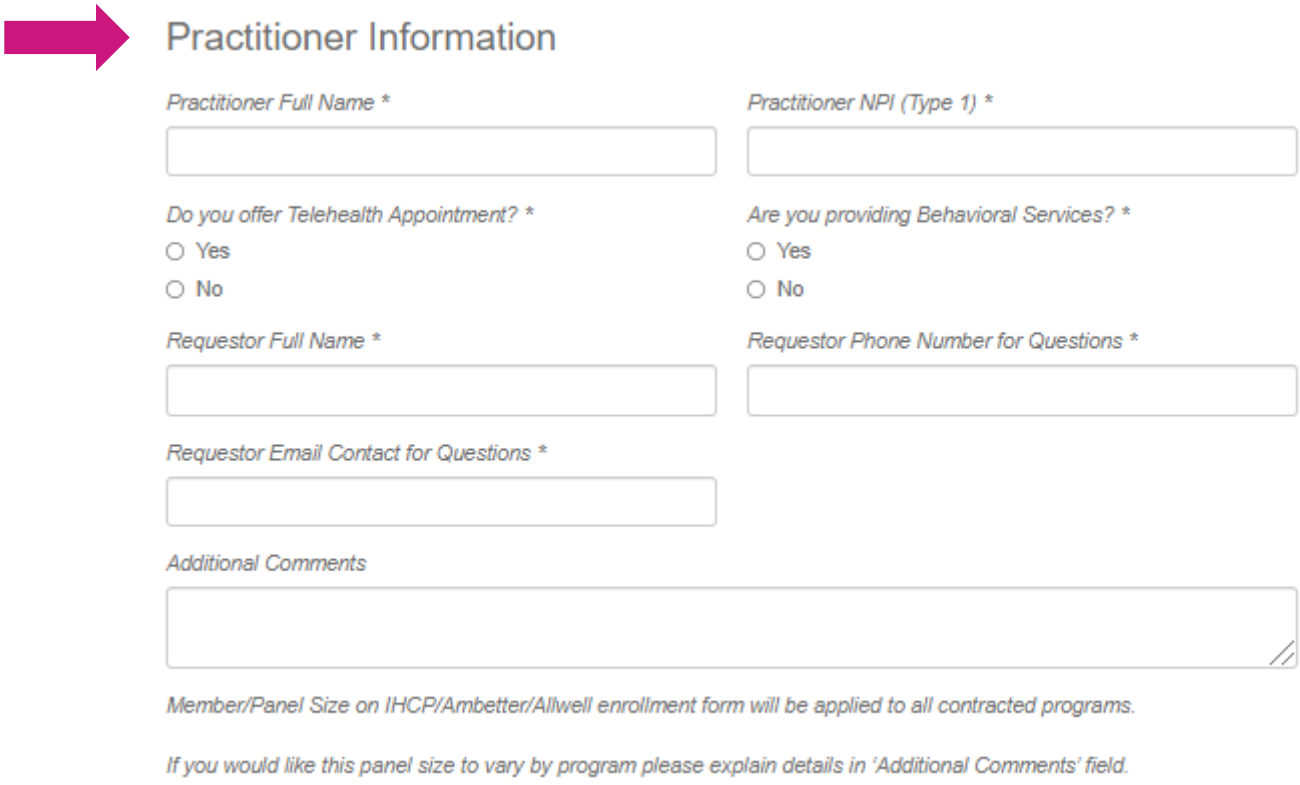
Do you wish to enroll in Medicaid? (HCC, HHW, HIP)

- ○ Yes
- ○ No

Provider Enrollment – Medical or BH



Provider Enrollment – Medical or BH



Practitioner Information

*Practitioner Full Name **

*Practitioner NPI (Type 1) **

*Do you offer Telehealth Appointment? **

- Yes
- No

*Are you providing Behavioral Services? **

- Yes
- No

*Requestor Full Name **

*Requestor Phone Number for Questions **

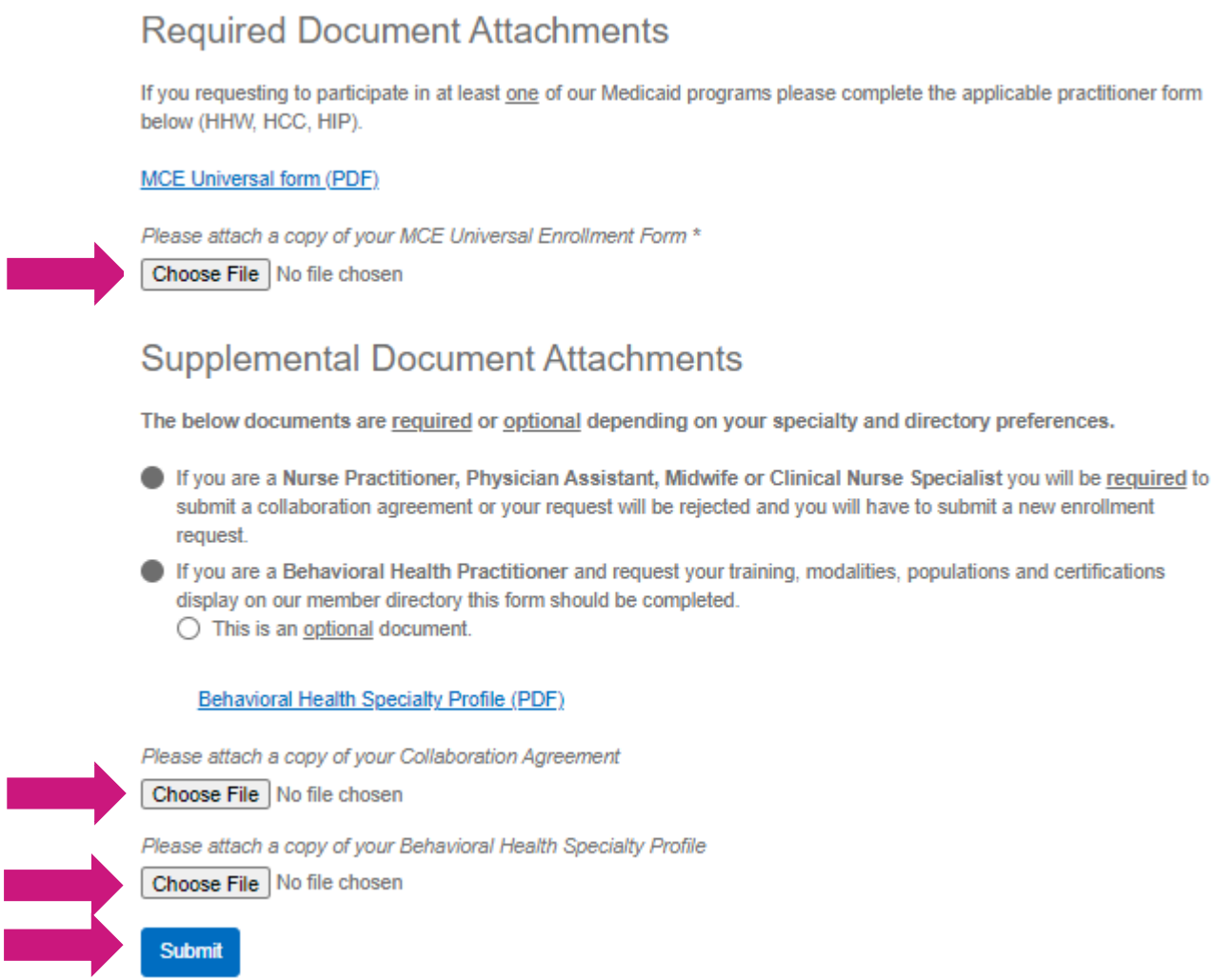
*Requestor Email Contact for Questions **

Additional Comments

Member/Panel Size on IHCP/Ambetter/Allwell enrollment form will be applied to all contracted programs.

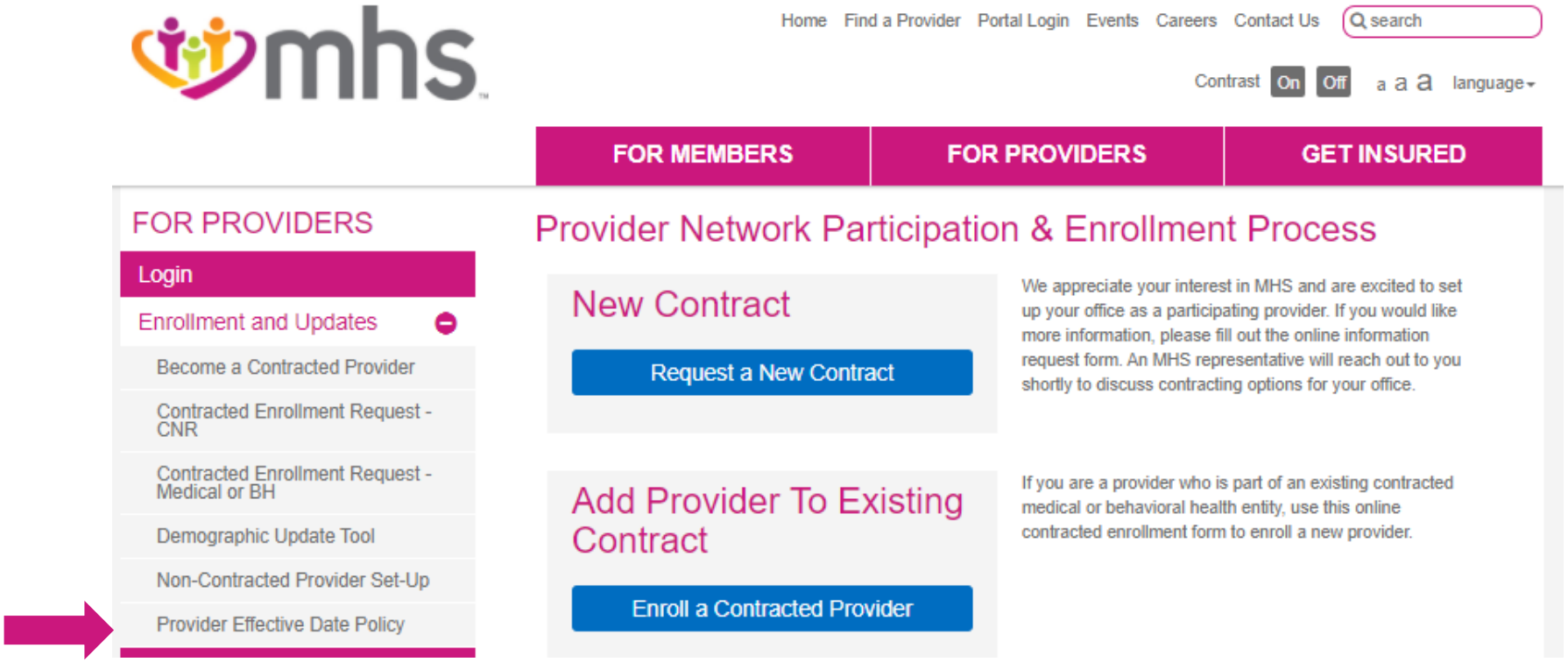
If you would like this panel size to vary by program please explain details in 'Additional Comments' field.

Provider Enrollment – Medical or BH



New Effective Date Policy

Effective Date Policy



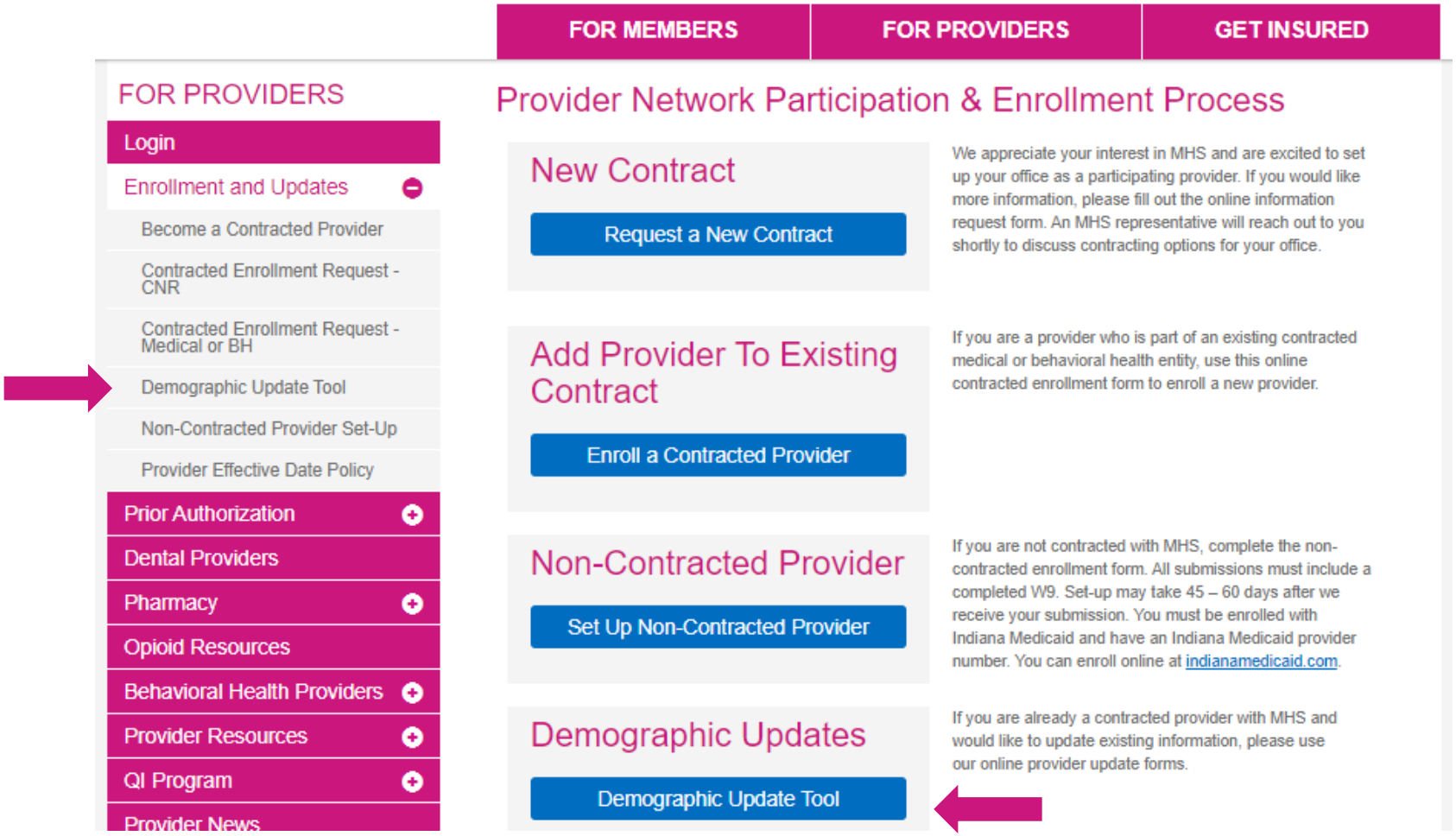
Effective Date Policy

Effective Date Policy: (effective 1/1/2022)

- A brand-new provider that is not part of an existing contract with MHS will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date MHS receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- A provider that is being added to an existing contract will also be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date MHS receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- Providers must be enrolled and effective with IHCP prior to being effective with MHS.
- The effective date will be the first of the month following the receipt of a complete network participation request, regardless of the contract execution date or credentialing completion date In most cases, the effective date will be retroactive back to the first of the month following receipt of the complete network participation request since providers will not be fully effective until they are credentialed by and have a signed contract or contract amendment with MHS.
  - If a provider requires credentialing and is not able to be credentialed, the provider will not be effective with MHS.
  - If a provider and MHS cannot come to terms with a contract, the provider will not be effective with MHS.
- Providers should hold all claims until the final welcome letter from MHS is received confirming that they are effective with the MHS network. Claims submitted prior to receipt of a welcome letter will not automatically be reprocessed and providers will need to submit a Medical Claim Dispute/Appeal Form to request reconsideration of the claim. MHS and providers are expected to complete all pieces of the network participation process timely. However, in instances where the network participation process extends for a time period longer than the standard timeframe, MHS will not hold providers to the timely filing limit for claims rendered before the provider was confirmed effective.
- If the contracting phase cannot be completed within 60 days, the providers request will be denied by MHS. Providers will be able to submit a new request for network participation.
- Exceptions to the effective date policy outlined may be granted by MHS in the following circumstances:
  - When the retroactive date is in the best interest of member care. The effective date cannot be prior to the date established by IHCP.
  - In situations involving changes of ownership, including provider mergers, acquisitions, or tax identification changes. The effective date cannot be prior to the date established by IHCP.
  - In situations where a provider has a preexisting contractual relationship with a MCE and has sought a change in their provider enrollment type or classification with the IHCP (i.e., when a provider was enrolled as a Billing provider but has decided to enroll as a Group provider). The effective date cannot be prior to the date established by IHCP
  - Upon request from providers in federally qualified health centers (FQHCs) or rural health clinics (RHCs). The effective date cannot be prior to the date established by IHCP.

Provider Demographic Updates

Provider Demographic Updates



Provider Demographic Updates

- Providers can utilize the Demographic Update Tool to update below information.
- Address Changes
- Demographic Changes
- Update Member Assignment Limitations
- Term an Existing Provider
- Make a Change to an IRS Number or NPI Number

Provider Demographic Updates

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our Provider Directory to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our Contact Us page is always available for general questions as well.

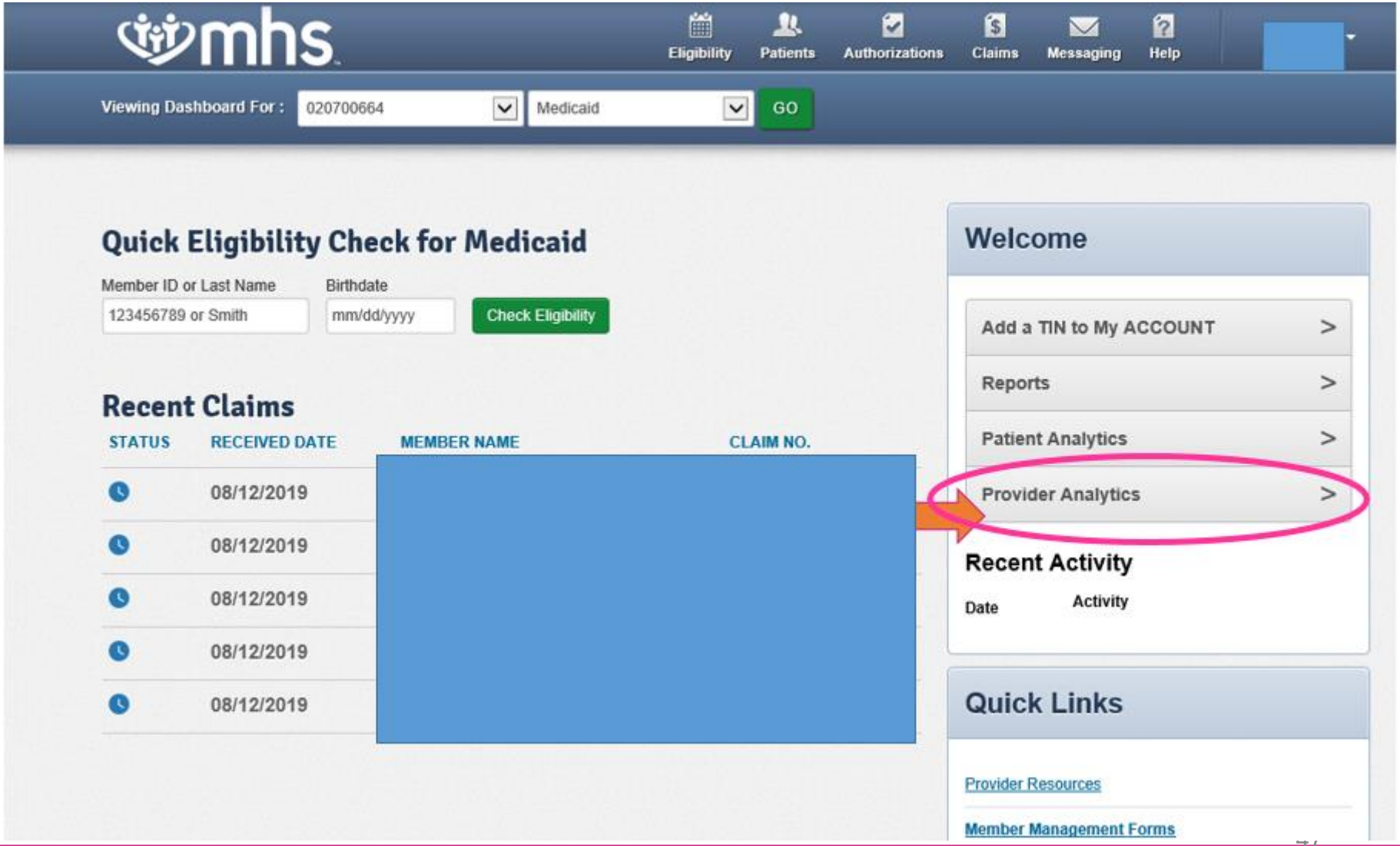
Ambetter only provider? Visit our Ambetter website.

What would you like to do?

- *MAKE AN ADDRESS CHANGE?*
- *MAKE A DEMOGRAPHIC CHANGE?*
- *UPDATE MEMBER ASSIGNMENT LIMITATIONS?*
- *TERM AN EXISTING PROVIDER?*
- *MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER?*

Pay for Performance (P4P) Overview

MHS Secure Portal



Getting Started with P4P

- Providers are you ready to get started in the Pay for Performance Program?

- Are you ready to enhance quality of care through a focus on preventative and screening services while promoting engagement with our members?

It's easy to get started.

1. Register on the MHS Provider Secured Portal
2. Log in
3. Click on Providers
4. Click on Provider Analytics
5. Now you can view P4P member reporting details and much more!

You can also contact your Provider Partnership Associate for One-on-One provider education sessions.

Go to www.mhsindiana.com for more details.

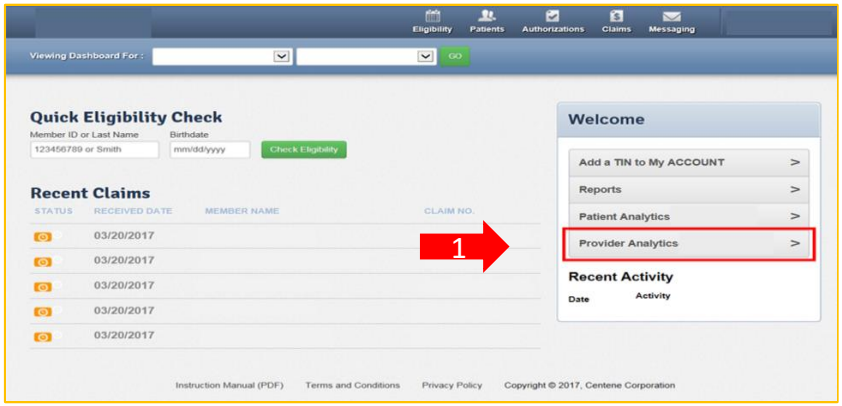
2021 P4P Program Overview

Objective	Enhance quality of care through a PMP driven pay for performance program with a focus on preventive and screening services.
Member Attribution	Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW), and Hoosier Care Connect (HCC) members who have been formally assigned to a Provider group.
Performance Incentive	• MHS has funded an incentive pool of $2.00 PMPM for each program (HIP, HHW, HCC). • Each program has its own set of measures, targets and incentive amounts.
Measurement Time Period	• HEDIS calendar year January 1 – December 31. • Contract effective date is January 1st, allowing for full credit of all gaps closed during the measurement period.
Requirements for Payout	• Minimum number of covered persons must be achieved for the applicable measure. • Payouts are earned for each compliant member after reaching the minimum Target score applicable for each measure.
Reports and Payouts	• Member level care gap reporting and scorecards are available monthly on Provider portal. • Final reconciliation and payout will be processed no later than 180 days following the measurement period.

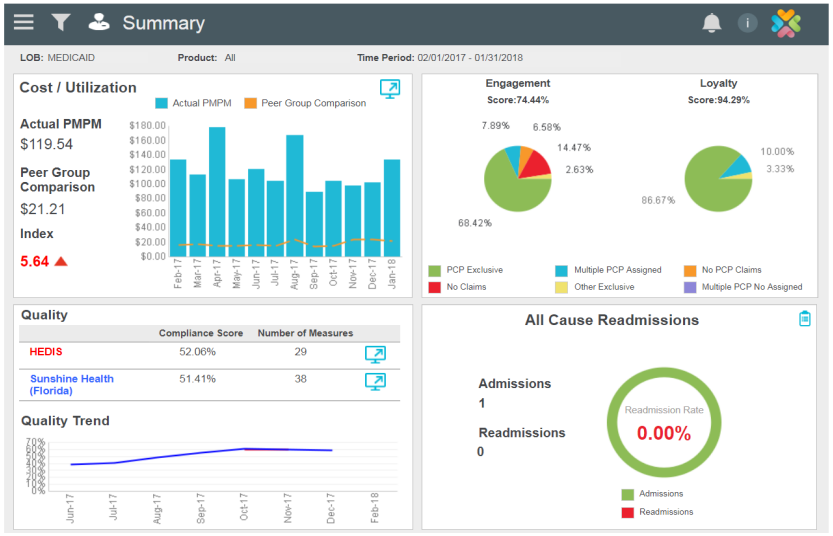
Overview and Navigation Guide

To navigate Provider Analytics:

1. From the Provider Portal, click on the ***Provider Analytics*** link to be directed to the landing page

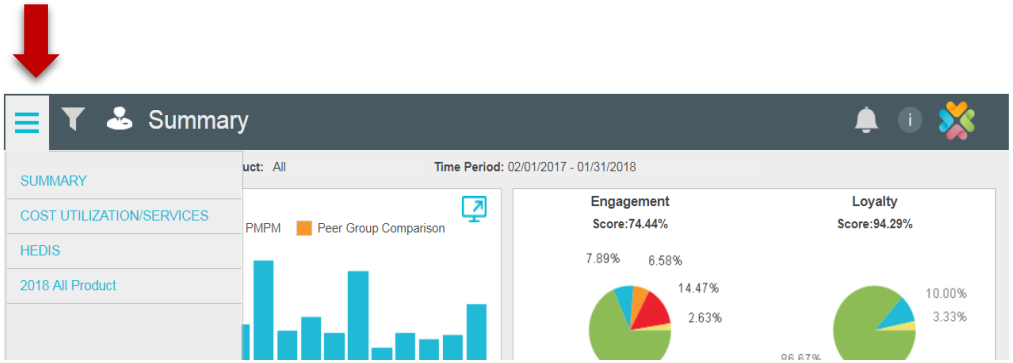


2. Here you will be able to view four dashboards:
   a. Cost/Utilization
   b. Engagement Analysis
   c. Quality
   d. Readmission by Disease State



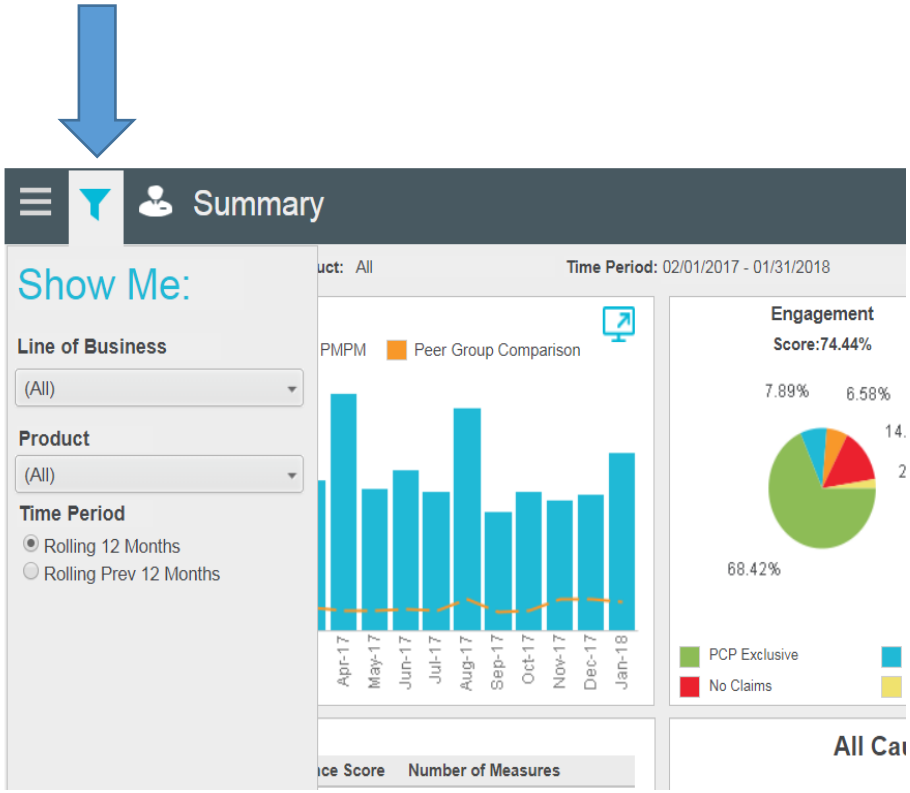
Landing Page Overview

- **Summary Banner:** The dark grey banner contains five icons that will help you navigate the information on the page. You can hover over each icon to view a definition of each icon's purpose.
  - Navigation Bar (three horizontal lines)
  - Funnel – Used to filter data
  - Person – Provider information
  - Bell – Alerts
  - An "i" with a circle – Information
- **Navigation Bar Drop Down:** The following options appear:
  - Summary
  - Cost/Utilization Services
  - Quality
  - Lab
  - Pharmacy
- Case studies have been developed that highlight detailed use cases for each tab.



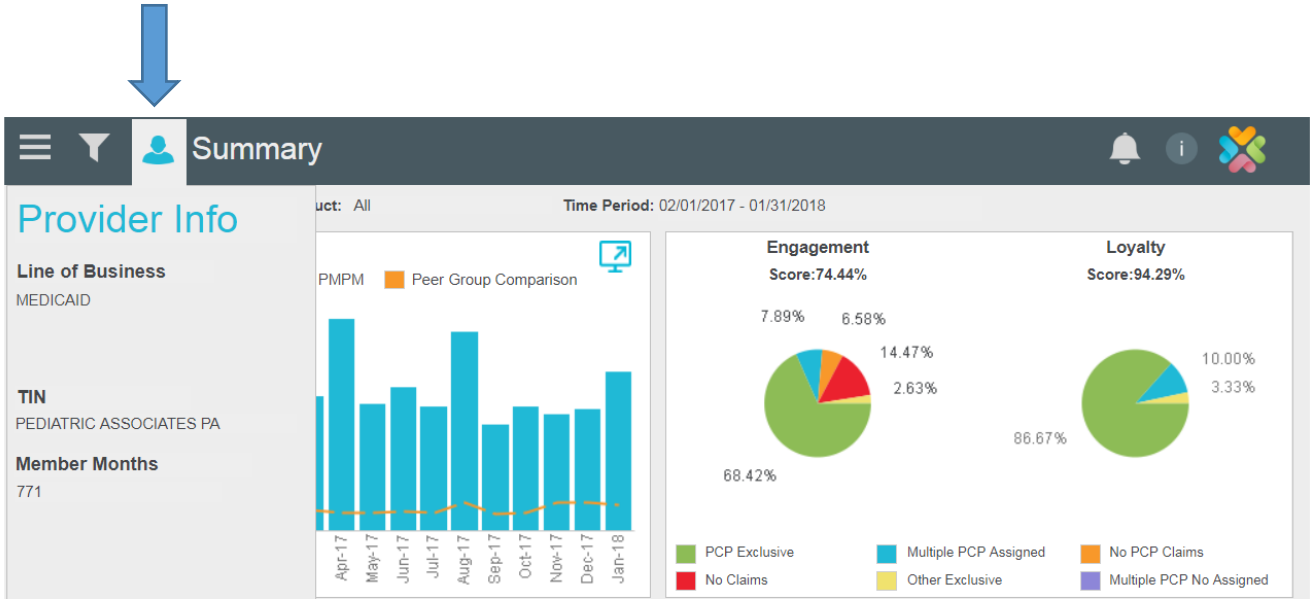
Landing Page Overview

- **Funnel Icon:** Use this to select an option to view data specific to selected criteria
  - Line of Business
    - Commercial
    - Medicaid
    - Medicare
  - Product
    - Medicaid
    - Marketplace
    - Medicare
  - Time Period
    - Rolling 12 months from current date
    - Previous rolling 12 months
    - Note: There is a 3-month data lag



Landing Page Overview

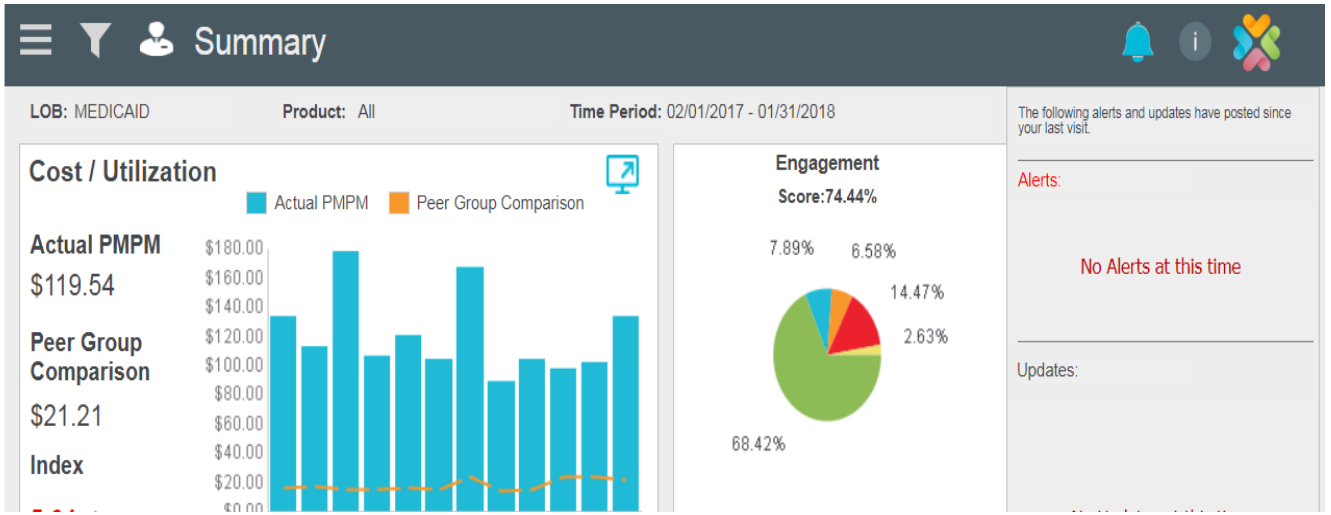
- Person Icon: Use this to select a provider information option to view data specific to selected criteria:
  - Line of Business (LOB)
  - TIN
  - Member Months*



A **member month is defined as **one member** being enrolled for **one month.** For example, an individual who is a patient of a provider for a full year generates 12 member months; a family of five enrolled for six months generates 30 member months*

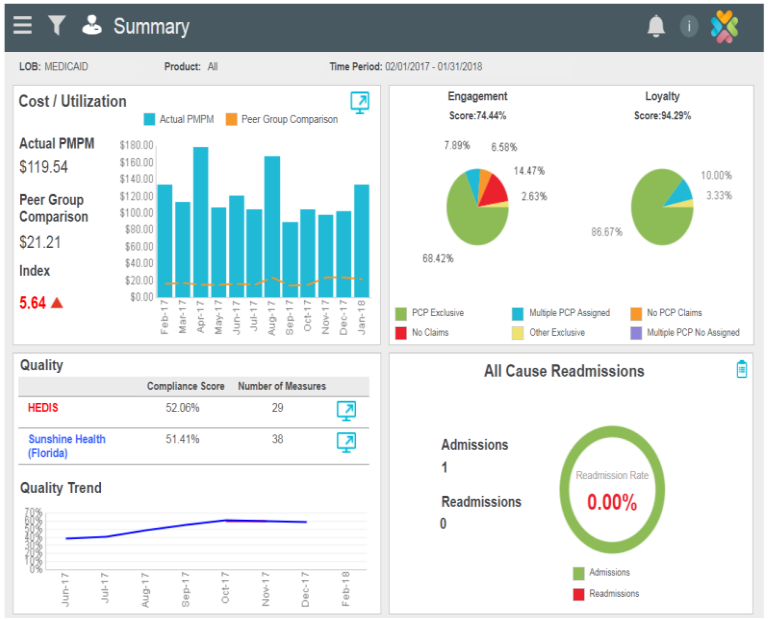
Landing Page Overview

- **Bell Icon:** Alert icon with two features
  - **Blue** bell – Indicates an update, such as a new feature being added to the dashboard or a data refresh
  - **Red** bell – Indicates an issue (can be specific to a particular health plan or can be for all users)
- Click on the bell for a description of the alert



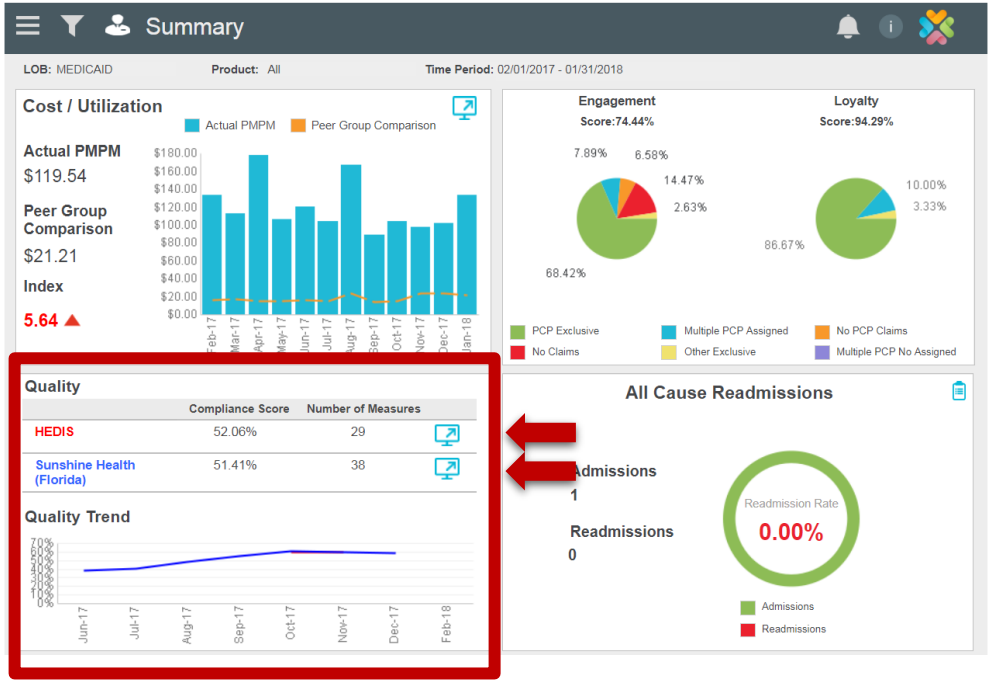
Dashboard View

- **Cost/Utilization:** This dashboard will show your actual PMPM compared to expected PMPM on a monthly basis.
- **Quality:** The Quality dashboard in the lower left quadrant shows HEDIS and VBC performance
- **Engagement Analysis:** This dashboard will show a view of your members' utilization of PCP and healthcare services.
- **Readmission by Disease State:** This dashboard will show total inpatient visits and total readmits. It will show the number of total readmits and those without PCP follow-up and follow-up rate.
- The Cost/Utilization and Quality sections have dashboards providing more specific data down to the member level. To view this data, click on the **blue computer monitor icons.**



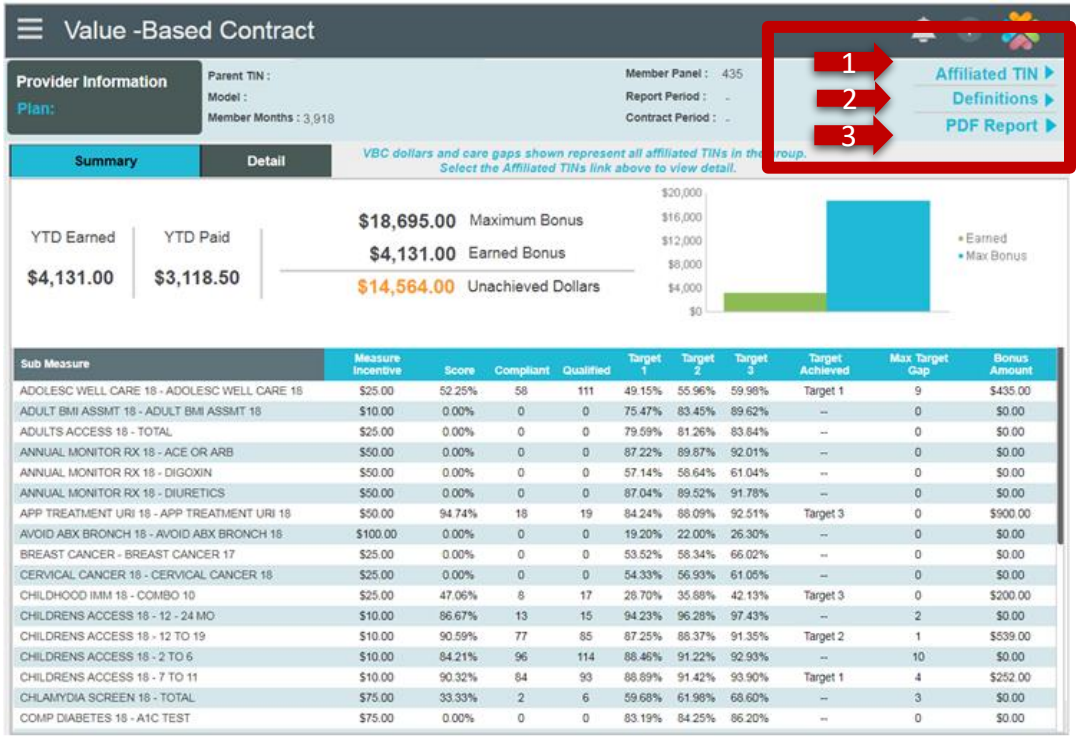
Quality HEDIS View

- Shows trends in closing HEDIS care gaps and earnings from any P4P programs
- Click the blue screen next to HEDIS to view performance in 100+ care gaps and export member-level reports
- Click the blue screen next to VBC PPM to see earnings from P4P program, amount outstanding and amount left to earn per measure



Quality HEDIS View: VBC

- For providers in P4P arrangement
- Value-Based Contract: Shows measure incentive, amount earned, and unachieved dollars
- In right hand corner:
  1. All TINs associated with P4P program
  2. List of definitions and meanings
  3. Scorecard summarizing provider's performance in Quality and VBC

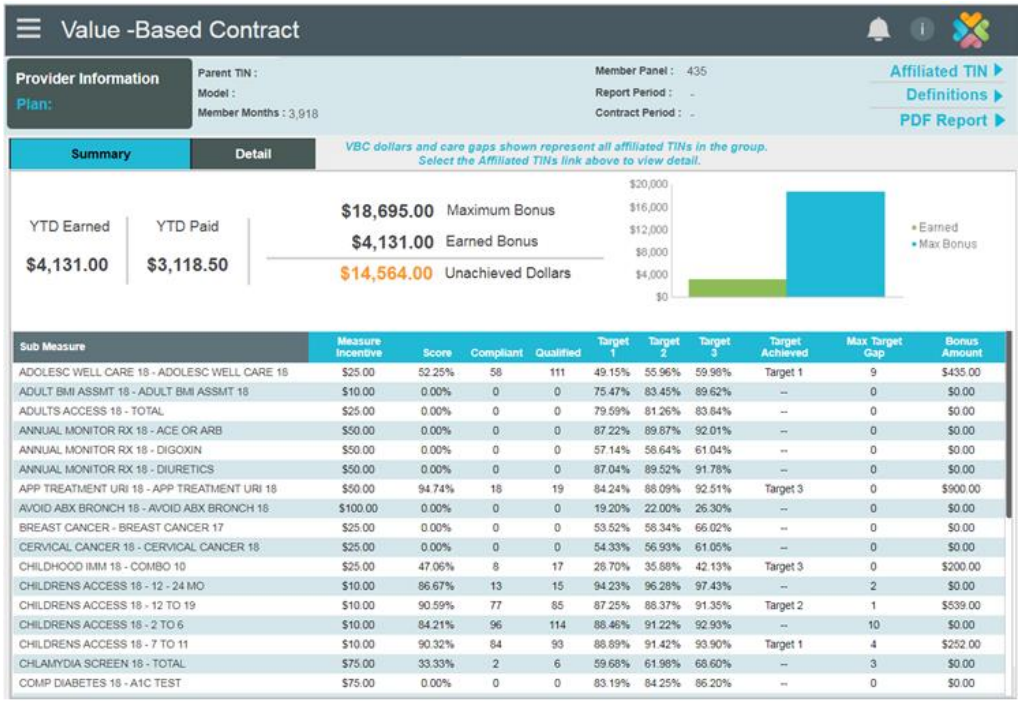


Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target 3	Target Achieved	Max Target Gap	Bonus Amount
ADOLESC WELL CARE 18 - ADOLESC WELL CARE 18	$25.00	52.25%	58	111	49.15%	55.96%	59.98%	Target 1	9	$435.00
ADULT BMI ASSMT 18 - ADULT BMI ASSMT 18	$10.00	0.00%	0	0	75.47%	83.45%	89.62%	--	0	$0.00
ADULTS ACCESS 18 - TOTAL	$25.00	0.00%	0	0	79.59%	81.26%	83.84%	--	0	$0.00
ANNUAL MONITOR RX 18 - ACE OR ARB	$50.00	0.00%	0	0	87.22%	89.87%	92.01%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIGOXIN	$50.00	0.00%	0	0	57.14%	58.64%	61.04%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIURETICS	$50.00	0.00%	0	0	87.04%	89.52%	91.78%	--	0	$0.00
APP TREATMENT URI 18 - APP TREATMENT URI 18	$50.00	94.74%	18	19	84.24%	88.09%	92.51%	Target 3	0	$900.00
AVOID ABX BRONCH 18 - AVOID ABX BRONCH 18	$100.00	0.00%	0	0	19.20%	22.00%	26.30%	--	0	$0.00
BREAST CANCER - BREAST CANCER 17	$25.00	0.00%	0	0	53.52%	58.34%	66.02%	--	0	$0.00
CERVICAL CANCER 18 - CERVICAL CANCER 18	$25.00	0.00%	0	0	54.33%	56.93%	61.05%	--	0	$0.00
CHILDHOOD IMM 18 - COMBO 10	$25.00	47.06%	8	17	28.70%	35.68%	42.13%	Target 3	0	$200.00
CHILDRENS ACCESS 18 - 12 - 24 MO	$10.00	86.67%	13	15	94.23%	96.28%	97.43%	--	2	$0.00
CHILDRENS ACCESS 18 - 12 TO 19	$10.00	90.59%	77	85	87.25%	88.37%	91.35%	Target 2	1	$539.00
CHILDRENS ACCESS 18 - 2 TO 6	$10.00	84.21%	96	114	88.46%	91.22%	92.93%	--	10	$0.00
CHILDRENS ACCESS 18 - 7 TO 11	$10.00	90.32%	84	93	88.89%	91.42%	93.90%	Target 1	4	$252.00
CHLAMYDIA SCREEN 18 - TOTAL	$75.00	33.33%	2	6	59.68%	61.98%	66.60%	--	3	$0.00
COMP DIABETES 18 - A1C TEST	$75.00	0.00%	0	0	83.19%	84.25%	86.20%	--	0	$0.00

Quality HEDIS View: VBC

You can also view:

- Compliant Score
- Compliant and Qualified number per Sub Measure
- Target levels for compliant percentage needed to earn a payout
- Target level achieved
- Number of gaps needed to close to reach Maximum Target Level
- Bonus Amount earned



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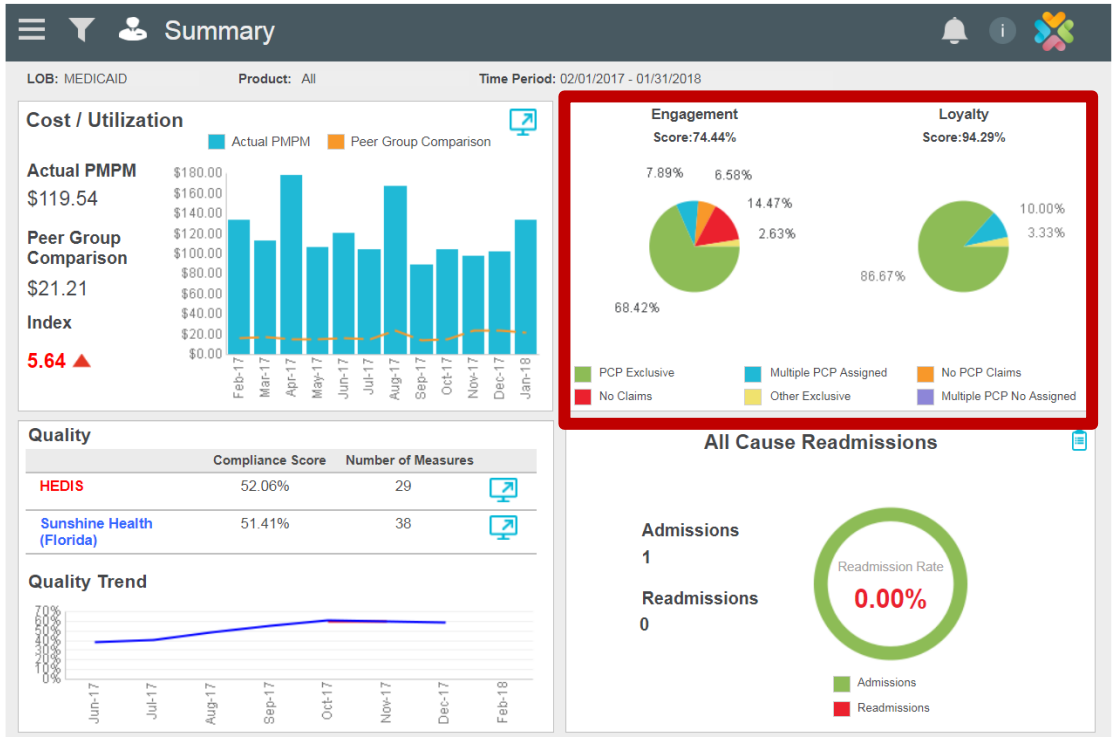
Engagement & Loyalty Analysis

Classifies member interactions with PCP services into two main categories:

- **Provider Engagement:** Measures provider's efficiency with engaging assigned members to be seen for a primary care vis annually; **includes all assigned members**
- **Provider Loyalty:** Measures the provider's ongoing effort to maintain exclusivity as the PCP for assigned panel once members have PCP activity; **excludes assigned members without any PCP visits**



Engagement & Loyalty Analysis

Provider Engagement vs. Provider Loyalty

Provider Engagement*	Provider Loyalty
Assigned PCP Exclusive	Assigned PCP Exclusive
Multiple PCP with Assigned Visits	Multiple PCP with Assigned Visits
Multiple PCP with No Assigned Visits	Multiple PCP with No Assigned Visits
Other Exclusive	Other Exclusive
No PCP Claims	
No Claims	

*In order to improve quality and cost, it's important to engage members who are not actively being managed; therefore, provider engagement provides the most inclusive view of member activity

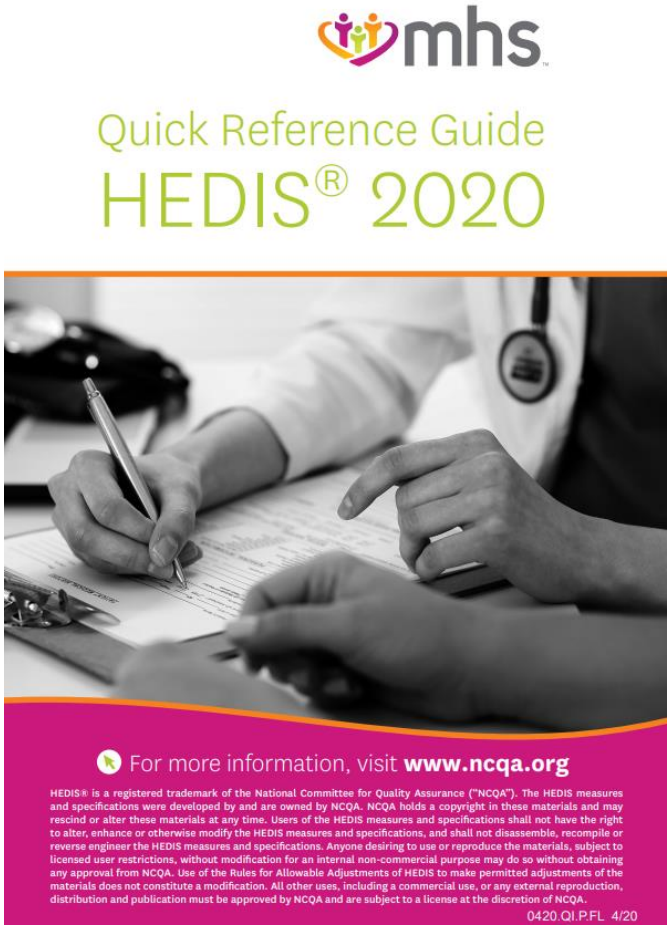
Engagement & Loyalty Analysis

- Provider Engagement is broken into six sub-categories to help identify patient activity and prioritize for outreach

Patient Segment	Segment Traits	Engagement Strategy
PCP Exclusive	These patients have been assigned to you and have been seen by you or one of your partners	Identify which of these members have care gaps and close at their next appointment
Multiple PCP Assigned	These patients are assigned to you, but have been seen by your practice ***AND*** other PCP groups	Initiate a patient outreach plan, set an appointment if appropriate, close care gaps, discuss benefits of PCP loyalty
No PCP Claims	These are patients who seek all of their care from specialists, ER, and Urgent Care.	Outreach and set an appointment for a PCP visit, identify health risks and set follow-up appointments, discuss benefits of loyalty
Other Exclusive	These patients are assigned to you, but have been seeing another PCP group exclusively	Outreach to members to discuss updating their assigned PCP to the doctor they have been seeing for care
No Claims	These patients are assigned to you but have no claim data to indicate they have received any medical care from a PCP, emergency department or urgent care center	Outreach and set an appointment for PCP visit. Identify health risks and set follow-up appointments, discuss benefits of loyalty
Multiple PCP No Assigned	These patients are assigned to you, but have only been seen by other PCP groups.	Outreach to members to discuss benefits of loyalty and promote hours and availability, identify members with care gaps and set appointment for PCP visit

Measure Requirements and Coding

- Find additional information on the measurement requirements and some tips for coding on our website located under HEDIS.



Pay Above Initiatives

- Comprehensive diabetes care-Hb1Ac tests
- Lead screening in children
  - Measure criteria: children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

- $50 additional bonus for services rendered through 12/31/21
- PMP incentive-separate bonus
- Noncompliant listings on MHS portal

Pay Above Initiatives

- Additional Pay above initiative for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect for closing these gaps from October 1, 2021 to December 31, 2021

Measure	Pay Above Amount
Childhood Immunization Status-Combination 10	$20
Lead Screening in Children	$20
Well-Child Visits in the First 15 Months	$20
Adult Access to Preventive/Ambulatory Health Services	$20

COVID-19 Resources

- BT 202152
- COVID-19 Vaccine Status Campaign - $5,000 grant opportunity.
  - The top 100 providers with the highest increase in vaccination rates as a result of this initiative will each receive a $5,000 grant for medical equipment.
  - https://www.mhsindiana.com/newsroom/covid-vaccine-status-campaign.html
  - To navigate to the roster of your unvaccinated members, log into the secure portal at mhsindiana.com. Go to the Welcome Center on the right-hand side of the screen and click on the “Reports” tab. From there you will be able to find and download a date-stamped member roster.
    - Member outreach based on risk factors, vulnerability and loyalty scores.
    - Obtain vaccination status.
    - Review vaccination details - date of 1st and 2nd dose, if applicable.
    - View date of last COVID-19 test, if applicable.

Lead screening in children (LSC)

- Measure evaluates percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
  - 83655
  - View listing of noncompliant members @Mhsindiana.com/portal/provider analytics/scorecard.

Smoking Cessation

- BR 202125
- Tobacco counseling visits:
  - 3-10 minutes: 99406
  - 10+ minutes: 99407/omit U6
  - D1320
- Hoosier Care Connect only: $50 “pay above” incentive for initial counseling visit. The Indiana Tobacco Quitline.
  - 1-800-QUIT-NOW (1-800-784-8669)
  - Free phone-based counseling service that helps Indiana smokers quit.
  - One-on-one coaching for tobacco users trying to quit.
  - Resources available for both providers and patients.

Continuity of Care Program

CoC Program Overview

- Continuity of Care (CoC)- Risk Adjustment bonus program for our Providers
- Bonuses paid for completed and verified appointment agendas and/or submission of a Comprehensive Physical Exam (CPE) medical record
- Providers receive bonus payments based on annual assessments of patient's chronic conditions
- The intent of the CoC Program is to promote proactive management of chronic conditions and preventative services
- Appointment Agendas - provide historical diagnosis data for providers to ensure annual assessment of chronic conditions
- Claims based program – patient's annual assessment performed by PCP and claim is submitted
- Improved health and quality care for members

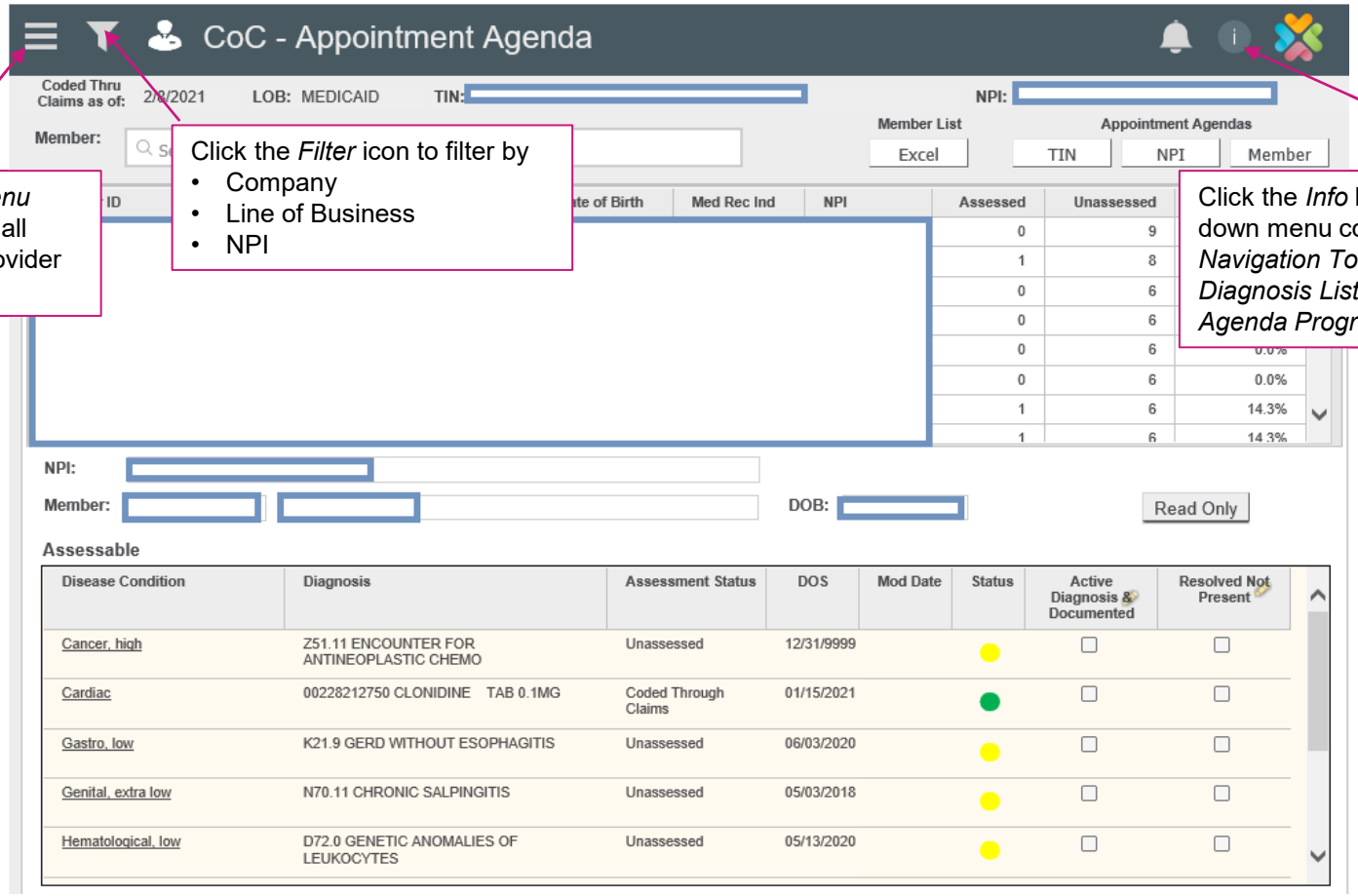
Provider Incentives

% of Appointment Agendas Completed/Paid	Bonus per Paid Appointment Agenda
≤ 50 %	$100
>50 to ≤80 %	$200
>80 %	$300

- 100% of the Risk Adjustment gaps are assessed in the CoC Dashboard
  - Check Active Diagnosis and Documented box or Resolved / Not Present box then authenticate and submit the agenda in the Dashboard **or**
  - **Fax or email** the printed and completed paper Appointment Agent
  - Submit all appropriate diagnoses on a claim
- Providers will be paid quarterly

Dashboard Navigation

CoC Portal Navigation

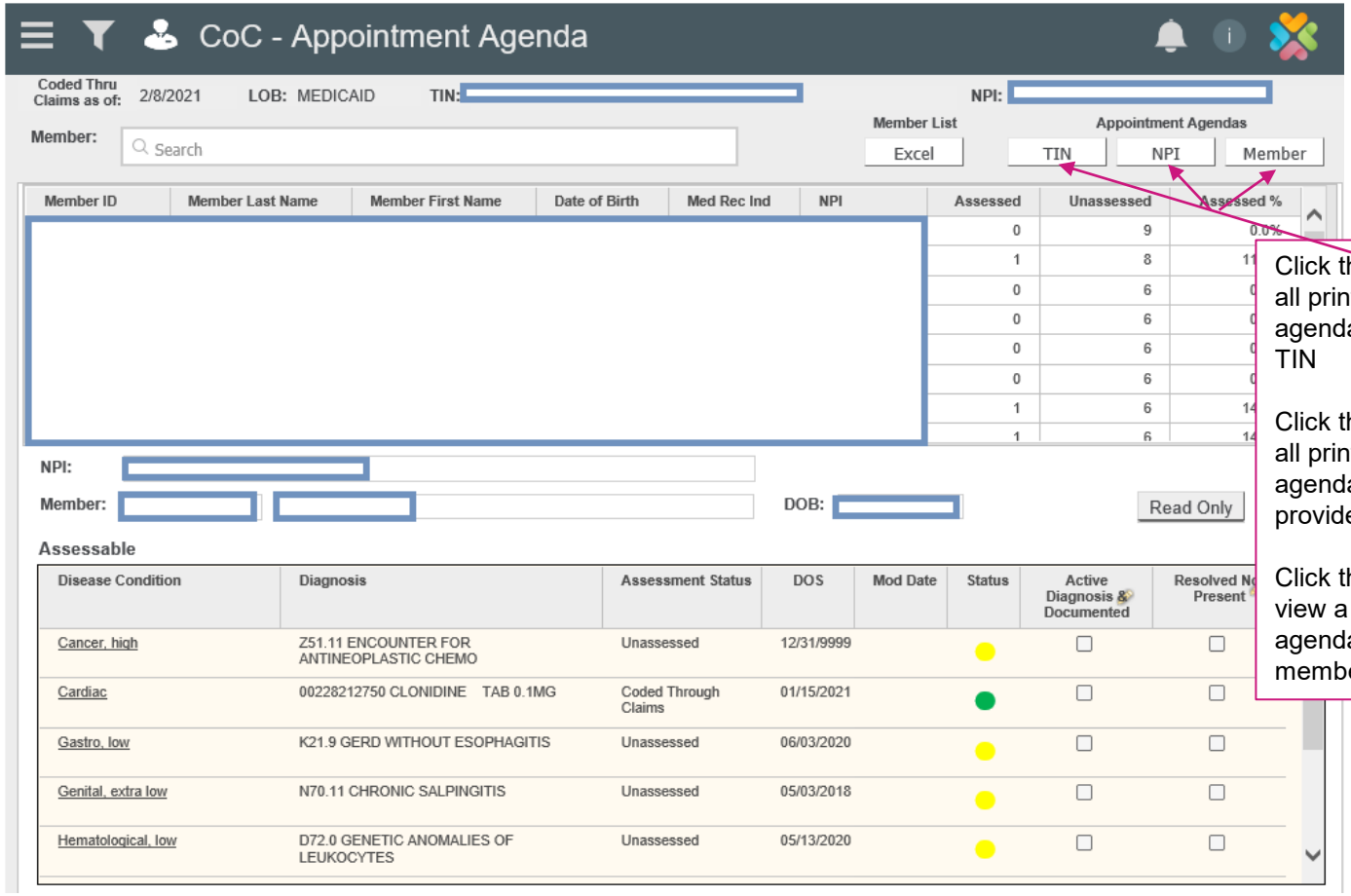


Click the *Menu* icon to view all available provider portals

Click the *Filter* icon to filter by
- Company
- Line of Business
- NPI

Click the *Info* button to view a drop-down menu containing links to the *Navigation Tool, Case Study, FAQ, Diagnosis List, and CoC Appointment Agenda Program Rules documents*

COC Portal Navigation



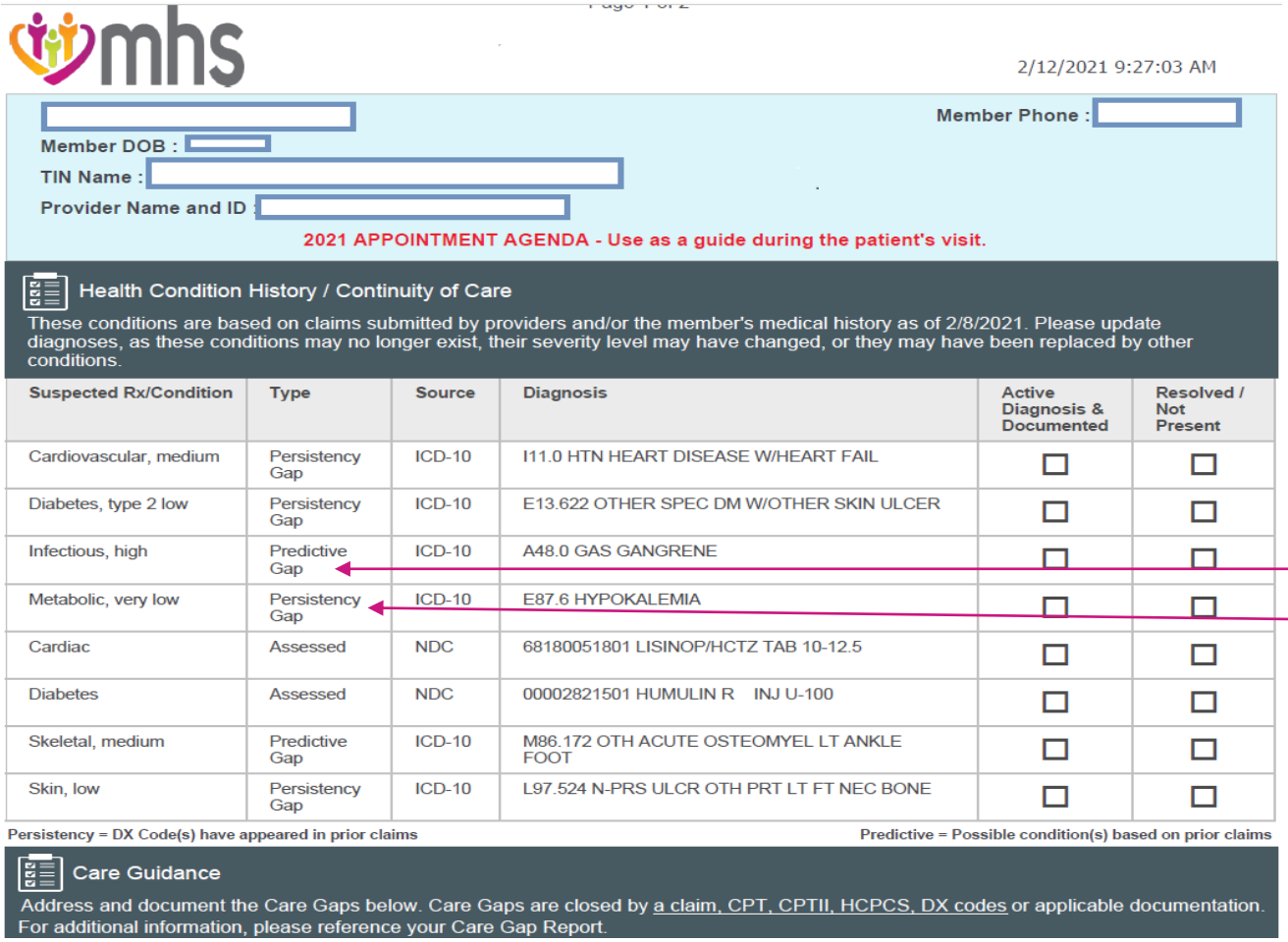
Click the “TIN icon” to view all printable appointment agendas under this specific TIN

Click the “NPI icon” to view all printable appointment agendas under a specific provider

Click the “Member icon” to view a printable appointment agenda for an individual member

COC Portal Navigation

Printable Appointment Agenda



2/12/2021 9:27:03 AM

Member Phone :

Member DOB :

TIN Name :

Provider Name and ID :

2021 APPOINTMENT AGENDA - Use as a guide during the patient's visit.

Health Condition History / Continuity of Care

These conditions are based on claims submitted by providers and/or the member's medical history as of 2/8/2021. Please update diagnoses, as these conditions may no longer exist, their severity level may have changed, or they may have been replaced by other conditions.

Suspected Rx/Condition	Type	Source	Diagnosis	Active Diagnosis & Documented	Resolved / Not Present
Cardiovascular, medium	Persistency Gap	ICD-10	I11.0 HTN HEART DISEASE W/HEART FAIL	☐	☐
Diabetes, type 2 low	Persistency Gap	ICD-10	E13.622 OTHER SPEC DM W/OTHER SKIN ULCER	☐	☐
Infectious, high	Predictive Gap	ICD-10	A48.0 GAS GANGRENE	☐	☐
Metabolic, very low	Persistency Gap	ICD-10	E87.6 HYPOKALEMIA	☐	☐
Cardiac	Assessed	NDC	68180051801 LISINOP/HCTZ TAB 10-12.5	☐	☐
Diabetes	Assessed	NDC	00002821501 HUMULIN R INJ U-100	☐	☐
Skeletal, medium	Predictive Gap	ICD-10	M86.172 OTH ACUTE OSTEOMYEL LT ANKLE FOOT	☐	☐
Skin, low	Persistency Gap	ICD-10	L97.524 N-PRS ULCR OTH PRT LT FT NEC BONE	☐	☐

Persistency = DX Code(s) have appeared in prior claims

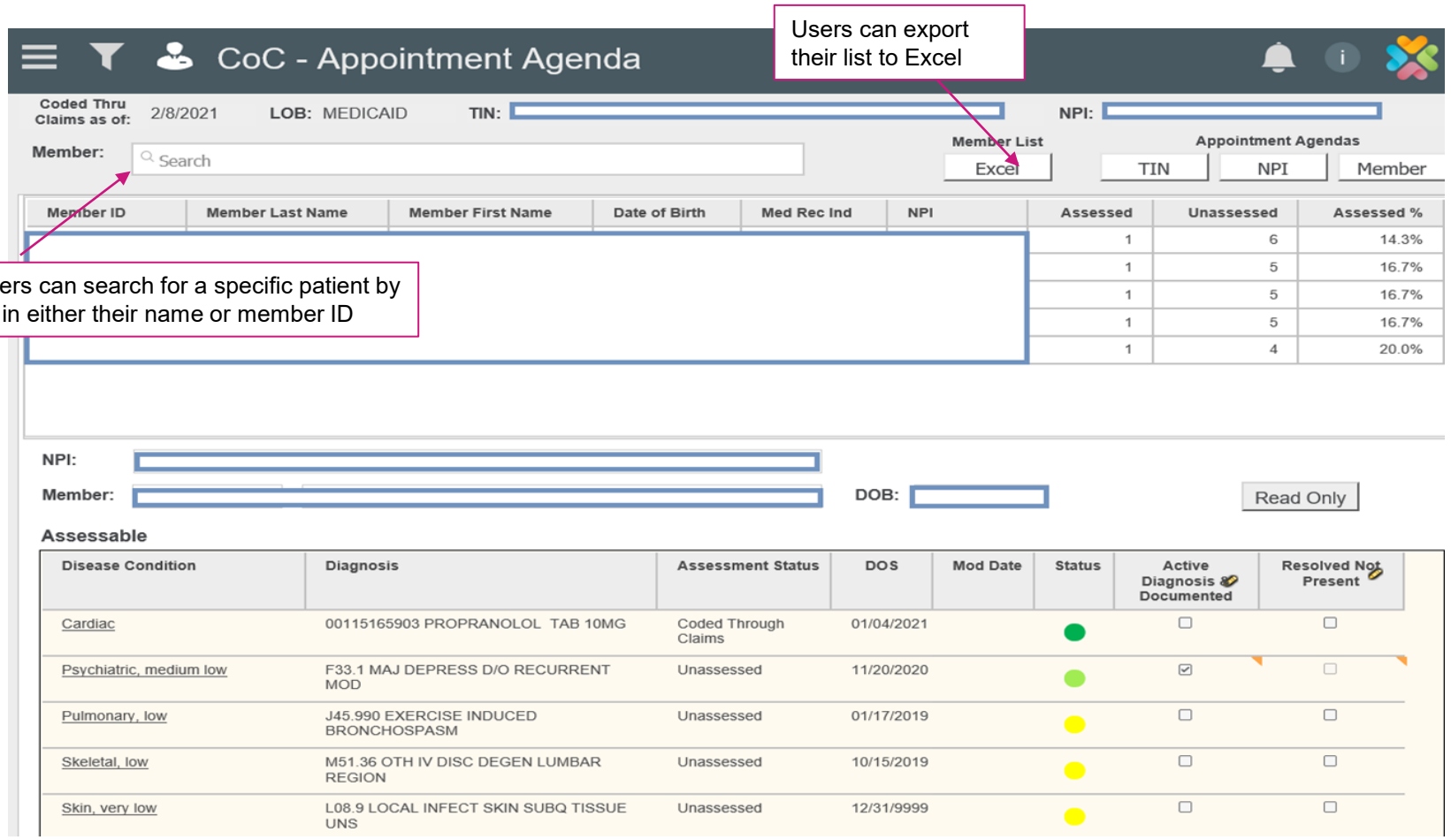
Predictive = Possible condition(s) based on prior claims

Care Guidance

Address and document the Care Gaps below. Care Gaps are closed by a claim, CPT, CPTII, HCPCS, DX codes or applicable documentation. For additional information, please reference your Care Gap Report.

Type:
Predictive Gap
and
Persistency Gap

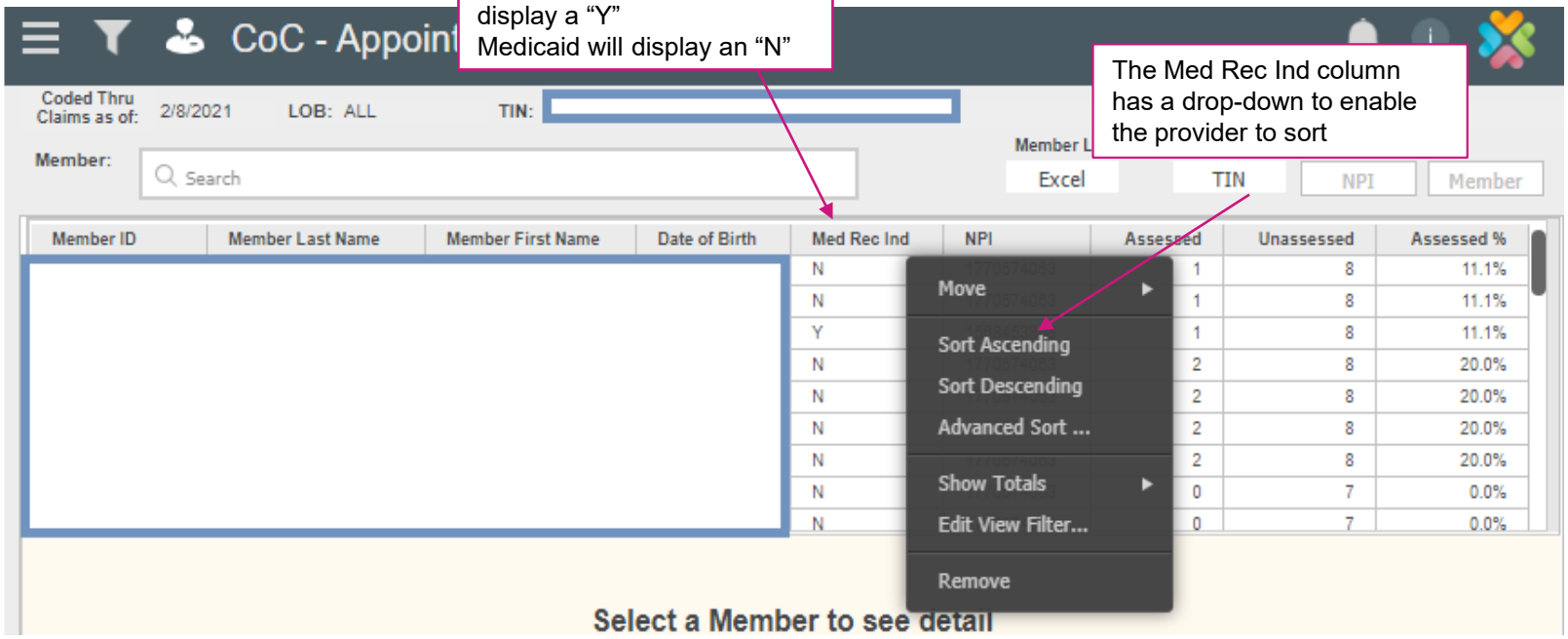
COC Portal Navigation



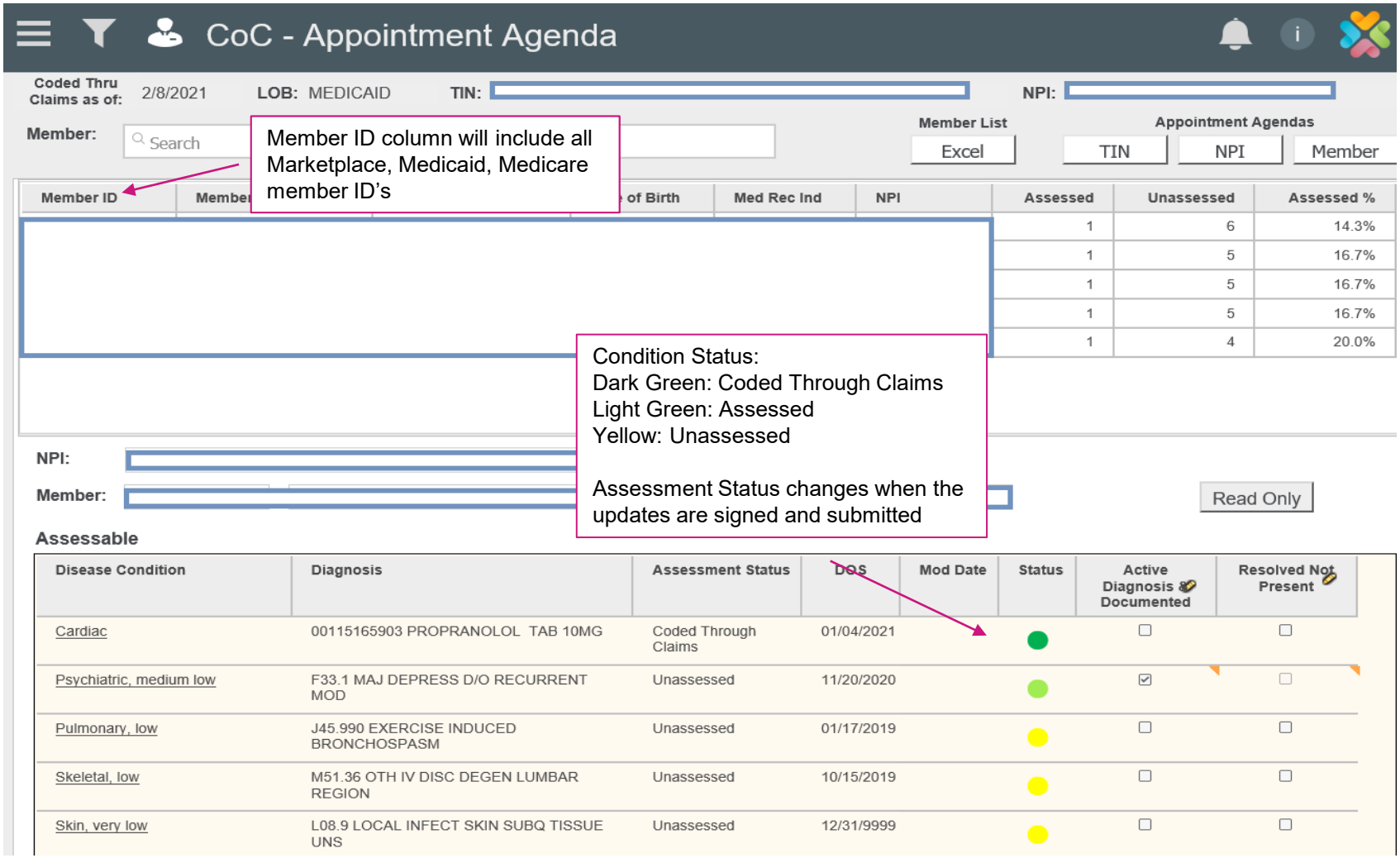
COC Portal Navigation

New in 2021
Medical Record Indicator:
Indicates if we will accept a CPE in-lieu of the Agenda
Medicare/Marketplace will display a “Y”
Medicaid will display an “N”

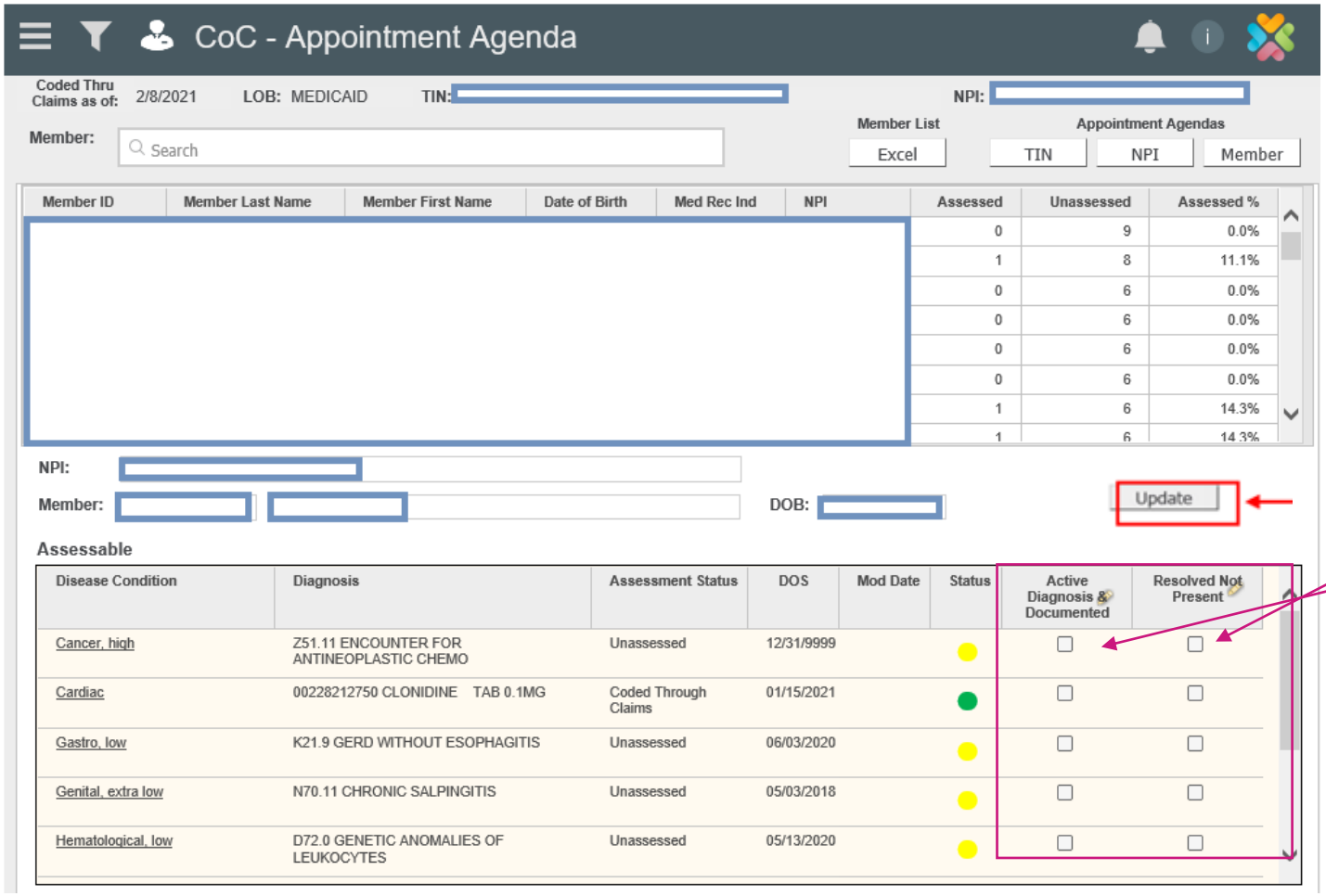
The Med Rec Ind column has a drop-down to enable the provider to sort



COC Portal Navigation



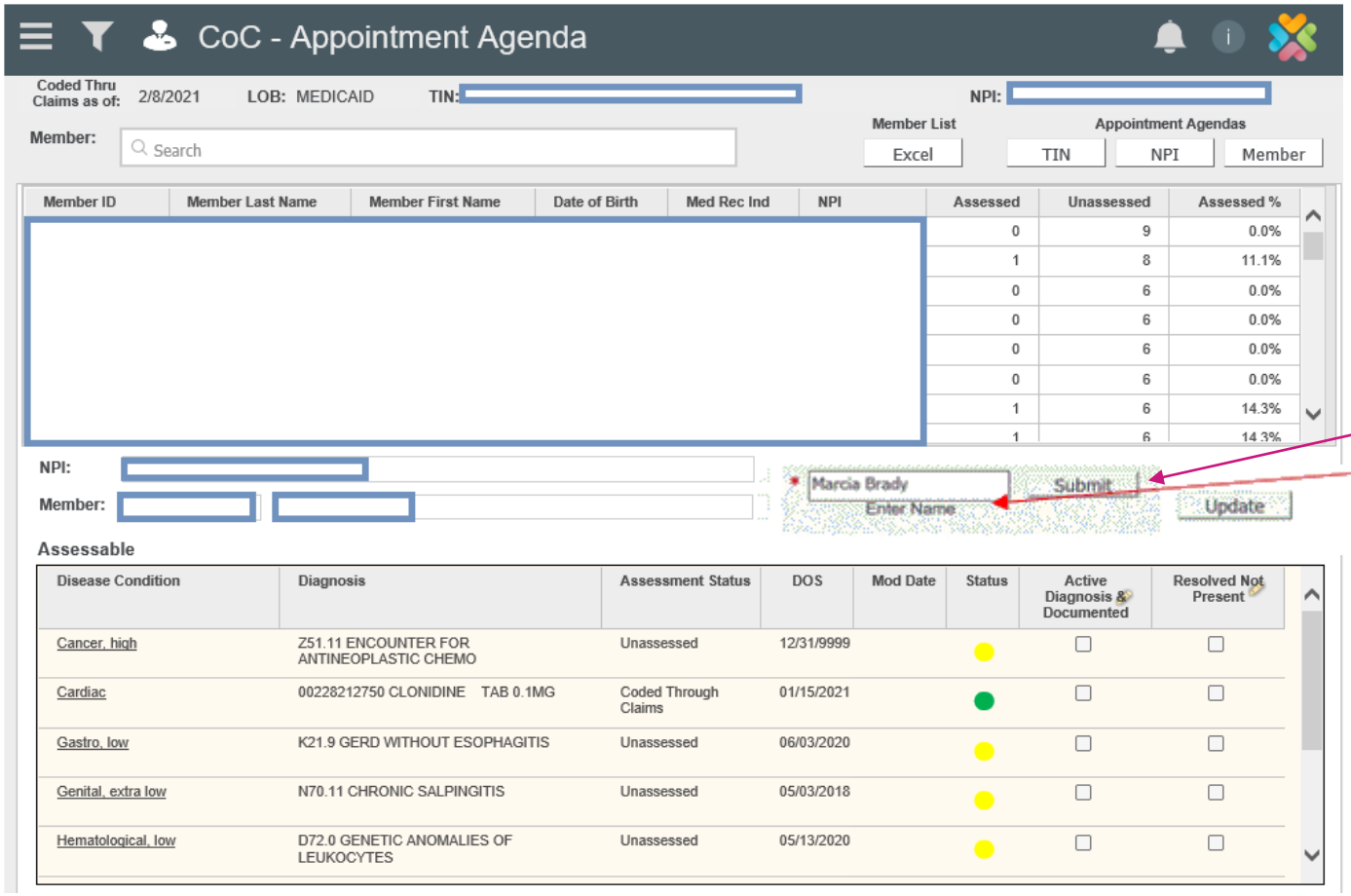
COC Portal Navigation



Once a box is checked or unchecked the provider or provider representative will need to click *Update* to save the changes

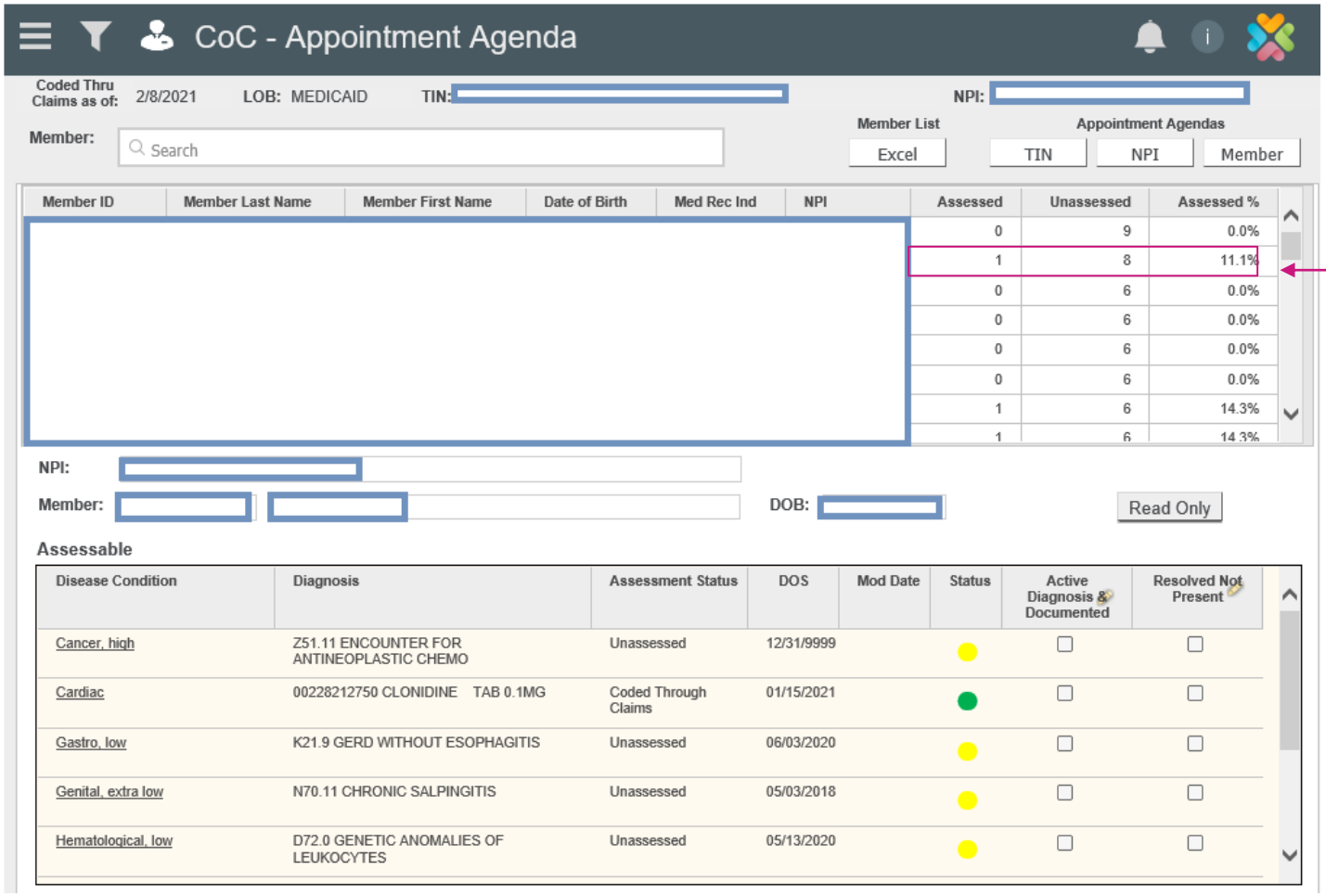
Note: If users export to Excel they still need to go back into the portal dashboard to check boxes, update, sign and submit

COC Portal Navigation



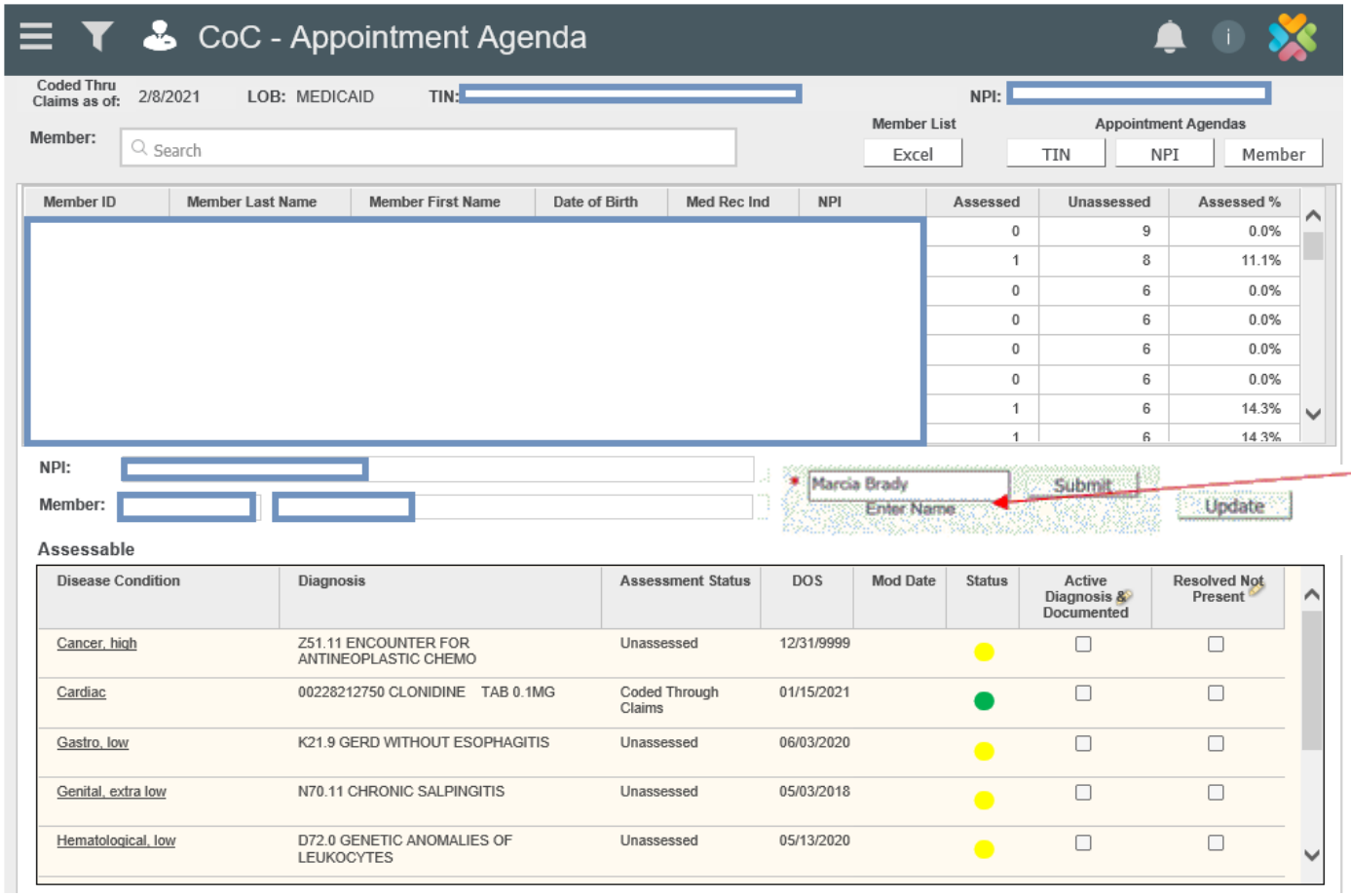
Authorized personnel needs to enter their name to attest to the changes then hit submit to send the appointment agenda updates to MHS

COC Portal Navigation



The members record will now reflect the updated data

COC Portal Navigation



Authorized personnel needs to enter their name to attest to the changes

MHS Partnership

MyHealthDirect

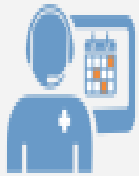
- What is MyHealthDirect?

- MyHealthDirect is a service sponsored by MHS to schedule healthcare appointments for MHS members. You specify the type and quantity of appointments to make available and a MHS team member schedules those appointments with your patients on your behalf.

MyHealthDirect

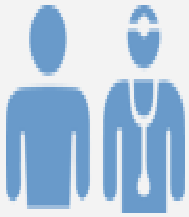
MHS contacts and schedules with your patient

Both you and the patient get a confirmation email



You enter the appointment into your PM system

Automatic reminder(s) sent to patient



The patient attends their appointment

Once a week you complete a simple attendance report in MyHealthDirect

MyHealthDirect

- How do I get started?

Go out to MHSINDIANA.COM

- 1. Complete the Clinic Setup Form and User Agreements
- 2. Activate your user account
- 3. Schedule and complete the training webinar (est. 45 minutes)

MyHealthDirect:
Overview
myhealth direct
MyHealthDirect is a service sponsored by
MHS to schedule healthcare appointments for MHS members.
How is MyHealthDirect different from other services?
MHS makes scheduling appointments for your members easy. We reach out to schedule appointments with your patients on your behalf.
Together we close gaps in care.
How does MyHealthDirect work?
MHS contacts and schedules with your patient
Both you and the patient get a confirmation email
You enter the appointment into your PM system
Automatic reminder(s) are sent to patient
Patient attends their appointment
MyHealthDirect is FREE to you and your patients. You still keep full control over your calendar and appointments. We do the rest.
Want to learn more? Contact your Provider Representative or MyHealthDirect today!
Liz McDonell
Account Specialist II, MyHealthDirect
liz.mcdonell@experian.com | 615.830.0546
myhealth direct
mhs
mhsindiana.com

My HealthDirect

- Further questions?

- Contact your Provider Partnership Associate in your area
- MyHealthDirect (469) 748-6263

ConferMED Overview

Who is ConferMED?

- ConferMED is a telehealth company with expertise in primary care and asynchronous telehealth using eConsults.
- eConsults are responded to b a board-certified specialist with 2-business days.
- PCPs will have access to eConsults. ConferMED will work with the PCP practice to implement eConsult into the practice's current referral process.
- The ConferMED specialists are IN licensed, board certified and Medicaid enrolled. ConferMED works to recruit local IN specialist to join our virtual eConsult network.
- ConferMED contract directly with the specialist and is reimbursed for each eConsult performed.

How ConferMED Works

- Provider orders consults in their Electronic Health Record (HER) following usual referral workflow.
- Specialist reviews consult information responds with advice and guidance for the PCP.
- eConsults note returned to PCP's referral inbox within their EHR.
- The eConsult solution is:
  - HIPAA – compliant clinical integrations
  - Interoperable with all major EHRs
  - Workflow is tailored to your organization.

ConferMED Specialty Network

- Nearly 200 Specialists in adult and Pediatrics
- Board Certification in specialty or subspecialty
- Key 15 specialties and building on other specialties
- NCQA level credentialing process

ConferMED Key Benefits

PMP Experience:

- MHS will cover all costs for ConferMED eConsults for MHS patients.
- Expand scope of practice
- Get rapid guidance and answers to clinical questions from specialists
- Keep more of your patients in primary care
- Consult with our extensive network of board-certified specialists in numerous specialties and subspecialties
- Increased access to needed specialty care for patients.

Patient Experience:

- Patients avoid unnecessary medical visits
- Patients get more care in primary care with expedited guidance from specialist
- Reduce co-pays and medical cost sharing
- Avoid unnecessary travel
- Avoid unnecessary time off from work

More information about ConferMED is available at www.confermed.com

Provider Resources for Members

Member Resources

- Brochures and Guides
- Complaints and Appeals
- FAQ's
- Get the most from your coverage
- Helpful Links
- Maximize your health
- Member and Community Events
- Member Forms
- Members Rights and Responsibility
- New Member Check List
- Newsletters
- Quality Improvement Program
- Special Programs and Services
- Interoperability and Patient Access
- Community Connect

24 Hour Free Nurse Advice Line

- The Nurse Advice Line is available 24 hours a day, seven days a week, including weekends and holidays. Callers can talk to experienced nurses when they call. The main goal of the Nurse Advice Line is to direct members to the appropriate level of care. Any time a member is referred to the emergency room by the Nurse Advice Line, a copay will not be required. Nurse Advice Line staff use state-of-the-art advice protocols and plan methodologies. All calls taken by Nurse Advice Line staff are logged and tracked.
- 1.877.647.4848

Culturally and Linguistic Appropriate Services (CLAS)

- CLAS refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of patients.
- Visit mhsindiana.com provider guides page for a brochure about CLAS standards.

Translation Services

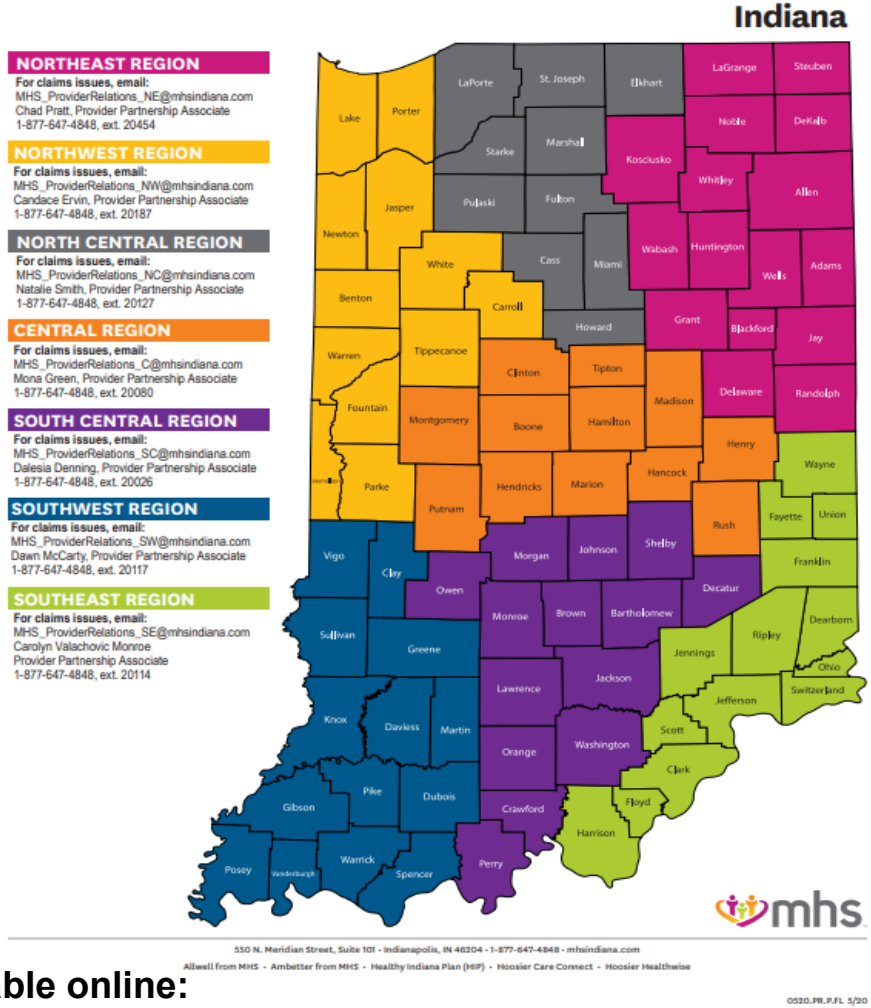
- Available to MHS members/providers at no cost.
- Can accommodate most languages and locations.
- Interpretation services available in person or telephonically.
- Please contact MHS Member Services at 1-877-647-4848 for specific information on accessing these services.
- Spanish speaking representatives available to speak with members if needed (additional languages are available upon request).

Stop Smoking or Using Tobacco

- Call the FREE, CONFIDENTIAL Indiana Tobacco Quitline today at 1-800-QUIT-NOW. The Quitline is an evidence-based telephone counseling program that offers one-on-one coaching to tobacco users who have decided to quit, provides professional support throughout your journey and discusses medication support. If you are not ready to quit, the Quitline staff will help you figure out what you can do to prepare yourself to successfully quit. Additionally, the Quitline offers a Web Coach and texting support – Text2Quit

MHS Team

MHS Provider Network Territories



Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

NORTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

SOUTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

SOUTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114

MHS Provider Network Territories

TAWANNA DANZIE
Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS

- Beacon Medical Group
- Franciscan Alliance
- HealthLinc
- Heart City Health Center
- Indiana Health Centers
- Lutheran Medical Group
- Parkview Health System
- South Bend Clinic

JENNIFER GARNER
Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS

- American Health Network of Indiana
- Columbus Regional Health
- Community Physicians of Indiana
- HealthNet
- Health & Hospital Corporation of Marion County
- Indiana University Health
- St. Vincent Medical Group

ENVOLVE DENTAL, INC.

ANTWAN PEREZ-ALVAREZ
Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

CHANTEL MCKINNEY
Chantel.McKinney@EnvolveHealth.com
Yojani Benitez
Yojani.Benitez@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

Network Leadership

NETWORK LEADERSHIP

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MARK VONDERHEIT
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NEW PROVIDER CONTRACTING

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tbalko@mhsindiana.com

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

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Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

Questions?

Thank you for being our partner in care.