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the Communicator

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Change in Member HIP POWER Account Cards

MHS is no longer issuing POWER Account debit cards to HIP members. Current POWER Account debit cards will be deactivated as of June 1, 2017. Communication was sent to members who already have a card advising them that their POWER Account debit card is no longer needed. HIP members will be issued a new HIP identification card by MHS on June 1, 2017, to confirm enrollment.

The new MHS HIP POWER Account ID Card looks like this:

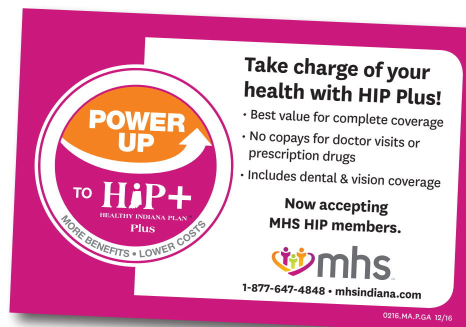
For additional information about the discontinued use of the POWER Account debit cards, please refer to IHCP Bulletin BT201729 released on May 2, 2017. Additional changes to the POWER Account program will be communicated via IHCP Bulletins in the coming months.

MHS will update the Provider Manual to reflect these recent plan changes. Please visit mhsindiana.com for additional details on the POWER Account, claims submission, and other important information.

Encourage Your Patients to POWER Up to HIP Plus!

HIP Plus is the preferred plan for all HIP members. It's the plan for the best value – members receive enhanced benefits, including dental and vision services, all for a low, predictable monthly cost with no copays. Our research shows that our HIP Plus members are more engaged in their healthcare. Engaged patients make office visits more productive, reduce after-hours phone calls, and decrease emergency room visits and follow-up appointments. They actively participate in their healthcare by having preventive services and asking questions during appointments.

Our members tell us they value the advice given to them by their providers. Take this opportunity to encourage all of your HIP members to POWER Up to HIP Plus, and to keep paying their monthly payments so they can keep their HIP Plus benefits. They get more benefits at lower costs, and you get healthier, more engaged patients – it's a win-win! Want to help spread the word?



MHS can provide free POWER Up window clings for your office. Contact your Provider Partner Associate to learn more.

CentAccount Healthy Rewards for POWER Up

Did you know? MHS rewards members for being proactive in their health with the CentAccount Healthy Rewards program. Members can earn rewards by doing things like completing a health needs screening, getting their annual checkups and screenings, enrolling in a smoking cessation program and more. Then HIP members can use those reward dollars to POWER Up to HIP Plus. MHS encourages you to talk with your patients about the CentAccount program and how they can earn rewards to POWER Up to HIP Plus.

MHS is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise, the Healthy Indiana Plan and Hoosier Care Connect. MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS. MHS is your choice for affordable health insurance.

MHS Has Moved!

On August 1, 2017, we moved to our central office. Our new location is 550 N. Meridian St., Suite 101 in downtown Indianapolis. That's just a few blocks from our previous location.

Please send contracts, information about upcoming events and additional information to the new building.

Our new address is:

MHS
550 N. Meridian St.
Suite 101
Indianapolis, IN 46204

Continue to submit your claims to the Farmington location, and continue to submit your refunds to the Chicago location.

Submit claims to:

- **MEDICAID CLAIMS**
  Managed Health Services
  P.O. Box 3002
  Farmington, MO 63640-3802

- **AMBETTER CLAIMS AND REFUNDS**
  Ambetter from MHS
  Attn: Claims
  P.O. Box 5010
  Farmington, MO 63640-5010

Submit refunds to:

- **MEDICAID REFUNDS**
  Coordinated Care Corporation
  75 Remittance Dr.
  Suite 6446
  Chicago, IL 60675-6446

Any questions? We're here to help!
Call MHS Provider Services at 1-877-647-4848 or visit us online at mhsindiana.com.

A Connection to Care: Care Managers Are Useful Links to a Member's Healthcare Team

A member's health situation often warrants additional resources in order to help the individual navigate complex treatment and recovery options. Our care management programs are a valuable resource available to members that support our providers' treatment plans.

On the Job: Care managers are trained nurses and other healthcare professionals who coordinate the needs of patients. Typically, care managers work with chronically and/or catastrophically ill and injured patients with complex needs. They are assigned by the health plan to a member when it's recognized the member's particular condition needs complex coordinated care that the member may not be able to facilitate on his or her own. A care manager connects the member with the healthcare team by providing a communication link between the member, his or her primary medical provider, the member's family or other support system, and additional healthcare providers such as physical therapists and specialty physicians. Care managers also collaborate to develop a plan for following treatment plan regimens including medication, diet and exercise recommendations.

On Your Team: Care managers do not provide hands-on care, diagnose conditions or prescribe medication and treatment. The care manager helps a member understand the benefits of following a treatment plan and the consequences of not following the plan outlined by the physician. In this way, they become the eyes and ears for the healthcare team, and a resource for physicians, the member, and the member's family. Our case management team is here to support your team for such events as: Non-adherence • New diagnosis • Complex multiple co-morbidities.

Providers can directly refer members to our case and care management programs at any time. Providers may call 1-877-647-4848 for additional information about these services, or to initiate a referral.

The MHS care management team includes:

- Children with Special Needs
- Behavioral Health
- OB Care Management
- Early Childhood Development
- Complex Care Management for Asthma, Diabetes, COPD, CKD, CHF, CAD, Hypertension, Lead

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Hoosier Care Connect: Become a Contracted Provider

Are you a contracted provider with Hoosier Care Connect? If not, we would love to have you on board! Please visit our Become a Provider page for more information or if you are interested in contracting with MHS. Thank you for being our continued partner in care. [link will be updated to new site as needed]

WHAT IS HOOSIER CARE CONNECT?
Hoosier Care Connect is a coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare. Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical providers. Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services.

Always check the IHCP Provider Healthcare Portal or mhsindiana.com for member package and benefit information.

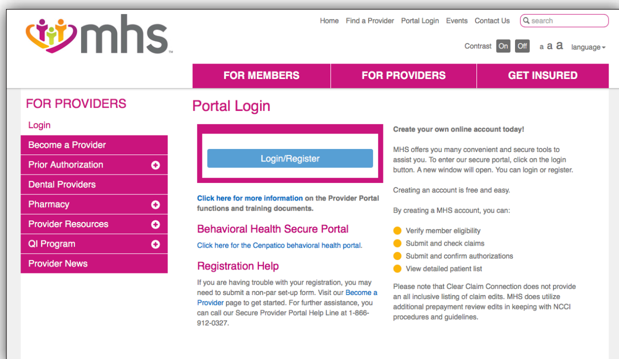
Have You Signed Up For The MHS Secure Provider Portal?

The MHS secure provider portal provides real-time information in a protected online environment to help you manage your practice with quick information at your convenience.

KEY FEATURES:

- Check eligibility & view member roster
- Submit & check authorizations, claims, and batch claims
- View care gaps for members
- Access EOPs & capitation reports
- Send secure messages to MHS

And more!



Notification of Pregnancy

Complete a Notification of Pregnancy and earn $60! The Notification of Pregnancy (NOP) is a form designed to identify risk factors for pregnant women enrolled in Healthy Indiana Plan (HIP), Hoosier Healthwise, Hoosier Care Connect, and women in the Presumptive Eligibility (PE) program. Recognized providers are eligible for reimbursement of $60 for successful submission of the NOP.

It's fast and easy as 1, 2, 3!

1. **Complete a Notification of Pregnancy (NOP) form for your pregnant patients.** The revised NOP is just four simple questions about member demographics, high-risk pregnancy indicators and basic pregnancy information.

2. **Submit the NOP via the IHCP Provider Healthcare Portal.** NOP must be submitted within five calendar days of the date of service and at less than 30 weeks gestation. It must not be a duplicate submission for the same member and pregnancy.

3. **Earn $60 per completed NOP.** Providers must bill MHS for the NOP incentive payment using Current Procedural Terminology (CPT®1) code 99354 with modifier TH. The date of service (DOS) on the NOP claim should be the date of the office visit on which the information on the NOP is based.

MHS Health Library at mhsindiana.com/health

Patients appreciate being able to leave the office with information in-hand about their condition. Do you currently have a health information sheet resource available in your office? Go to the Provider Resources section of the MHS website, then click on Health Library to access a free health library with over 4,000 printable health information sheets to give to your MHS members. The health sheets are available in English and Spanish, with other languages available on request.

JUST A THOUGHT

BY DR. YANCY

Per the NCQA HEDIS measure for ADHD, children with newly prescribed ADHD medication should receive at least three follow-up care visits within a 10 month period, one of which should occur within 30 days of when the first ADHD medication was dispensed.

Dr. Eric A. Yancy
MHS Chief Medical Officer and practicing pediatrician

MHS Member Rights and Responsibilities

MHS Members have certain rights and responsibilities under state and federal laws. You can find a copy of these rights and responsibilities in the MHS Provider Manual, or the MHS Member Handbook, available on mhsindiana.com. You may request printed copies of any materials found on our website. Just call MHS Provider Services at 1-877-647-4848 to request.

Advise Smokers to Quit: The Two-Question Approach

Providers are encouraged to discuss tobacco cessation with all patients, advising and imploring smokers to quit. Ask two simple questions, “do you smoke?” and “can I help you quit?,” to start a dialogue with your patient about their tobacco use.

MHS covers tobacco cessation counseling according to IHCP policy. Counseling must be provided as follows: A minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within 12 weeks. Counseling will be billed in 15-minute increments.

Diagnosis Code	HCPCS Procedure Code	Unit of Service
F17.200-F17.299 Nicotine dependence	99407 U6 – Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes; per 15 minutes	1 Unit = 15 minutes

Prescription cessation aids are covered as well. Providers are encouraged to refer patients age 18 and older to the Indiana Tobacco Quitline, 1-800-QUIT-NOW. The Quitline offers education and coaching over the phone. The services offered by the Quitline are confidential and provided free of charge to Indiana residents.

The Quitline staff will fax a report to your office to tell you that the client was enrolled in services. Remind your patients they can earn $20 in CentAccount rewards for enrolling with the Quitline.

Ask your Provider Relations Specialist for patient and provider materials that further explain the Quitline program.

Monitoring and Evaluating Diabetes

Uncontrolled diabetes can affect a person’s entire well-being. People with diabetes are twice as likely to develop depression as those without diabetes. Similarly, those with diabetes are two to four times more likely than those without diabetes to die from a heart attack or stroke. Diabetes is also the leading cause of new blindness in adults.

Women are especially affected by diabetes. They are six times more likely to develop heart disease (particularly CAD) than women without diabetes. Women are more likely than men with diabetes to have a higher rate of obesity and high blood pressure.

Due to the disease’s extensive reach, it is imperative to closely monitor and evaluate your patients with diabetes. NCQA® has set multiple diabetes-related HEDIS® measures in place to monitor the quality of diabetes evaluation and treatment. HEDIS® requires the following services for those patients identified as living with diabetes:

- **At least one Hemoglobin A1C screening each year AND a value of < 7.0**
- **A retinal exam, each year, by an eye care professional if diabetic retinopathy is present. A retinal exam is only required every other year if no signs of retinopathy are present.**
- **Urine screening for albumin or protein, each year, to monitor for nephropathy (if the patient has no pre-existing renal disease).**
- **Blood pressure control of <140/90**
- **At least one LDL screening each year AND a value < 100**

Visit the Provider Guides section at mhsindiana.com for further details and billing codes in our Quick Reference HEDIS Guides.

Preferred Drug Lists

Providers can view the preferred drug list (PDL) for each program at mhsindiana.com.

The PDLs contain important information on how members can use their pharmacy benefits; a list of preferred drugs; explanations of limits, prior authorization and step therapy; and requirements for generic medications when they are available.

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Help Your Patients 'Get Smart About Antibiotics'

The CDC has developed materials for providers to help educate patients about when it is and is not appropriate to prescribe antibiotics, and to explain why antibiotic resistance is such a pressing health problem. Materials include fact sheets, a sample letter, and 'prescription pads' suggesting alternate treatments that can be given to patients in lieu of prescribing an antibiotic.

All materials are free of charge and available to download at cdc.gov/getsmart.

MHS' Commitment to CLAS

Culturally and Linguistically Appropriate Services (CLAS) refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of your patients. MHS is committed to ensuring the linguistic needs and cultural differences of our members are met, and we provide an array of services through internal sources and external partnerships.

- Access to individuals who are trained, professional interpreters. MHS offers face-to-face or telephonic interpreter services that may be arranged through Member Services. MHS requests a five-day prior notification for face-to-face services.
- Language line services are available 24/7, in approximately 150 languages, to assist providers and members in communicating with each other when there are no other translators available for the language.
- TDD access is available to members who are hearing-impaired.
- MemberConnections® helps MHS Members that need social services to facilitate successful medical treatment.
- Family Education Network meets personally with MHS Members and teaches them about MHS programs and services (facilitated through our partnership with the Indiana Minority Health Coalition).
- MHS Ombudsman helps advocate for MHS members that are having difficulty navigating MHS services.
- Free 24-hour nurse advice line that can assist members with medical questions and triage care in multiple languages.

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