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COVID-19 Provider Resources

MHS wants to make sure that providers are staying as up to date as possible during this COVID-19 pandemic. The novel coronavirus disease (COVID-19) is an emerging illness. Many details about this disease are still unknown, such as treatment options, how the virus works, and the total impact of the illness. New information, obtained daily, will further inform the risk assessment, treatment options and next steps.

We always rely on our provider partners to ensure the health of our members, and we want you to be aware of the tools available to help you identify the virus and care for your patients during this time of heightened concern.

In order to ensure that all MHS providers and members have access to normal health plan operations, we are providing a summary of each department's operations during the COVID-19 Shelter in Place order at https://www.mhsindiana.com/newsroom/operations-shelter-in-place.html.

COVID-19 Guidance for Ambetter can be found on our website at https://ambetter.mhsindiana.com/provider-resources/manuals-and-forms/coronavirus-guidelines.html.

MHS HIP, HHW and HCC follow the IHCP guidelines. Please make sure that you are staying up to date on all the changes regarding COVID-19 by reading the Bulletins and Banners provided at https://www.in.gov/medicaid/providers/737.htm.

To assist with protecting patient privacy through secure connections, MHS has partnered with Teladoc to deliver virtual care to our members. Please contact Teladoc directly to begin the contracting process at 1-800-835-2362 (Option 5) or at teladoc.com/providers.

As always, we are here to help. There are three ways you can contact us: via the Provider Secure Portal; through MHS Provider Services at 1-877-647-4848, Monday – Friday from 8 a.m. to 8 p.m.; and through your assigned Provider Partnership Associate.

My Health Pays Rewards

Members can earn My Health Pays rewards by doing things like completing a health needs screening, getting their annual checkups and screenings and enrolling in a smoking cessation program. HIP members who complete the Indiana Tobacco Quitline program can receive up to $145 in rewards. HIP members can use their reward dollars to POWER Up to HIP Plus or pay their monthly POWER Account contributions. MHS encourages you to talk with your patients about the My Health Pays program and how they can earn rewards to POWER Up to HIP Plus.

myhealthpays™

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!

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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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
- Disease Management for Asthma, Diabetes, COPD, CKD, CHF, CAD, Hypertension, and Lead
- Complex Case Management for poorly controlled disease states, poor health and high risk for readmission

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, and Hoosier Care Connect. 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.

MHS Health Library

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.

CHECKING IN WITH 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.

Member Rights and Responsibilities

As an MHS member, you have the right to:

- request and obtain information about MHS, our services, healthcare providers and member rights and responsibilities
- be treated with respect, dignity and privacy
- equal access to health care services without discrimination
- information on care and treatment options given in a way you understand and can follow
- talk with your doctor and make decisions about your care regardless of cost or benefits
- say no to treatment or therapy
- a second opinion
- make a complaint about MHS or the service or care you received
- ask for an appeal if you are unhappy about the outcome of a complaint or decision
- call MHS to suggest how we can improve our member rights and responsibilities statement or policy
- receive a Member Handbook
- ask and get a copy of your medical records and to be able to ask that the record be changed or corrected if needed
- know that MHS must follow all federal and state laws and regulations
- be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge

You have the responsibility to:

- provide MHS and your doctors the information needed for your care
- tell your doctor how you feel so you both understand your health and any problems you might have
- work with your doctor to develop a treatment plan you can follow and ask questions if you don't understand what you need to do

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.

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.