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ISSUE 3 • 2020 • MHS' NEWSLETTER FOR PHYSICIANS

COVID-19 Provider Resources

MHS wants to make sure providers are staying as up to date as possible during this COVID-19 pandemic. The novel coronavirus disease (COVID-19) is an emerging 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.

On July 23, 2020, HHS Secretary Alex Azar renewed the COVID-19 Public Health Emergency. This extends flexibilities and funding tied to the public health emergency (PHE) to continue for another 90 days. With this renewal the various testing, screening, billing, and telehealth coverages that were implemented in response to the COVID-19 Public Health Emergency earlier this year will be extended to MHS members through late October, until the PHE is either terminated or extended again. This extension does not affect coverages that had already been made effective through December 31, 2020. In accordance with this extension, MHS has updated the General Guidance for COVID-19 Testing, Screening, and Treatment document, as well as the COVID-19 Telehealth Guidance for Providers documents posted on our website.

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 pandemic 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.

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.

Engaging with Patients Who Have an Elevated Risk for COVID-19

During this time of heightened need, it is more important than ever to build strong relationships with your patients – our members. The Provider COVID Hotspot Report (PCHR) is a new, weekly, Excel-based report designed to help pinpoint members with an elevated risk for COVID-19 and highlight different outreach and prevention support opportunities. You can easily access this report via our secure provider portal.

This guidance provides simple ways you can help strengthen vital connections with at-risk patients, and closely follows recommendations from the Centers for Disease Control (CDC) and our medical leadership. Together, we can protect vulnerable people and help stop the spread of this disease. Learn more at https://www.mhsindiana.com/newsroom/covid-19-high-risk-member.html.

Help Your Patients 'Be Antibiotics Aware'

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/antibiotic-use/index.

BE ANTIBIOTICS AWARE
SMART USE, BEST CARE

Required Lead Screenings

Reminder: Providers must perform lead screenings for all children enrolled in Medicaid. This is a federal requirement.

The Family and Social Services Administration (FSSA) requires that all children enrolled under Medicaid receive a blood lead screening test between 9 months and 12 months and again at 24 months of age. If the member is at high risk for lead exposure, the initial screening should be performed at the 6-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months must receive a blood lead screening if they have not been previously tested for lead poisoning. A blood lead test result equal to or greater than 5 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for at-risk patients.

Providers are required to report all results of blood lead tests to the Indiana State Department of Health (ISDH) no later than one week after the screening.

Prior authorization is not required for coverage of screening. For billing recommendations, providers should turn to this reference guide. And for more information on lead poisoning and blood lead screenings, MHS has free brochures that providers can give to their patients. Contact your Provider Relations Representative to request brochures.

CHECKING IN WITH DR. YANCY

Did you know you can answer four simple questions about your pregnant patients, 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. Providers are eligible for reimbursement of $60 for successful submission of the NOP.

To qualify for reimbursement, the NOP must:

- Be submitted via Health Care Portal within five calendar days of the date of service
- Be submitted at less than 30 weeks' gestation
- Not be identified as a duplicate submission for the same member and pregnancy

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

ADD Measure for HEDIS

As more and more children are diagnosed with ADHD, it is imperative to follow up with these children in a timely manner to ensure that medication is prescribed/managed/monitored appropriately.

To ensure this, NCQA has a HEDIS measure to Follow-Up Care for Children Prescribed ADHD Medication (ADD).

Two rates are measured for ADD:

- Initiation Phase measures children 6–12 years old, diagnosed with ADHD, who were prescribed an ADHD medication who had a follow-up within 30 days of their first prescription with a practitioner with prescribing authority.
- Continuation of Maintenance Phase measures those children (6–12 years old) after the ending of the Initiation Phase, on ADHD medication for at least 210 days of therapy, who had at least two follow-up visits within 270 days (9 months).

Put simply, a child (6–12 years old) who is newly prescribed an ADHD medication must have a total of three follow-up care visits within a 10-month period (one of which must be within the first month).

Description	Prescription
CNS stimulants	• Amphetamine-dextroamphetamine • Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine • Methylphenidate • Methamphetamine
Alpha-2 receptor agonists	• Clonidine • Guanfacine
Miscellaneous ADHD medications	• Atomoxetine

Helping Children Transition to Other Care

It's important that members see the right provider for their age and health needs. The transition from a pediatrician to an adult provider is a critical one. MHS can help members who are aging out of their childhood provider find an adult provider if needed. Here's what we tell members:

Before turning 18, children should:

- Be involved in health care decisions.
- Be comfortable talking to the doctor.
- Be able to schedule appointments and follow-up care.
- Understand any health conditions and how insurance works.
- Know when to see the doctor, visit urgent care, or go to the emergency room.

Remember to encourage parents to help their children prepare to make their own healthcare decisions! Parents need to include their children in these decisions so they can be successful as adults. Doctors who only care for children will continue to provide care up to the ages of 18-21. If a parent needs help changing their child's doctor to an adult health care provider, they can call MHS Member Services at 1-877-647-4848.

Utilization Management

Utilization Management (UM) decision-making is based on appropriateness of care and services and the existence of coverage. MHS does not reward providers, practitioners, staff or any other UM decision maker for issuing denials of coverage or decisions that result in underutilization.

UM Review Criteria have been established to ensure services provided to members are medically necessary, conform to nationally recognized standards of care, and are provided in a cost-effective and quality manner. Criteria are based on Milliman Care Guidelines, federal and state mandates, MHS and Centene Corporation policy. They address medical and surgical admission, outpatient procedures and ancillary services. The criteria are used as a screening guide as part of the decision process. They are never used as a substitute for practitioner judgment, as decisions are based on currently accepted medical and behavioral health care practices, member needs, and local delivery systems. Providers can request a copy of the criteria used to make a specific, adverse decision by calling the MHS Peer-to-Peer line, 1-855-696-2613. If you have a question or concern about UM, contact the UM team at 1-877-647-4848 and follow the prompts for Prior Authorization.

Asthma Best Practices Summary

Good asthma control is achieved when a patient has achieved minimization of both impairment and risk:

- Impairment: typical frequency of daytime/nighttime symptoms; lung function; activity impairment; activity avoidance; rescue medication use
- Risk: frequency and severity of exacerbation

The presence of the following should indicate to the provider that the patient has uncontrolled asthma:

- Hospitalization
- Multiple ED visits per year
- >1 systemic steroid course per year
- Activity limitation or activity avoidance
- Frequent albuterol usage (e.g., frequent albuterol refills)

Poor control can be caused by a number of factors, including (but not limited to):

- Adherence
- Device technique
- Spacer usage/technique (for HFA inhalers)
- Environmental exposures
- Comorbidities (allergic rhinitis, anxiety, obesity, OSA, reflux, vocal cord dysfunction)

Preferred agents:

- Inhaled corticosteroids: Flovent, budesonide (nebulizer)
- ICS or generic Advair and generic Symbicort
- LTRA: montelukast

Best practices include:

- Examine refill history via pharmacy data, AMR, and/or MMA.
- Have open, non-judgmental conversation with patient/family regarding refill data and potential adherence issue.
- Identify and address barriers to getting/taking medications.
- Review inhaler technique at each visit:
  - Utilize teach back method.
- Step up therapy if not well controlled.
- Consider a step down in therapy if well controlled >three months (for some patients, a longer period of control before stepping down will be appropriate).

Consider referral to asthma specialist at step 3–4 of therapy, particularly if control is not improving.

- Specialist can explore contributing factors.
- Specialist may consider add-on therapy/biologic agent: omalizumab, mepolizumab, benralizumab (prior authorization required).

Late Notification for Hospital Authorization

The following outlines the process to be followed when a member is not covered by Indiana Medicaid upon presentation to the facility. This process is not a legal interpretation of Indiana Administrative Code.

FAST TRACK

If an adult, 19 years or older, presents for services without insurance, and for a reason beyond the facility's control are unable to complete the HPE process, the facility may assist the member or the member may apply for HIP coverage using the standard application process or the Fast Track process, which includes a $10 payment via credit card. The Fast Track payment will provide for coverage the first of the month that payment was made, if the member is determined eligible. Providers must follow the process as outlined in BT201913 and use the following process for inpatient stays to ensure that they can properly submit a retroactive PA request for individuals utilizing a Fast Track prepayment:

- The provider must assist an individual in completing an application for health coverage.
- As part of the application process, the provider will assist the individual with submitting a Fast Track prepayment.

After assisting with the application for health coverage, the provider must complete a Fast Track Notification Form (available on the Forms page at in.gov/medicaid/providers) and fax the form to the managed care entity (MCE) selected on the application. This process must be completed within 5 days of the date of admission. To locate the fax number for the applicable MCE, see the IHCP Quick Reference Guide at in.gov/medicaid/providers.

After eligibility has been established, the MCE will return a Full Eligibility Notification Form (available on the Forms page at in.gov/medicaid/providers) to the provider via fax. This form will contain the member's MCE assignment and Member ID (also known as RID). The notification will occur within 7 days following eligibility discovery.

The provider will then be able to submit a PA request for the service rendered since the first day of the month of the Fast Track prepayment. Providers must submit the PA request within 60 days of receiving the Full Eligibility Notification Form. Providers must verify eligibility, using the IHCP Provider Healthcare Portal, prior to submitting the PA request.

NO FAST TRACK

If an adult, 19 years or older and not a HIP member, the facility must notify MHS of the admission within 60 days of becoming aware of the member's date of Medicaid eligibility using the IHCP PA form and the MHS Late Notification of Services Submission form, with clinical information supporting the medical necessity for the admission. It is presumed that the facility would become aware of the member's eligibility within one week of visibility on the State Portal.

NEWBORNS

MOTHER COVERED BY INDIANA MEDICAID MCE

The facility must notify MHS of an admission of an infant who remains hospitalized after the mother is discharged within 2 business days. The facility is responsible for determining the mother's coverage and chosen/assigned MCE. The facility should assume that the member will be assigned to the mother's MCE.

MOTHER NOT COVERED BY INDIANA MEDICAID MCE

If the infant's mother is not covered by an MCE at the time of delivery, the facility must notify MHS of the admission within 60 days of becoming aware of the member's eligibility using the IHCP PA form and the MHS Late Notification of Services Submission form, with clinical information supporting the medical necessity for the admission. It is presumed that the facility would become aware of the member's eligibility within one week of visibility on the State Portal.

The form to notify MHS of late notification due to retro eligibility can be found here. Please note: If all requested documentation is not provided, the request will be returned.

Pharmacy Highlight: Preferred Drug List Changes

MHS routinely reviews the medications available on the MHS Preferred Drug List (PDL). Items are added, removed or modified periodically due to industry standards, market availability, and/or assessment of use. The MHS PDLs are designed to assist healthcare prescribers with selecting the most clinically and cost-effective medications available. MHS has reviewed the PDL in its entirety and will be removing agents that are no longer commercially available, or where there are clinically superior and more cost-effective alternatives available.

Any provider and member that would be affected by this change will receive a notice in the mail. All PDL changes are posted on our MHS Provider Blog and the latest PDL is always available for review on our Pharmacy Benefit Information for Providers page. MHS works with e-prescribing vendors to make the MHS PDLs available through many commonly used EMR prescribing platforms.

Helping Members Use Emergency Services Appropriately

MHS wants to help make sure that our members are visiting their primary care doctor for their health needs. We offer an ER diversion program that is facilitated by our Medical Case Management team. Our Care Managers provide advice about when and where emergent care is appropriate for specific conditions. Members will be outreached to by telephone within 10 days of referral.

MHS also offers a nurse advice line to all members, 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. Staff use state-of-the-art advice protocols and plan methodologies. All calls taken by nurse advice line staff are logged and tracked.

If you would like to refer a member to the ER diversion program, or if you would like to learn more about MHS Case Management programs, please contact MHS Case Management at 1-877-647-4848.

Pay for Performance (P4P) Notifications

Want to receive notifications when updated P4P scorecards are available on the Secure Provider Portal, as well as important updates related to P4P?

Visit mhsindiana.com/providers/email-sign-up to sign up for P4P and other provider communications.

Provider Portal Features

Have you visited the Secure Provider Portal at mhsindiana.com recently? Make sure you create and use an account on the portal to take advantage of many features and resources to help make your job easier.

Some of the features include:

- Integration of both medical and behavioral health information from one portal account
- Patient and Provider Analytics reports
- Online Member Management Forms
- Demographic information updates
- And more!