Welcome to HIP 2.0 *Provider Orientation*

mhs
Your Choice for Better Healthcare

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

Agenda

- HIP 2.0 Overview
- Pregnancy
- Hospital Need to Know
- Hospital Presumptive Eligibility
- POWER Account
- Pharmacy Preferred Drug Listing (PDL)
- Website Tools and Features

HIP 2.0
HEALTHY INDIANA PLAN SM
Health Coverage = Peace of Mind

Overview

HIP 2.0 Basics:

What is new in HIP 2.0?

- POWER account will increase to $2,500
- Introduction of HIP Plus, HIP Basic, HIP State Plan options
- Additional services covered
  - dental & vision (HIP Plus & State Plan only)
- New Cost-sharing structure
- No wait list for applicants
- Health Coverage for adults that have income no more than 138% FPL

HIP 2.0 Basics:
Key Changes

- Personal Wellness and Responsibility (POWER) Account - combination of member and state contributions covers first $2,500 of health care services received each year.
  - Members pay a portion, as low as $1 per month
- Members who don't pay monthly contributions face penalties
  - If income is over 100% FPL (up to $1,378/mo. for an individual)
    - Member is subject to a 6 month lockout period in which they may not receive HIP benefits
  - If income is under 100% of FPL (up to $973/mo. for an individual)
    - Member receives reduced benefits and must make copayments each time they receive a health service (HIP Basic)
    - Failure to pay the monthly contribution make receiving health care more expensive for the member

HIP 2.0 Basics: *Eligibility*

Who is eligible for HIP 2.0?

- Indiana residents*
- Age 19 to 64*
- Income **under 138%** of the federal poverty level **(FPL)***
- Not eligible for Medicare or other Medicaid categories*
- Also includes individuals currently enrolled in:
  - Family planning services (MA E)
  - Healthy Indiana Plan (HIP)
  - Hoosier Healthwise (HHW)
    - Parents and Caretakers (MAGF)
    - 19 and 20 year olds (MA T)

Monthly Income Limits for HIP 2.0 Plans

# in household	HIP Basic Income up to 100% FPL	HIP Plus Income up to ~138% FPL**
1	$973	$1,358.10
2	$1,311	$1,830.58
3	$1,650	$2,303.06
4	$1,988	$2,775.54

*Adults not otherwise Medicaid eligible who have children must make sure their children have minimum essential coverage to be eligible for HIP

**133% + 5% income disregard; income limit for HIP program. Eligibility threshold is not rounded.

HIP 2.0 Basics: *Timelines*

When does service coverage begin?

- February 1, 2015
- HIP & applicable HHW members converted to HIP 2.0 without having to reapply
- New applicants submit Indiana Application for Health Coverage to be considered for HIP coverage
  - **No longer using separate HIP application**
  - No retroactive coverage

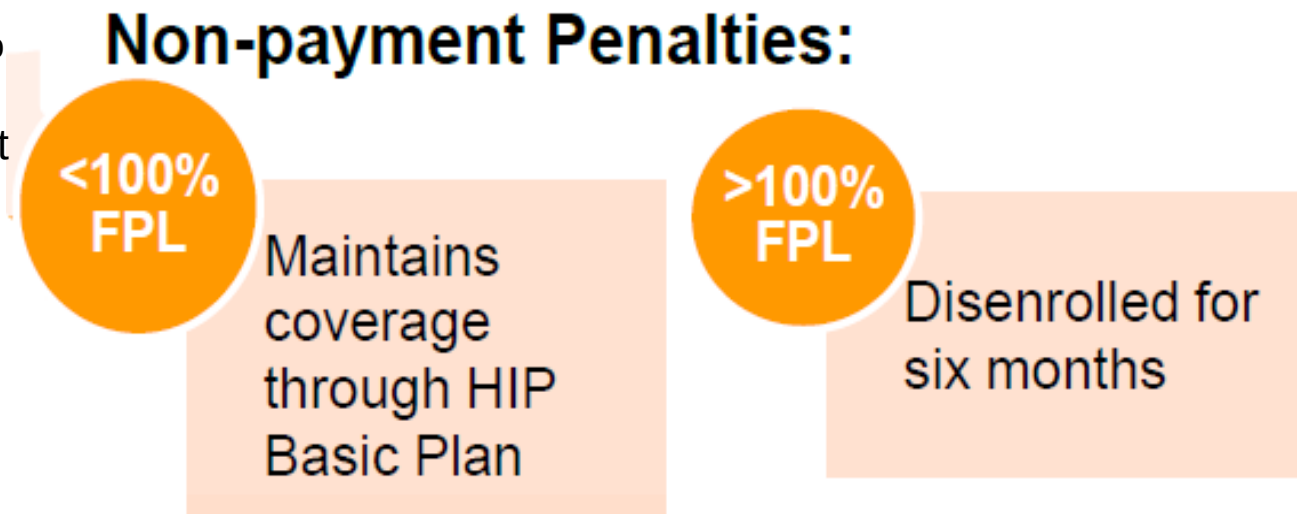
What types of services are covered?

- HIP **Basic** members
  - Minimum Essential Coverage providing Essential Health Benefits
- HIP **Plus** members
  - HIP Basic benefits with additional services including:
    - Vision
    - Dental

HIP 2.0 Enrollment

- Eligible Members will be automatically enrolled as a “Conditional HIP Plus member”
- CE member has 60 days to make their first POWER Account Contribution
- HIP Plus benefits begin retroactively the first day of the month the member pays
- Non-payment of POWER account contribution will result in transfer from HIP Plus to HIP Basic if member’s income is at or less than 100% FPL.

- Non-payment of POWER account contributions for members above 100% FPL results in loss of benefits with a lock out from HIP for 6 months



HIP 2.0: Plan Options

Best Value

HIP Plus

- Initial plan selection for all members
- **Benefits**: Comprehensive, including vision and dental
- **Cost sharing**:
  - Must pay affordable monthly POWER account contribution: Approximately 2% of member income, ranging from $1 to $100 per month
  - No copayment for services*

HIP Basic

- Fall-back option for members with household income less than or equal to100% FPL only
- **Benefits**: Meet minimum coverage standards, **no vision or dental coverage**
- **Cost sharing**:
  - May not pay one affordable monthly POWER account contribution
  - Must pay copayment for doctor visits, hospital stays, and prescriptions

HIP State Plan

- Individuals who qualify for additional benefits
- **Benefits**: Comprehensive, with some additional benefits including vision and dental
- **Cost sharing**:
  - HIP Plus **OR** HIP Basic cost sharing

HIP Link

- ***More information coming soon!***
- To help member pay for employer-sponsored health insurance

*EXCEPTION: Using Emergency Room for routine medical care

HIP 2.0: Plan Options

HIP Plus

*Preferred plan for all HIP members

*Offers best value for members.

*Comprehensive benefits including vision and dental.

*To be eligible, members pay a monthly contribution towards their portion of the first $2,500 of health services.

*Contributions are based on income – approximately 2% of household income per year – ranging from $1 to $100 per month.

*No copayment required when visiting doctors or filling prescriptions.

HIP Basic

*Fallback option for lower-income individuals.

*HIP Basic benefits that cover the essential health benefits but not vision and dental services for adults.

*Members pay between $4 and $75 for most health care services.

*Receiving health care is more expensive in HIP Basic than in HIP Plus.

HIP Link

Coming Soon!

*Members receive help paying for the costs of employer-sponsored health insurance.

*Members with a **qualified and participating** employer are eligible for the employer-sponsored health insurance.

*Member may choose HIP Link or other HIP plans.

*HIP Link will be an option on the coverage application.

Other benefit and cost sharing options: Individuals who qualify may receive additional benefits through the HIP State Plan Basic & HIP State Plan Plus options, or have cost sharing eliminated per federal requirements.

HIP Plus vs. HIP Basic for Members with Income Less than or equal to 100% FPL

HIP Plus

HEALTHY INDIANA PLAN Plus

- More affordable
- Predictable monthly contributions
- More benefits
- Option to earn reductions to future monthly contributions
  - May reduce future contributions by **up to 100%**

HIP Basic

HEALTHY INDIANA PLAN Basic

- May be more expensive
- Unpredictable costs
- Fewer benefits (no dental or vision benefits)
- Potential to reduce future monthly contributions for HIP Plus enrollment, but these reductions are **capped at 50%**
- **Only an option for members at or below 100% FPL**

HIP 2.0: State Plan

- Available for certain qualifying individuals
  - Low-income (<19% FPL) Parents and Caretakers
  - Low-income (<19% FPL) 19 & 20 year olds
  - Medically Frail
  - Transitional Medical Assistance (TMA)
- Benefits equivalent to current Medicaid benefits
  - All HIP Plus benefits covered with additional benefits, including transportation to doctor appointments
  - State Plan benefits replace HIP Basic or HIP Plus benefits
    - State Plan benefits are the same, regardless of HIP Basic or HIP Plus enrollment
- Keep HIP Basic or HIP Plus cost sharing requirements
  - HIP State Plan Plus: Monthly POWER account contribution
  - HIP State Plan Basic: Copayments on most services

Exceptions to Non-payment Penalties

- Exceptions to penalties for select HIP Plus members with household income over 100% FPL who stop paying their POWER account contributions (PACs)
  - Native Americans
    - No required contributions
    - No copayments for using the emergency room for routine care
    - May opt out of managed care and into fee-for-service at any time, effective April 1, 2015
  - Medically frail
    - Must pay copayments until outstanding PAC is paid
  - Individuals qualified for Transitional Medical Assistance (TMA)
    - Move to HIP State Plan Basic
    - HIP State Plan Basic copayments apply

HIP Plus Contributions Are Not Premiums

- Unlike premiums, members own their contributions
- If members leave the program early with an unused balance, the portion of the unused balance they are entitled to is returned to them
  - Members reporting a change in eligibility and leaving the program (e.g. move out of state) will retain 100% of their unused portion
  - Members leaving for non-payment of the POWER account will retain 75% of their unused portion
- If members leave the program early but incurred expenses, they may receive a bill from their health plan for their remaining portion of the health expenses
- Members remaining in the program may be eligible to receive a rollover of their remaining contributions
  - Rollover is applied to the required contribution for the following year

5% of income limit

- Member cost sharing is subject to a 5% of income limit
  - Members are protected from paying more than 5% of their **quarterly** income toward HIP cost sharing requirements, including the total of all:
    - POWER account contributions (PAC)
    - Emergency Room copayments
    - HIP Basic copayments
- Members meeting their 5% of income limit on a quarterly basis will have cost sharing responsibilities eliminated for the remainder of the quarter
  - Individuals meeting the 5% limit and enrolled in HIP Plus will receive the minimum $1 minimum monthly contribution for the remainder of the quarter

RECOMMENDATION:
Members should keep record of their expenses and if they think they have met their 5% of income limit, they should contact MHS

Primary HIP Eligibility Categories

HIP Plus (MARP)

- Preferred plan for all HIP members
- Household income up to ~138% FPL
- Best value plan
- Pay monthly POWER account contribution
- No copayments for most medical services

HIP Basic (MARB)

- Household income less than or equal to 100% FPL
- No POWER account contribution
- Pay copayments for most medical services

HIP State Plan Plus (MASP)

- Income under 138% FPL and:
  - Medically Frail, OR
  - Low-income Parents/Caretakers, OR
  - Low-income 19 & 20 year olds OR
  - Transitional Medical Assistance (TMA)*
- Make monthly POWER account contribution

HIP State Plan Basic (MASB)

- Income less than or equal to 100% FPL** and:
  - Medically Frail, OR
  - Low-income Parents/Caretakers, OR
  - Low-income 19 & 20 year olds, OR
  - TMA*

*No household income limit for first six months. Income cannot exceed 185% FPL for additional six months of coverage. Individual may have additional coverage options if also medically frail.

**EXCEPTION: TMA does not have to have income under 100% to be eligible for HIP State Plan Basic

Eligibility Verification

- You will still be able to verify member eligibility via normal processes
- Verification will indicate member's benefit plan and cost sharing responsibility

Benefit Plans	Copayments	Special Flags
HIP Basic	Copayments for services – check card or contact MCE for values	Pregnancy – maternity services included
HIP Plus	No copayments	Low-income populations – facility services paid at Medicaid rates
State Plan Plus		
State Plan Basic		

HIP Basic Plan –Copay

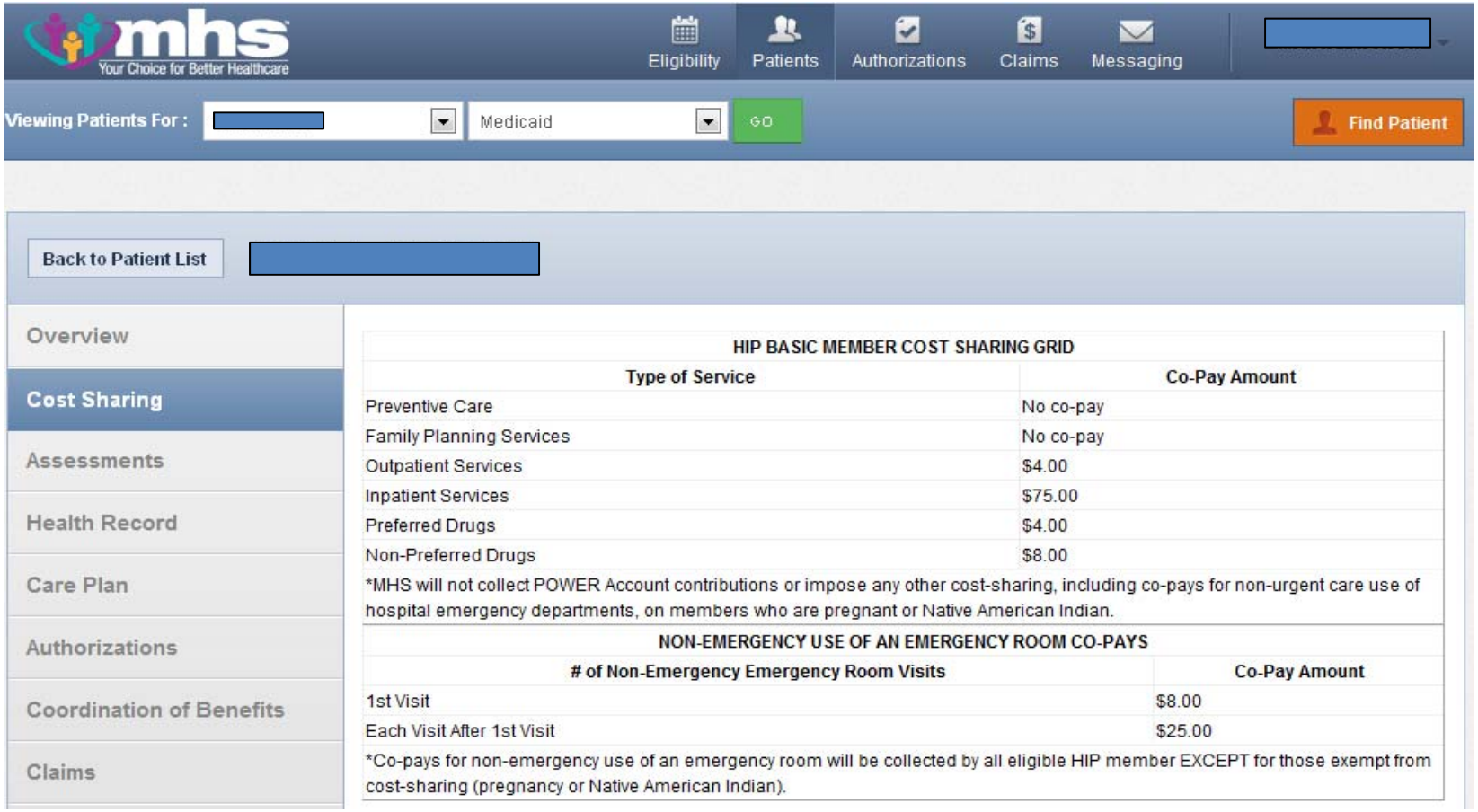
When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic Members are responsible for making the below copayments for health and pharmacy services.
**Copayments may not be more than the cost of services received.*

Service	HIP Basic Co-Pay Amounts <=100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

Benefit Overview

	HIP Link Employee Benefit	HIP Plus	HIP Basic	State Plan
Who's eligible?	Optional for individuals with access to cost-effective employer-sponsored insurance Exception: Medically frail	• Income up to 138% FPL • Consistent POWER Account contributions	• Income below 100% FPL only • Fail to make POWER Account contribution	**Individuals with complex medical or behavioral conditions** • Very low income parents • Pregnant women
How do you pay?	**Enhanced POWER Account can be used for premiums, co-payments or deductibles**	**POWER Account contributions** No co-payments, except: Non-emergency ER visit: $8-25	**Copayments for most services** More expensive than HIP Plus	Copayments or POWER Account Contribution • Exception: Pregnant women are exempt from cost-sharing
What are the Benefits?	Employer Plan Benefits	Comprehensive medical benefits incl. maternity • Vision & dental benefits • Increased service limits • Comprehensive drug benefit	**Comprehensive medical benefits incl. maternity** • Lower service limits • Limited drug benefit	Comprehensive medical benefits incl. maternity • Current Medicaid benefits as required by federal law • Enhanced behavioral health services

MHS' Secure Provider Portal provides Member Co-pay information



HIP BASIC MEMBER COST SHARING GRID

Type of Service	Co-Pay Amount
Preventive Care	No co-pay
Family Planning Services	No co-pay
Outpatient Services	$4.00
Inpatient Services	$75.00
Preferred Drugs	$4.00
Non-Preferred Drugs	$8.00
*MHS will not collect POWER Account contributions or impose any other cost-sharing, including co-pays for non-urgent care use of hospital emergency departments, on members who are pregnant or Native American Indian.	

NON-EMERGENCY USE OF AN EMERGENCY ROOM CO-PAYS

# of Non-Emergency Emergency Room Visits	Co-Pay Amount
1st Visit	$8.00
Each Visit After 1st Visit	$25.00
*Co-pays for non-emergency use of an emergency room will be collected by all eligible HIP member EXCEPT for those exempt from cost-sharing (pregnancy or Native American Indian).	

Pregnancy

HIP Coverage for Pregnant Women

1. **Women Enters Medicaid Pregnant**
   a. Income above 138% FPL, enrolled into Hoosier Healthwise
   b. Income below 138% FPL, enrolled into HIP Maternity

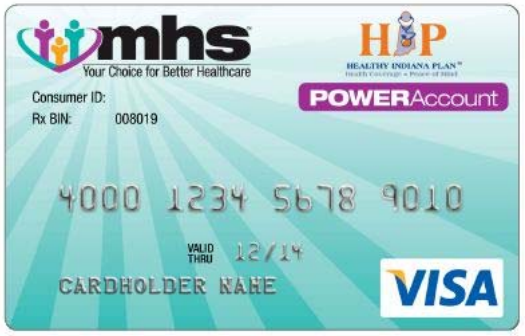
2. **HIP Member Becomes Pregnant**
   a. Can stay in HIP
   b. Can switch to HIP Maternity

3. **HIP Member Pregnant at Redetermination**
   a. Automatically moved to HIP Maternity

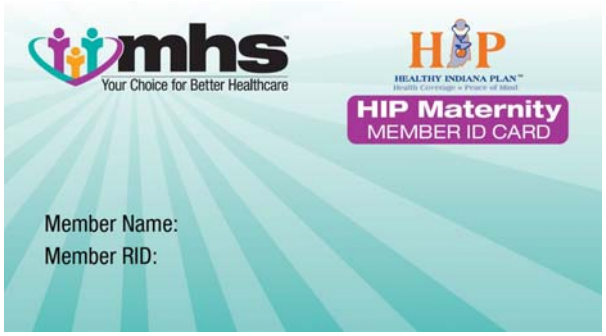
Pregnancy ID Cards

A pregnant HIP member will either present a POWER Account Member ID Card

HIP POWER Account Member ID Card



HIP Maternity Member ID Card



Pregnant member receives the same benefits, regardless of which card she presents at the time of service. Providers use HIP Web Interchange or mhsindiana.com for package coverage and copayment information at each encounter.

Pregnant HIP members are NOT subject to copayments or other cost sharing.

HIP Coverage for Pregnant Women

Woman becomes pregnant while enrolled in HIP

- HIP member becomes pregnant
- Additional pregnancy-only benefits begin
  - No cost sharing during pregnancy/post-partum period
  - OPTION: May request to move to HIP Maternity (MAGP)

Woman is pregnant at application or redetermination

- Woman eligible for HIP 2.0 and is pregnant at the time of application or at her annual redetermination timeframe will receive HIP Maternity (MAGP)
  - No cost sharing during pregnancy/post-partum period
  - May have coverage gap when reentering HIP after pregnancy if end of pregnancy not reported on time

RECOMMEND:
Report end of pregnancy promptly to guarantee continued HIP coverage without a gap

Pregnancy Benefits

- Pregnant women receive benefits only available to pregnant women, regardless of selected HIP plan
  - Exempt from cost sharing
  - Additional benefits continue for a 2 month post-partum period

Additional Benefits Include:
Vision
Dental
Non-emergency transportation
Chiropractic

Pregnancy Benefits, cont.

How long will maternity services be covered?	• Up to two months (60 days) post-partum • Woman must report end of pregnancy BEFORE end of 60 day post-partum period to avoid coverage gap
How will member costs change for pregnant women?	• There is no cost sharing for pregnant women • POWER account is frozen during pregnancy/post-partum period • No cost sharing for HIP 2.0 or HIP Maternity (MAGP) during pregnancy/post-partum period

How will health care provider know maternity benefits status?	• Eligibility verification will show provider:
	  • Maternity benefits coverage
	  • No cost sharing obligation

End of Pregnancy

Post-partum period begins

Pregnancy ends

Report to health plan or Division of Family Resources

Members with HIP Maternity coverage (MAGP) receive notice that HIP Maternity coverage ending, with opportunity to re-enroll in HIP

60 day post-partum period

Member receives post-partum coverage without cost sharing

Member with MAGP should pay POWER account contribution to regain HIP Plus and **avoid a possible gap in coverage**

Member who did not transfer to MAGP will continue her HIP Plan after her 60 day post-partum period, with additional pregnancy-only benefits ending after post-partum period

Post-partum period ends

Member must report end of pregnancy before end of post-partum period or must re-apply for HIP

POWER account contributions or cost sharing reinstated

POWER Account

HIP Power Account

In the HIP program, the first $2500 of medical expenses for covered services are paid with a special savings account called a Personal Wellness and Responsibility (POWER) account. The state will contribute most of this amount, but the member will also be responsible for making a small contribution to their account each month. The amount of the member's contribution is based on income.

**MHS will not collect POWER Account contributions or impose any other cost-sharing, including co-pays for non-urgent care use of hospital emergency departments, on members who are pregnant, medically frail or Native American Indian.*

HIP Power Account

- Provider must visit the Patient Responsibility Estimator at mhsindiana.com to determine the amount chargeable to the card.

- Providers must still submit “claims” for any HIP services whether or not the services covered have been paid via POWER card.
  - *MHS may recover POWER Account payments from providers who do not file a claim for services*

Rollover & Preventative Care Services

HIP Plus

By managing the POWER Account wisely and getting recommended preventive care, the member can eliminate their required contribution with rollover.

- If HIP Plus member has money left over in their POWER Account after 12 months, their monthly contribution can be reduced in the future

  Example:
  If $200 remains after 12 months, the member can get a $200 reduction in their annual required contribution in the future enrollment period.

- If HIP Plus member completes the preventive services, then the reduction amount can be doubled.

  Example:
  If $550 remains after 12 months, and member received recommended preventive services, the member can get a $1100 reduction in their annual required contribution in the future enrollment period.

Rollover & Preventative Care Services
HIP Basic

- HIP Basic member has the opportunity to enroll in HIP Plus at the end of their 12 month enrollment period by paying their required POWER Account contribution.
- If member has money remaining in their POWER Account after 12 months AND the member received their recommended preventive services, the member can enroll in HIP Plus with a 50% reduction in the cost of enrolling in HIP Plus

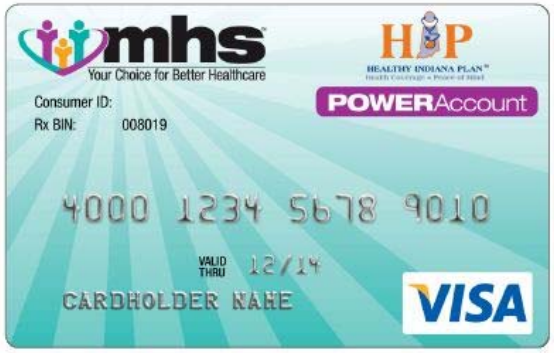
HIP – Preventative Care Services

Preventive Care Services Which Qualify for Rollover Credit*	Male	Female
Annual Physical	X	X
Mammogram	N/A	X
Pap Smear	N/A	X
Cholesterol Testing	X	X
Blood Glucose Screen	X	X
Tetanus-Diphtheria Screen	X	X
Flu Shot	X	X

*Check with your doctor about specific recommendations based on your age and medical history

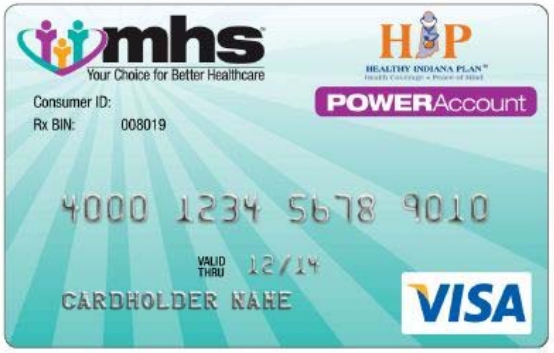
HIP Power Account Card

- The POWER Account card serves as the member ID card
- The POWER Account card is already activated and ready for use
- The POWER Account card does not need to be swiped to pay for services, BUT can be swiped at the time of service.
- Medical services provided are deducted from the individual's HIP POWER Account balance.
- POWER Account card cannot be used to pay for co-pays, which is an out of pocket expense for the member.



HIP Power Account Card

- Every new fully eligible Health Indiana Plan member will receive a POWER Account card in the mail.
- Members with an expired POWER Account card or in need of a replacement card will also receive one in the mail.
- The POWER account should be presented and used to obtain services such as visits to the doctor, pharmacy, or get any type of health care services.
- Health care providers use the card as information to notify MHS of the services and obtain payment



Hospital Need to Know

Emergency Department Copay

- HIP requires non-emergent Emergency Department (ED) copayments unless:
  - Member meets cost sharing maximum for the quarter
  - Member is referred to ED by physician (physician must notify MHS)
  - Member calls MHS Nurse-line and is told to go to ED
  - The visit is a true emergency
- HIP features a graduated ED copayment model
  - Providers should call the MHS to determine the member's copayment at each non-emergent ED visit

Reimbursement Rates

HIP Reimbursement Rates

- Medicare Rates
- 130% of Medicaid rate if no Medicare rate exists

Exceptions

- Inpatient claims for Low Income Parents, Caretakers and 19 and 20 year olds are reimbursed at the Hoosier Healthwise rate

Hospital Presumptive Eligibility (HPE)

Hospital Presumptive Eligibility

- Hospital Presumptive Eligibility (HPE) is a program created by the Affordable Care Act in which acute hospital participation is optional
- Any hospital qualified by the state to take HPE applications is able to make temporary Medicaid determinations based on questions asked by the hospital worker to the applicant
  - This includes contracted staff of the hospital regardless of the individual is seeking medical care at the time
- The implementation of HIP 2.0 also creates an HPE – Adult category for applicants
- HPE coverage is short-term **coverage limited up to 60 days**

Hospital Presumptive Eligibility

- Once an individual is enrolled and receiving HPE services, MHS will encourage member to complete the Indiana Application for Health Coverage
- Individual will have until the end of the 2nd month after receiving HPE to submit an application
- HPE is to only serve as temporary coverage for the individual while their completed *Indiana Application for Health Coverage* is being processed
- If individual does *not* complete the *Indiana Application for Health Coverage* during their HPE time frame, eligibility will end
- Individuals may only have one HPE coverage period per 12 months

HPE Process

- Once determined HPE eligible, adult is given opportunity to chose an MCE or will be auto-assigned on a rotational basis between the three health plans.
- Effective date of HPE coverage begins once the Qualified Hospital determines presumptive eligibility in real time which can be done 24 hours a day, 7 days a week.
  - HPE is immediate coverage, and can begin any day of the month
  - Adult HPE members receive HIP Basic benefits. They do not require a POWER Account contribution; however Adult HPE members will be responsible for paying all relevant copayments associated with HIP Basic
  - **HPE Coverage Ends to the earlier of one of the following:**
    - A determination has been made on their completed *Indiana Application for Health Coverage*
      OR
    - The applicant has not completed an *Indiana Application for Health Coverage*, therefore the coverage ends the last day of the month, following the month in which they were determined eligible for HPE
- **HPE Adults will be assigned a RID that begins with "6"**

HPE Benefits & Cost Sharing

Adults placed in MAHA will receive PE Basic which is equivalent to HIP Basic	HPE services are provided for a **maximum of 60 days**	Member will be placed into a Managed Care Entity upon enrollment
There will be no 12 month benefit period established	There will be no POWER account created for individual	Member 21 and older will receive HIP Basic benefits which do not include vision or dental services.
Member under 21 will receive HIP Basic benefits and also receive vision and dental services.	All services received during this time period will have same co-pays as HIP Basic	**Copay will be due at Point of Service** or when billed

PREFERRED DRUG LIST

(PDL)

Pharmacy Benefits

Pharmacy - High-Level Overview

- ✓ Managed Health Services (MHS) has contracted with US Script to provide the appropriate, high quality, and cost effective drug therapy to MHS HIP members.
  - ❑ US Script will handle call inquiries for provider and pharmacies.

    1-855-772-7121

    www.usscript.com/contact
  - ❑ For prior authorization questions providers should contact

    1-855-772-7125

    www.usscript.com/contact
  - ❑ Acaria will handle specialty pharmacy

    1-855-678-6976 (fax)
- ✓ MHS works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. MHS covers prescription medications and certain over-the-counter medications when ordered by an MHS provider. The pharmacy program does not cover all medications. Some require Prior Authorization or have limitations on age, dosage, and maximum quantities.

Preferred Drug List

- Level of drug benefit dependent upon package
- Preferred Drug lists can be found on website at www.mhsindiana.com
- Contact Pharmacy Benefit Manager (PBM) ***U.S. SCRIPT*** for approval for drugs that require a PA
- PA forms can be found on website at www.mhsindiana.com
- Confirmation via Fax
- Denials only made by PharmD

Pharmacy Benefits

Dispensing and Monitoring Requirements - PA

- Select medication on the approved formulary list may still require prior authorization (PA) by the plan to dispense the medication.

- For drugs that require prior authorization, MHS will provide a response by telephone or other communications within 24 hours of a request for PA.

- Prior Authorization of select medication may be a result of the following.
  - ❑ General member information
  - ❑ A justification of need for drug related to the medical needs of the member and planned course of treatment
  - ❑ Drugs that are medically necessary but not included on the formulary are considered and in select cases can be accessed by the member

Pharmacy Benefits

In select cases, MHS may provide dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation.

- An automated system is available to the pharmacy to request a 72 hour supply on behalf of the member until the next business day.

Pharmacy Benefits

e-Prescribing Services

MHS will provide e-Prescribing services. e-Prescribing activity is supported by prescribing providers through web and office-based application. A provider can access the services through a secure sign-on via MHS web portal and notify participating pharmacies of a medication dispensing request.

MHS WEBSITE

MHS Website

- mhsindiana.com
- Provider directory search functionality
- Payspan / EFT information
  - Convenient payments
  - One year retrieval of remittance information
  - No cost to providers
- Printable current forms, guides and manuals
  - Update billing information form
  - Denial and Rejection code listings
  - QRG-Quick Reference Guide
  - HIP 2.0 PDL and PA forms
- Patient education material
  - KRAMES online services – MHS members 24 hour a day access to info sheets about more than 4,000 topics relating to health and medication via MHS website. Most information is available in multiple languages including both English and Spanish: http://mhsindiana.kramesonline.com/
- Contact Us Feature

MHS Secure Portal Features

- Access for both contracted/non-contracted groups
- Online registration – multiple users
- Enhanced claim detail
- Direct claim submission
- Batch claim capabilities
- COB processing with or without attachments
- Claim adjustment
- Claim auditing tool
- Direct claim submission
- Prior authorization
- Eligibility and COB verification
- HIP member copay
- Pay For Performance Reporting
- Gaps in Care
- Online Health Record Vault for “your” patients (includes specialty care)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Careers
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For Members
For Providers
MHS is an insurance company that has been helping Indiana's Medicaid population for nearly two decades.
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Login / Create Account
Your Covered Services
New Member Checklist
Get CentAccount® Rewards
Become a Member
For Providers
Login
Join Our Network
ambetter.
from MHS
Make Ambetter Your Health Insurance Partner Today!
Learn More
Featured Items
ambetter.
from MHS
Ambetter
Introducing Ambetter from MHS Indiana.
Your Guide to the New Healthcare Laws
Understanding the ACA
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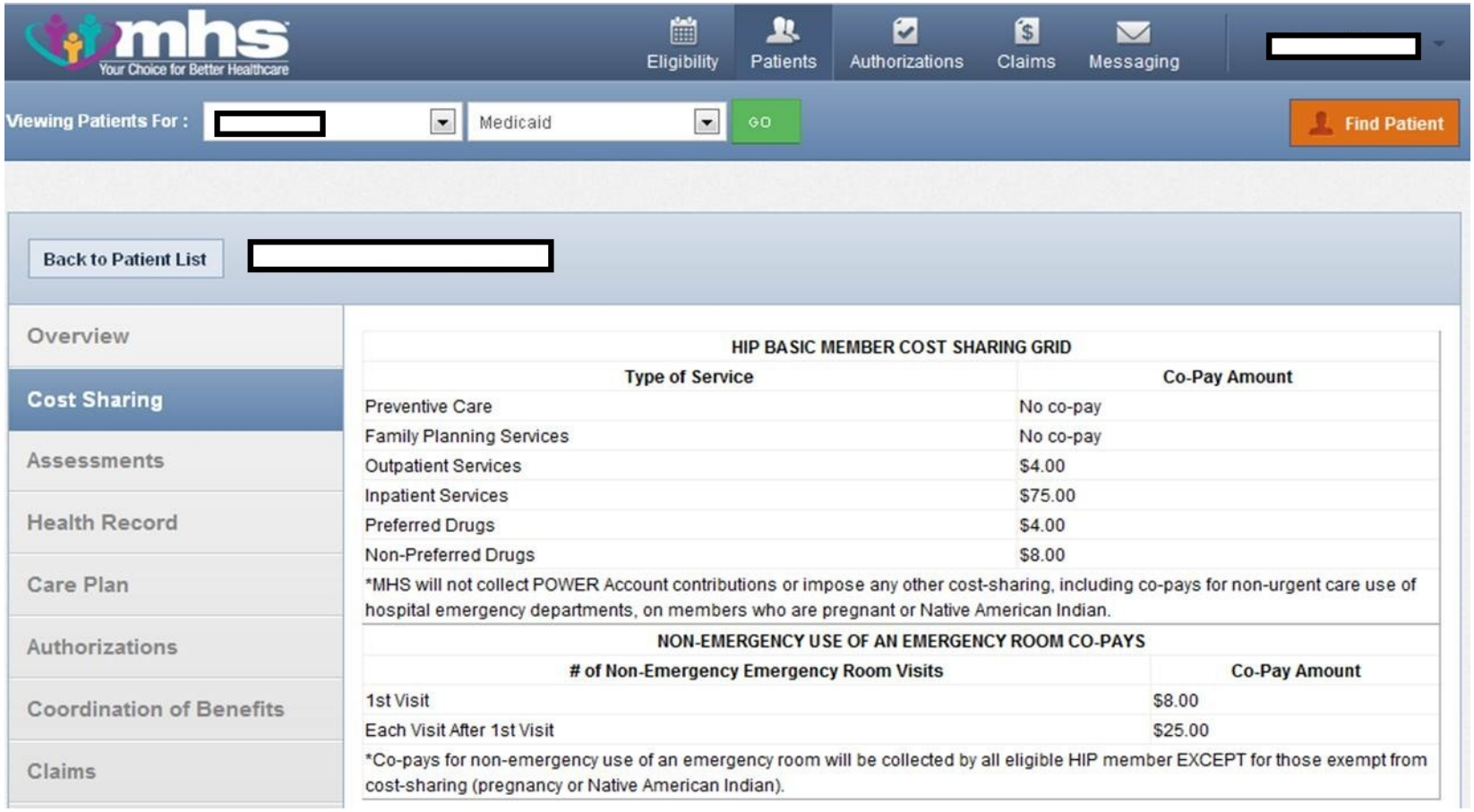
MHS Provider Portal Home Page



HIP BASIC MEMBER COST SHARING GRID

Type of Service	Co-Pay Amount
Preventive Care	No co-pay
Family Planning Services	No co-pay
Outpatient Services	$4.00
Inpatient Services	$75.00
Preferred Drugs	$4.00
Non-Preferred Drugs	$8.00

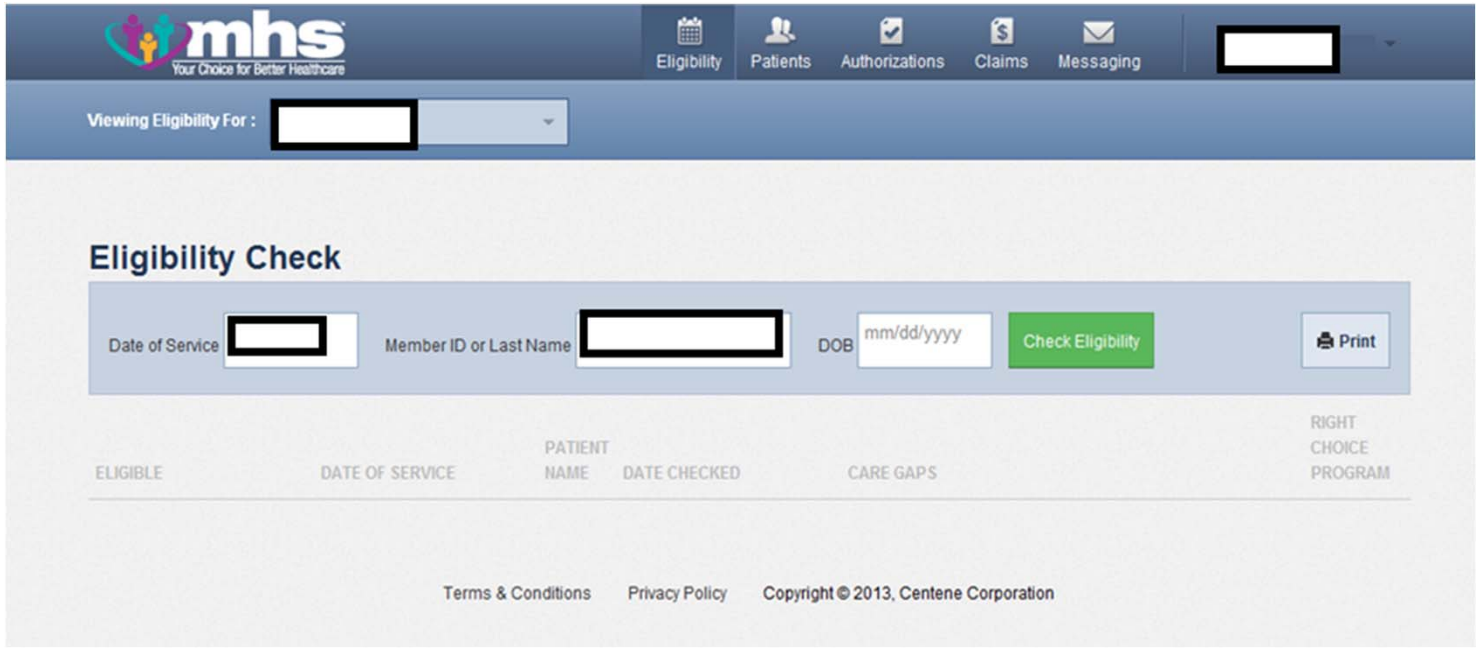
*MHS will not collect POWER Account contributions or impose any other cost-sharing, including co-pays for non-urgent care use of hospital emergency departments, on members who are pregnant or Native American Indian.

NON-EMERGENCY USE OF AN EMERGENCY ROOM CO-PAYS

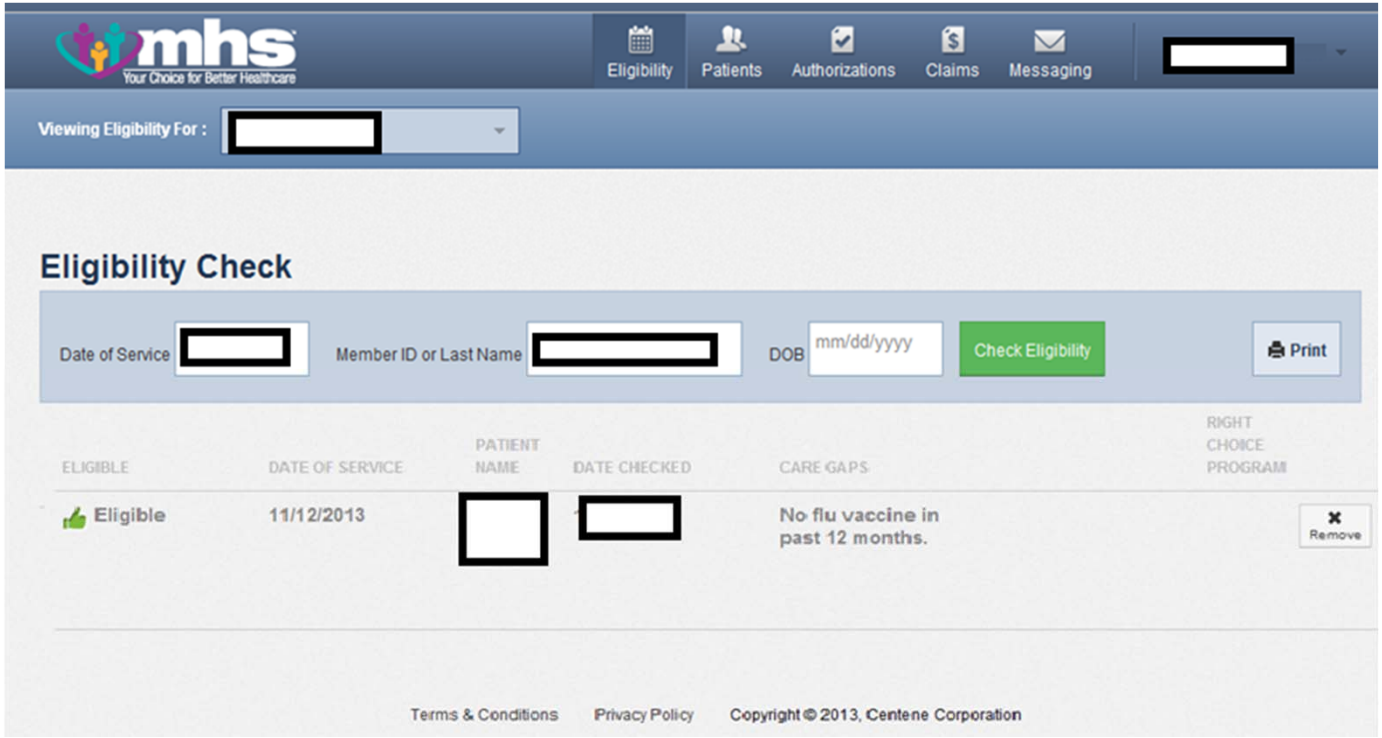
# of Non-Emergency Emergency Room Visits	Co-Pay Amount
1st Visit	$8.00
Each Visit After 1st Visit	$25.00

*Co-pays for non-emergency use of an emergency room will be collected by all eligible HIP member EXCEPT for those exempt from cost-sharing (pregnancy or Native American Indian).

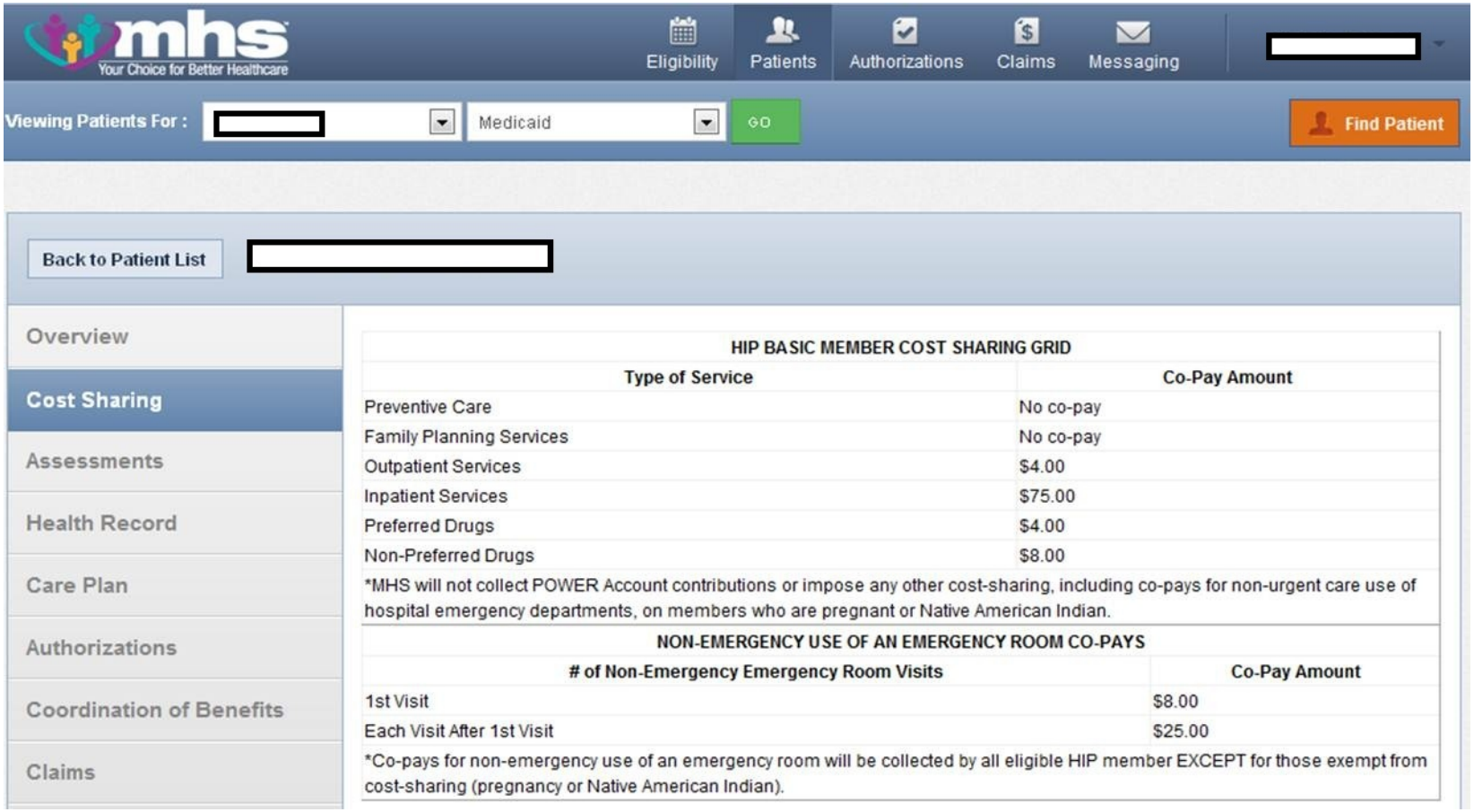
MHS Member Eligibility Check



Individual Patient Record



MHS Secure Provider Portal provides Member Co-pay information



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Individual Patient Overview

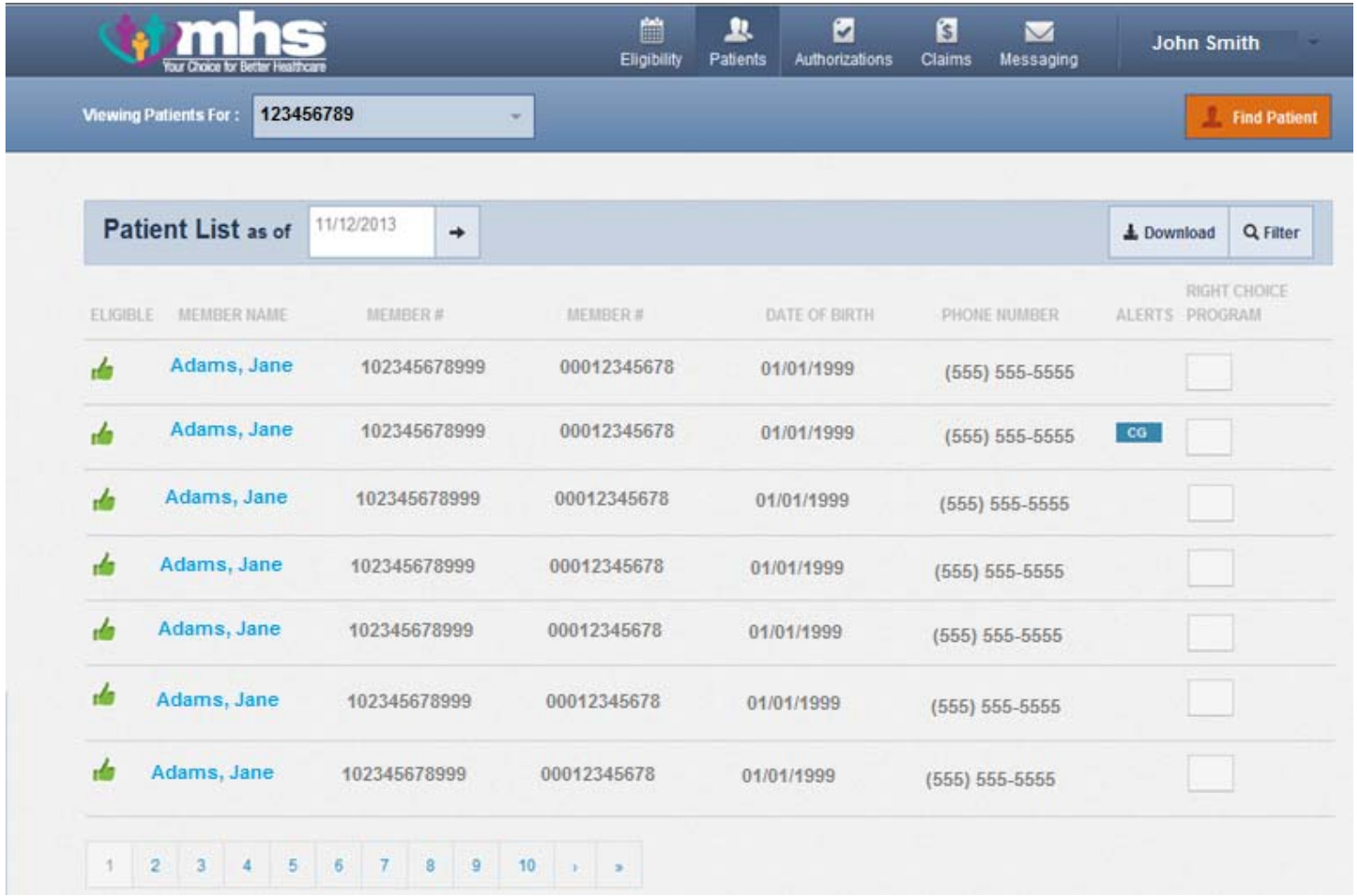
- This screen lists a member's:
  - Date of birth
  - ID number
  - Address
  - PMP information
  - Eligibility Information and History
  - PMP History
  - Care Gaps
  - Clinical Information
  - ER Visit History

Patient List

- The Patient list will pull up all MHS members for the currently selected tax ID number

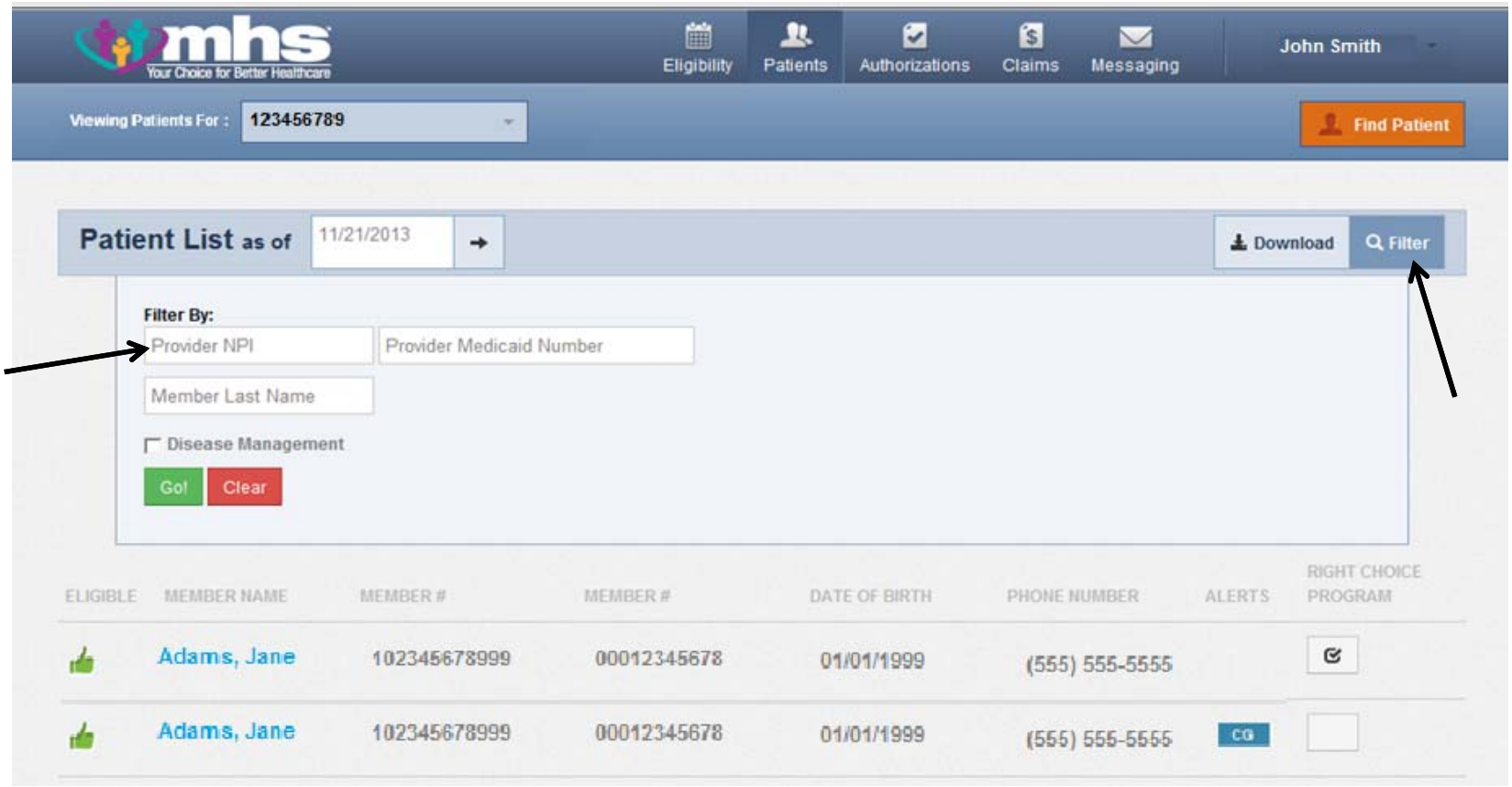
- The list can be filtered by
  - Provider's NPI
  - Provider's Medicaid Number
  - Member's Last Name
  - Disease Management

Patient List



*Test Data In Use

Patient List



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Questions and Answers