Managed Health Services (MHS) 101

2025 Indiana Health Coverage Programs (IHCP) Annual Works Seminar

Agenda

- MHS Overview
- Health Programs
- MHS Website
- Claim Process
- Prior Authorization Process
- Coordinated Care Programs
- Improving Access to Care
- MHS Provider Engagement Team
- Questions

Who is MHS?

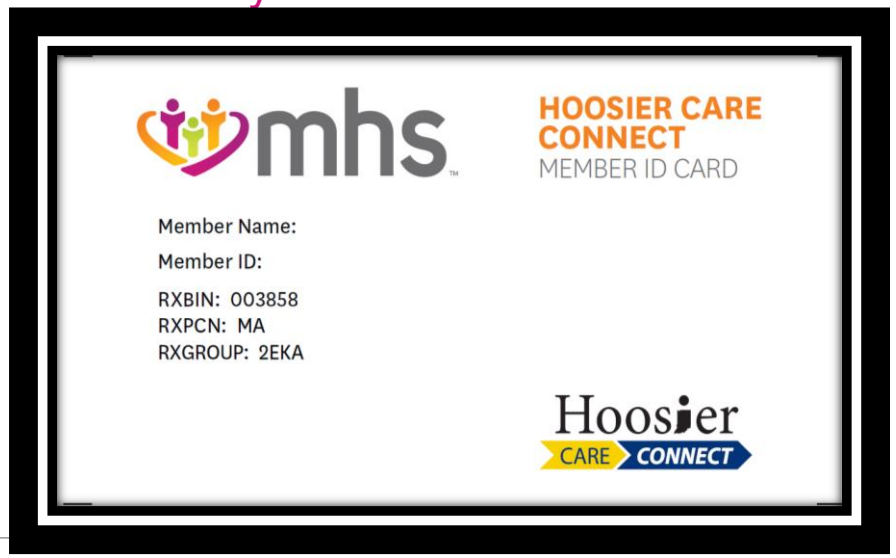
- Centene is our parent company, who is committed to helping people live healthier lives. Centene provides access to high-quality healthcare, innovative programs and health solutions that help families and individuals get well, stay well, and be well.
- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 30 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 and a Medicare Advantage product called Wellcare. All our plans include quality, comprehensive coverage with a provider network you can trust.

MHS is your partner in care.

Medicaid

MHS Medicaid ID Cards

*Used for both HIP and HIP Maternity



Member and Provider Contact Center

1-877-647-4848

- Dedicated staff available

  Monday - Friday from 8:00 a.m. – 8:00 p.m. EST
- Hoosier Healthwise, HIP and Hoosier Care Connect customer service, Ambetter Health and Wellcare
- Eligibility verification if needed
- Claims status and assistance
- Translation and transportation coordination
- Health needs screening- it is important for members to complete a health needs screening so that the appropriate programs can be identified for patients with needs.
- Interactive Voice Response (IVR) option-telephonic, self-service verification of claims and eligibility
- Spanish speaking representatives (additional languages available upon request)

Healthy Indiana Plan

Who is Eligible for the Healthy Indiana Plan (HIP)?

The Healthy Indiana Plan (HIP) is an affordable health insurance program from the State of Indiana for uninsured adult Hoosiers.

- HIP provides coverage for qualified low-income Hoosiers ages 19 to 64, who are not receiving Medicare and are interested in participating in a low-cost, consumer-driven health care program. HIP uses a proven, consumer-driven approach that was pioneered in Indiana.
- Pregnant HIP members benefits falls under HIP Maternity Plan which allows for additional coverage.
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.
- Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s).

Hoosier Care Connect

Who is Eligible for Hoosier Care Connect?

Hoosier Care Connect is a health care program for individuals who are aged 59 years and younger, blind, or disabled and some foster care children who are also not eligible for Medicare.

- Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services.
- Members will select an MCE responsible for coordinating care in partnership with their medical provider(s).
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.

Hoosier Healthwise

Who is Eligible for Hoosier Healthwise?

Hoosier Healthwise is a health care program for children up to age 19 and pregnant individuals.

- The program covers medical care such as doctor visits, prescription medicine, mental health care, dental care, hospitalizations and surgeries at little or no cost to the member or the member's family.

- The Children's Health Insurance Program (CHIP) falls under the Hoosier Healthwise program.
  - CHIP is for children up to age 19 whose families have slightly higher incomes.
  - CHIP members are required to pay a low monthly premium for coverage as well as copays for certain services.

MHS Website

MHS Website Resources

mhsindiana.com

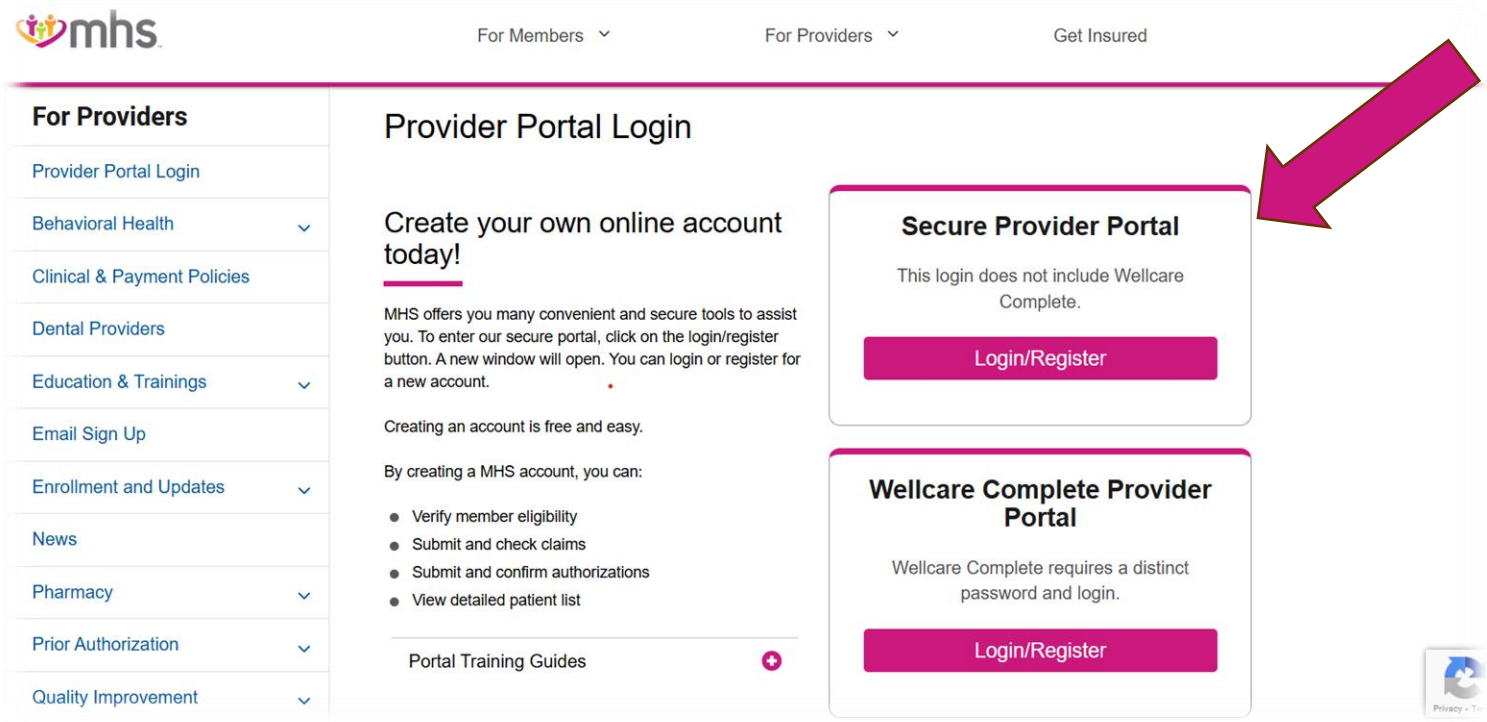
- Provides access to Medicaid, Ambetter and Wellcare
- Provider directory search functionality
- Pre-Auth Needed tool
- Payspan / Electronic Funds Transfer (EFT) information
- Printable current forms, guides and manuals
- Patient education material
- Secured Provider Portal
- Contact Us feature

MHS Secure Provider Portal Features

- Access for Medicaid, Ambetter and WellCare
- Manage multiple practices and lines of business under one account
- View panels and membership information
- View member's prescription and medical history
- Access Gaps in Care
- Access Quality Reports including Pay For Performance
- Direct claim submission
- Enhanced claim detail
- Coordination of Benefits (COB) processing with or without attachments
- Claim adjustment
- Claim auditing tool
- Eligibility and COB verification
- Prior authorization
- Care Management Plan

Secure Web Portal Login or Registration

The login/register tool is the same for all **MHS**, **Ambetter, and Wellcare** Providers.



Create a login or sign into the Online Portal to get started

Claim Process

Medical Claim Submission

- **Electronic Data Interchange (EDI) Submission:**
  - Preferred method of claims submission.
  - Faster and less expensive than paper submission.
  - MHS Electronic Payor ID **68069.**
- **Online through the MHS Secure Portal**
  - Provides immediate confirmation of received claims and acceptance
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
  - Claim review/Adjustments Request
- **Paper Claims:**

  Managed Health Services

  P.O. Box 3002

  Farmington, MO 63640-3802

Behavioral Health Claim Submission

- **Electronic Submission:**
  - Payer ID **68068.**
  - MHS accepts Third Party Liability (TPL) information via EDI.
  - It is the responsibility of the provider to review the error reports received from the clearinghouse (Payer Reject Report).
- **Online through the MHS Secure Portal**
  - Provides immediate confirmation of received claims and acceptance
  - Institutional and Professional
  - Batch Claims
  - Claim Adjustments/Corrections
  - Claim review/Adjustments Request
- **Paper Claims:**

  MHS Behavioral Health
  P.O. Box 6800
  Farmington, MO 63640-3818

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

PaySpan Health

Web based solution for:

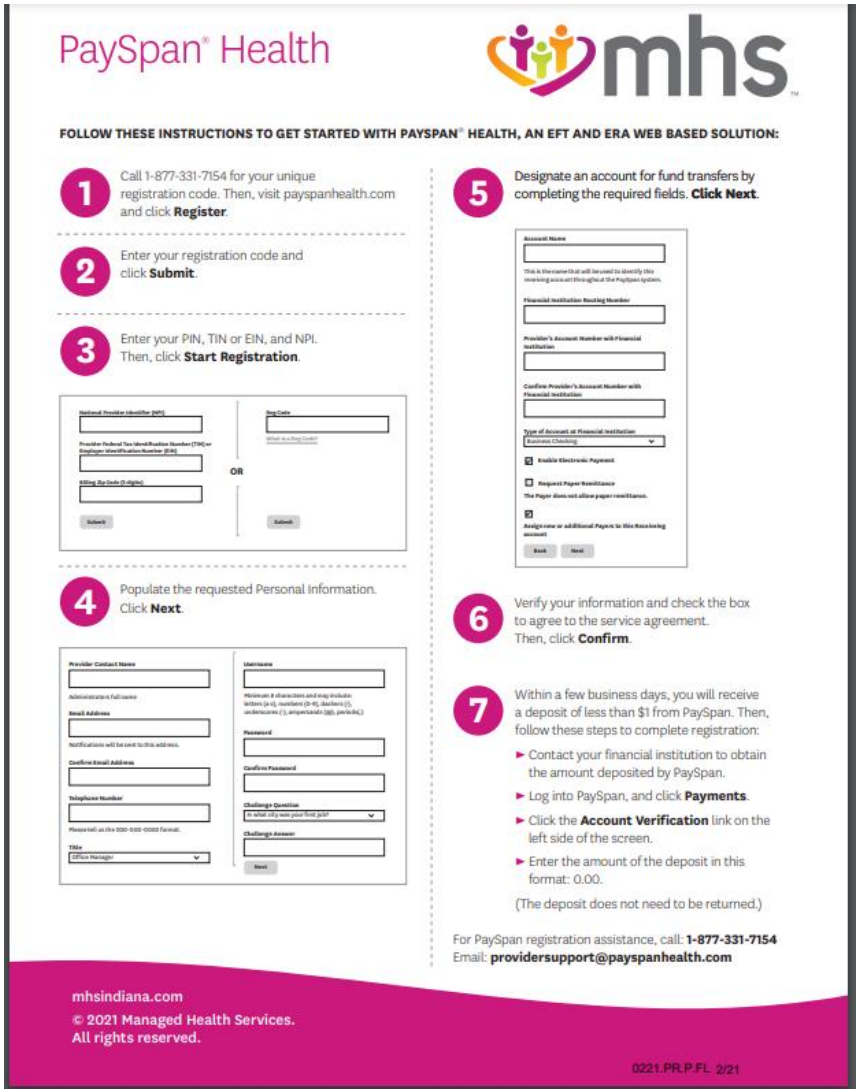
- EFT and ERA

One year retrieval of ERA.

Provided at no cost to providers and allows online enrollment.

Register at: PaySpan

For questions call 1-877-331-7154 or email providersupport@payspanhealth.com


PaySpan® Health

mhs

FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSPAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:

1 Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.

2 Enter your registration code and click **Submit**.

3 Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.

OR

4 Populate the requested Personal Information. Click **Next**.

5 Designate an account for fund transfers by completing the required fields. **Click Next**.

6 Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.

7 Within a few business days, you will receive a deposit of less than $1 from PaySpan. Then, follow these steps to complete registration:

- Contact your financial institution to obtain the amount deposited by PaySpan.
- Log into PaySpan, and click **Payments**.
- Click the **Account Verification** link on the left side of the screen.
- Enter the amount of the deposit in this format: 0.00.

(The deposit does not need to be returned.)

For PaySpan registration assistance, call: **1-877-331-7154**
Email: **providersupport@payspanhealth.com**

mhsindiana.com

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Claim Process

- Claims must be received within **90 calendar days** of the date of service.
- *Exceptions*
  - Newborns (30 calendar days of life or less)
    - Claims must be received within 365 days from the date of service. Claim must be filed with the newborns Member Identifier (MID) #.
  - Claims with primary insurance must be received within 365 calendar days of the date of service with a copy of the primary EOB. If primary EOB is received after the 365 days, providers have **60** *calendar days* from date of primary EOB to file claim to MHS.
  - Retro eligibility
    - Provider must submit claims within one year of retro eligibility assignment being established through IHCP.

Claim Resubmissions

Claim Resubmissions (Corrected Claims)

- Claims can be resubmitted:
  - The preferred method is via the Secure Provider **MHS Secure Portal**

    Or

  - Hard copy resubmissions:
  - All resubmission must include acceptable documentation
  - Such as proof of eligibility, timely filing, Coordination of Benefits

Providers have **60 calendar days** from the date of Explanation of Payment (EOP) to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*

Provider Dispute Process

- **Level 1**: Informal Claims Dispute or Objection Form
- **Level 2**: Formal Claim Dispute - Administrative Claim Appeal
- **Level 3**: Arbitration
- For assistance or questions after completing step one:
  - Provider Services Phone Requests & Web Portal Inquiries
- If additional assistance is needed anytime after Level 1 and after calling the Contact Center or completing Web Portal inquiry:
  - Contact your Provider Engagement Account Manger (PEAM) **MHS PEAM MAP**

Please note, this is different than an authorization appeal. A claim appeal cannot change denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal Form – Medical and Behavioral Health

Medical Claims Address:

Managed Health Services
P.O. Box 3002
Attn: Appeals Department
Farmington, MO 63640-3802

Behavioral Health Claims Address:

Managed Health Services BH
P.O. Box 6800
Attn: Appeals Department
Farmington, MO 63640-3817

Provider Relations Regional Mailboxes

Provider Relations Regional Mailboxes are not considered a formal notification of provider dispute.

If Level 1 results in an upheld denial and calling Provider Services or submitting inquiry through portal does not resolve the issue within 60 calendar days, please email your PEAM MHS PEAM MAP

Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers.

Please do not email your Provider Engagement Account Manger directly as this may delay the time in getting a response due to their travel.

Helpful Tips

Helpful Tips:

- Please submit the following information when sending an email for claims inquiry to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)
  - Issue Reference Number(s);
  - Tax identification number (TIN)
  - Group/Facility Name
  - Practitioner Name & NPI
  - Member Name and MID Number
  - Product (Medicaid/Ambetter/Wellcare)
  - Claim Number(s)
  - DOS or DOS Range if multiple denials
  - Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
  - Provider reason for dispute

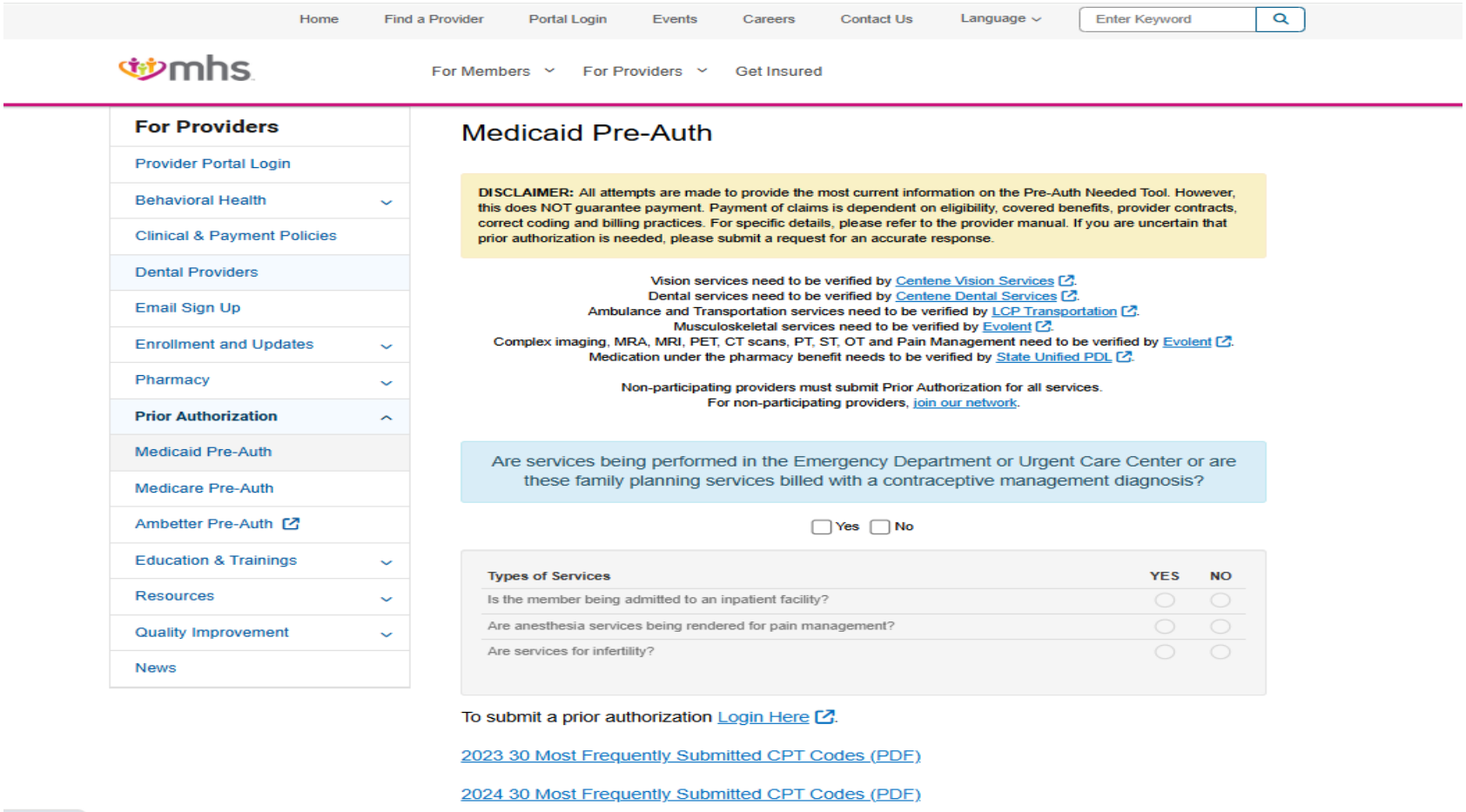
Prior Authorization Process

Prior Authorization (PA)

- Prior Authorizations should be submitted online via the Secure Provider Portal at: **MHS Provider Portal.**
- When using the portal, supporting documentation can be uploaded directly.
    - Authorization status can also be checked on the portal.
- Prior Authorizations must be completed via electronic fax or through the Availity Portal for Inpatient facilities.
- Prior Authorization (PA) can be initiated through the MHS referral line at 1-877-647-4848 Monday - Friday from 8:00 a.m. – 8:00 p.m. EST.
- The PA process begins at MHS by speaking with the MHS non-clinical referral staff.

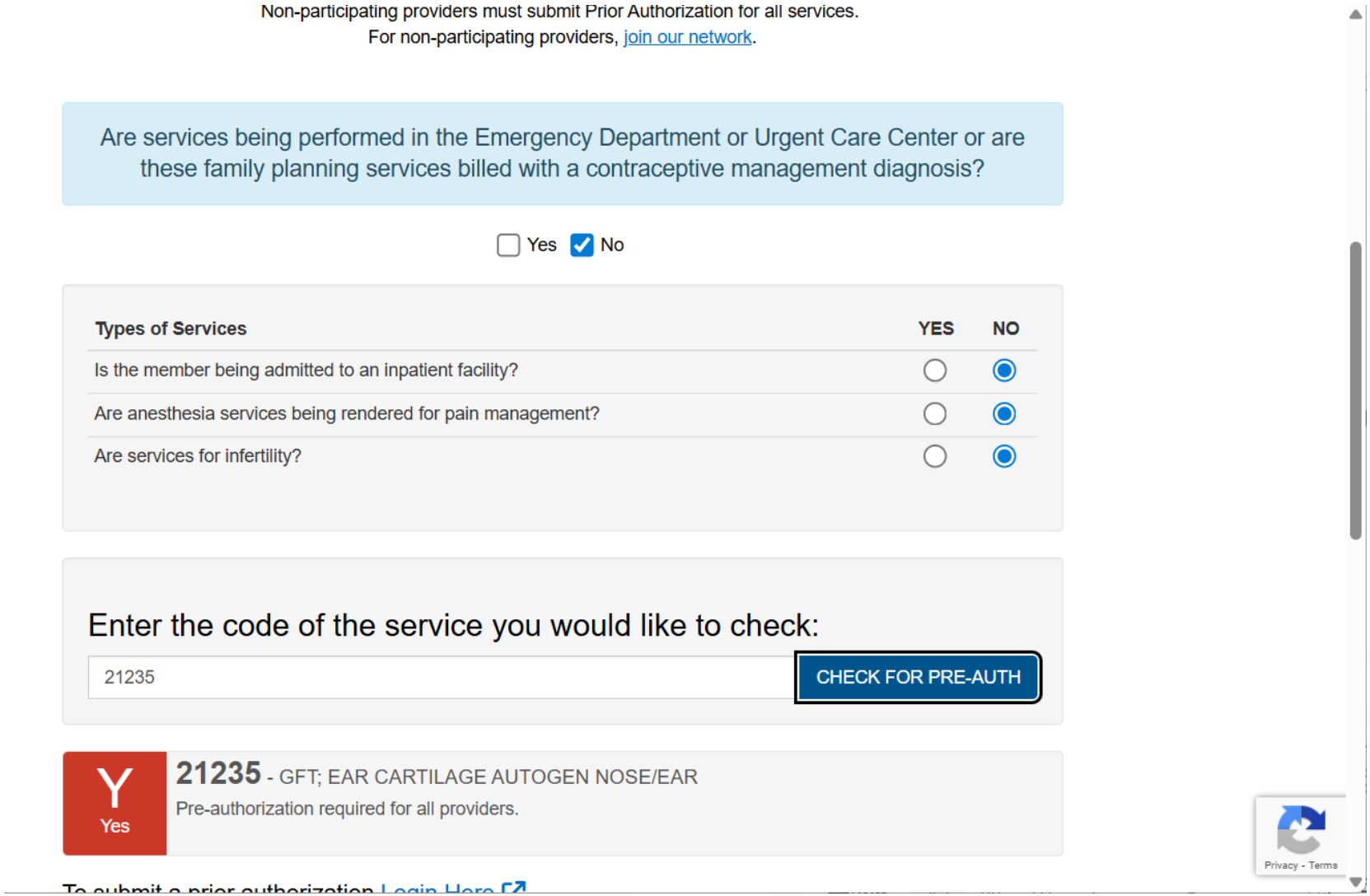
Prior Authorizations are not a guarantee of payment.

Pre- Authorization Tool



Check the **Pre Auth Tool** to verify authorization guidelines

Pre Authorization – Web Page



Evolent

Physical, Occupational and Speech Therapy

- Utilization management of these services is managed by Evolent for Medicaid
- All Health Plan approved training/education materials are posted on the Evolent website, **RadMD**, under the Resources tab. For new users to access these web-based documents, a RadMD account ID and password must be created.
- Chiropractors rendering therapy services are exempt from the Evolent program.

Evolent Cardiac Services

Evolent manages prior authorizations for the Cardiac Services below:

Automated Implantable Cardioverter Defibrillator

- Leadless Pacemaker
- Pacemaker
- Revision or Replacement of Implanted Cardiac Device
- Coronary Artery Bypass Grafting (Non-Emergent)
- Coronary Angioplasty and Stenting
- Non-Coronary Angioplasty and Stenting

Emergency Related Procedures do not require authorization. This is not an all-inclusive list.

Evolent Musculoskeletal

MHS has entered into an agreement with Evolent to implement a Musculoskeletal Safety and Management Program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.

- Emergency-Related Procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.

Evolent Utilization Management Contact Information

Web Portal Intake:

- Evolent

Contact Information:

- Medicaid: 1-866-904-5096
- Monday - Friday from 8:00 a.m. – 8:00 p.m. EST.

Inpatient Prior Authorization

MHS does not accept phone calls but accepts notification of an inpatient admission via fax at

1-866-912-4245, using the **IHCP Universal Prior Authorization Form**, or via the **Availity Portal.**

Prior Authorization Timelines

- All elective inpatient/outpatient services must be prior authorized with MHS at least 48 hours prior to the date of service.
- All urgent and emergent services must be faxed in or submitted via the MHS Secure Provider Portal to MHS within 24 hours after the admit.
- Approved prior authorizations must be updated for changes in dates of service or Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) codes within 90 calendar days of the original date of service.

Failure to obtain prior authorization for services may result in claim denials!

Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

Medicaid prior authorization/medical necessity denial appeals can be submitted to Managed Health Services via the secure provider portal and will allow for tracking.

If MHS denies the requested services, the attending physician has the right to a peer-to-peer discussion with an MHS physician, upon written member consent.

- Urgent PA turn around time is **24 hours**.
- Standard PA turn around time is **48 hours**.
- Peer-to-Peer requests must be within **48 hours** of the adverse determination.
- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.

Prior Authorization Grievance and Appeals

Medical Necessity and Grievance and Appeals

Managed Health Services

ATTN: Appeals

P.O. Box 441567

Indianapolis, IN 46244

Remember: Appeals must be initiated **within 48 hours** of the denial to be considered. Please note, this is different than a claim appeal request.

Behavioral Health Prior Authorization

Medical necessity behavioral health appeals should be mailed or faxed to:

MHS Behavioral Health
ATTN: Appeals Coordinator
12515 Research Blvd, Suite 400
Austin, TX 78701
FAX: 1-866-714-7991

Behavioral Health Medical Necessity appeals must be received by MHS within 48 hours of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal.

Coordinated Care Programs

Care Management Programs

- MHS Care Management is made up of nurses and social workers.
- **Care Managers will:**
  - Help members, doctors and other providers, including behavioral health providers.
  - Help members obtain services covered by their Medicaid benefit package.
  - Help explain and inform members about their condition.
  - Work with provider's healthcare plan for the member.
  - Inform members about community resources.

Disease Management Programs

MHS works with our disease management sister company **Envolve People Care Disease Management** to provide disease management services to members diagnosed such as:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)

Envolve People Care Disease Management provides outreach through personal health coaches.

Respiratory therapists and certified diabetic educators provide home visits to members at highest risk.

Members with diagnoses will receive educational materials and intervention based on severity.

MHS also provides disease management for behavioral health conditions such as depression and Attention Deficit Hyperactivity Disorder (ADHD).

Right Choice Program

- Members identified as high utilizers in need of specialized intervention are enrolled into the Right Choices Program (RCP).
- The member is “locked-in” to their primary physician and delivery of care for specialty services is coordinated through that provider’s office.
- RCP participants are assigned to:
  - One primary medical provider (PMP)
  - One pharmacy

Smoking Cessation

- 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.

Improving Access to Care

Appointment Standards

Primary Medical Provider (PMP) and Specialists	
Appointment Type	**Appointment Standard**
Urgent care appointments with PMP that do not require prior authorization	Within 48 hours of request
Urgent care appointments with specialist that do not require prior authorization	Within 48 hours of request
Non-urgent appointments with PMP	Within 10 business days of request
Non-urgent appointment with specialist	Within 15 business days of request
Physical exams and wellness check appointment	Within 30 calendar days of request
First prenatal appointment with PMP	Within 10 business days of request
First prenatal appointment with specialist	Within 10 business days of request
Well-child visit with PMP	Within 10 business days of request

Transportation Benefits

All MHS Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Plan (HIP) members qualify for transportation services

- Rides will take members to and from:
  - Doctor visits
  - Medicaid enrollment visits and reenrollment visits
  - Pharmacy visits
- Members need to call MHS Member Services at 1-877-647-4848 to schedule their ride at least three business days before their appointment.

Transportation

MHS will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance.

Claims for the following services should be sent to MHS:

- 911 transports
- Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).

Providers must submit prior authorization for air ambulance transport (non-emergent fixed wing airplane).

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 **CLAS**

Provider guides page for a brochure about CLAS standards.

Culturally and Linguistically Appropriate Services (CLAS) - Contact

- 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.

MHS 24/7 Nurse Advice Line

- The MHS Nurse Advice Line (1-877-647-4848) is available 24 hours a day, seven days a week to answer members' health questions.
- The Nurse Advice line staff is bilingual in English and Spanish. Additional languages are available.

MHS My Health Pays® Healthy Rewards Program

- MHS will reward members' healthy choices through our My Health Pays® Rewards program. Members can earn dollar rewards by staying up to date on preventive care.
- These rewards will be added to a My Health Pays® Prepaid Visa Card.
- Use My Health Pays® rewards to help pay for everyday items at Walmart, utilities, transportation, telecommunications (cell phone bill), childcare services, education and rent.

My Health Pays

MHS Provider Engagement

MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today

- Additional resources available at on the **MHS Website**

- Register online for additional **Monthly Web Sessions**

PEAM Contact Information

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
joy.k.diarra@mhsindiana.com
Joy Diarra, Provider Engagement Account Manager
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace.V.Ervin@mhsindiana.com
Candace Ervin, Provider Engagement Account Manager
1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie.Smith@mhsindiana.com
Natalie Smith, Provider Engagement Account Manager
1-317-379-9035

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
ldavis@mhsindiana.com
Latisha Davis, Provider Engagement Account Manager
1-317-601-5999

SOUTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
DDENNING@mhsindiana.com
Dalesia Denning, Provider Engagement Account Manager
1-317-951-3800

SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawnalee.A.McCarty@mhsindiana.com
Dawn McCarty, Provider Engagement Account Manager
1-317-556-6171

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
tiffany.calloway@centene.com
Tiffany Calloway,
Provider Engagement Account Manager
1-812-697-8126

PEAM Manager Map Color Key

Large Provider Groups - Carolyn

CAROLYN VALACHOVIC MONROE

Provider Engagement Account Manager

1-317-443-8243

CMONROE@mhsindiana.com

PROVIDER GROUPS

- Eskenazi/The Health and Hospital Corp.
- Baptist Health
- Lifespring
- Wellcare
- Deaconess (including Little Company of Mary)
- Good Samaritan
- Norton (including King's Daughters, Clark & Scott Memorial)
- Indiana University Health
- Reid Hospital
- St. Elizabeth Hospital
- Community Health

Large Provider Groups - Mona

MONA GREEN

Provider Engagement Account Manager
1-812-614-1003
mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent/Ascension
Wellcare Complete
Lutheran Medical Group
Parkview Health System
Beacon Medical Group
American Senior Care
CarDon & Associates
OrthoIndy
Heart City Health
ONE
Franciscan Health

Behavioral Health Provider Contact

ANGEL JOHNSON

Provider Engagement Account Manager
1-317-468-5184
angel.johnson3@centene.com

PROVIDER GROUPS

Park Center
Otis Bowen
Centerstone
Valley Oaks Health
Grant-Blackford
Four County
Hamilton Center
Community Mental Health Center (Lawrenceburg)
Oaklawn
Northeastern Center
Edgewater Health
Regional Mental Health
Swanson Center
Porter-Starke Services
Southwestern Behavioral
Community Mental Health Center (Vevay/Batesville)

Additional Contact Information

MHS Provider Network

NETWORK LEADERSHIP

JILL CLAYPOOL
Senior Vice President, Network Development & Contracting
1-877-647-4848
Jill.E.Claypool@mhsindiana.com

MARK VONDERHEIT
Senior Director, Provider Network
1-877-647-4848
MVONDERHEIT@mhsindiana.com

JENNIFER GARNER
Manager, Provider Relations
1-317-771-5537
jgarner@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR
Director, Network Operations
1-877-647-4848
Kelvin.D.Orr@mhsindiana.Com

NEW PROVIDER CONTRACTING

TIM BALKO
Director, Network Development & Contracting
1-877-647-4848
TBALKO@mhsindiana.com

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848
Michael.J.Funk@mhsindiana.com

CENTENE VISION

SIERRA HICKS
sierra.hicks@centene.com
Vision Provider Services: 1-844-820-6523

CENTENE DENTAL

THOMAS "TONY" SMITH
thomas.smith3@centene.com
Dental Provider Services: 1-855-609-5157

Thank You for Attending!

By taking a few moments to complete the event and sessions evaluations, you'll help us understand your experience and shape the future of our programs.

TQRCG

mhs

Questions?

Thank you for being our partner in care.