



# ProviderLink

2022



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## Behavioral Health Quality Update

There's never a bad time to review behavioral health HEDIS measures and confirm providers are following procedures aimed at best standards of care. Here is a brief overview of each measure. For more specific information regarding each measure please visit [mdwise.org/for-providers](http://mdwise.org/for-providers)

### Follow-up Care for Children Prescribed ADHD Medication (ADD)

When prescribing a new medication, be sure to schedule a follow-up visit within 30 days to assess how the medication is working and to address side effect issues. Schedule this visit while your member is still in the office. Schedule two more visits in the 9 months after the 30-day Initiation Phase to continue to monitor your member's progress. If your member cancels an appointment, be sure to reschedule right away.

### Antidepressant Medication Management (AMM)

Educate your patients on how to take their antidepressant medications.

Important messages include:

- How antidepressants work, their benefits and how long they should be used.
- Length of time patient should expect to be on the antidepressant before they start to feel better.
- Importance of continuing to take the medication even if they begin feeling better.
- Common side effects, how long the side effects may last and how to manage them.
- What to do if they have questions or concerns.



You may have heard that Hoosier Care Connect is having a plan selection period. This does not affect patients that have Hoosier Healthwise or HIP health coverage.



MDwise members in these programs don't need to take any action.

### Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Encourage patients diagnosed with schizophrenia to discuss any side effects, take their medication as prescribed, and refill their medication on time.

### Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

- Schedule an HbA1c test and an LDL-C test for members with schizophrenia and diabetes.
- Test yearly.
- To increase compliance, consider using standing orders to get labs done.

### Follow-up After Hospitalization for Mental Illness (FUH)

Schedule the Seven Day Follow-Up visit after discharge to allow flexibility in rescheduling. Appointments on the day of discharge will not count towards this measure. If the appointment doesn't occur within the first seven days post-discharge, please schedule within 30 days. Involve the patient's caregiver regarding the follow-up plan after IP discharge.

### Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Educate your patients on side effects of antipsychotics and risk of weight gain and diabetes. Perform at least one test for blood glucose or HbA1c, and at least one test for LDL-C or cholesterol yearly. Provide accurate billing to reflect that the above services were performed. Document what was done accurately and be specific.



### Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Educate your patients on the importance of following up with a mental health professional. Refer the patient to a behavioral health provider for individual, group and/or family therapy to help monitor symptoms. Follow up with the patient/family to confirm they went to the therapy appointment.

### Follow-up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence (FUA) and Follow-up After Emergency Department Visit for Mental Illness (FUM)

Educate your patients about appropriate use of the emergency department. Make sure patients have an appointment with a medical or behavioral health provider within 5 days of being seen in the emergency department. Follow up with your patient to see if they attended the appointment and if not, schedule another within 30 days of being seen in the emergency department.

## Provider Balance Billing



It is important to remember, except for a very few exceptions, a Medicaid member cannot be billed for health care services. Please review your provider manual for these exceptions and the criteria you must meet before billing a member.

If a provider has received payment on a Medicaid claim, the member may never be asked to pay an additional amount, or be balance-billed, for that claim. Providers may bill a Healthy Indiana Plan (HIP) member for a co-pay if the member was unable to pay at the time of service. These co-pays are anywhere from \$4 for an office visit to \$75 for a hospital stay. Due to the public health emergency, cost-sharing efforts have been suspended at this time.



## IHCP Rescinds Certain Temporary COVID-19 Policy Changes

As Indiana’s cases and hospitalizations have fallen significantly in recent months, the Indiana Health Coverage Programs (IHCP) has ended some temporary policy changes enacted in response to the public health emergency due to the coronavirus disease 2019 (COVID-19). This bulletin rescinds the temporary policy changes announced in the provider bulletins listed in Table 1.

For dates of service on or after April 1, 2022, providers are required to follow the appropriate IHCP guidelines in place prior to the effective date of the publications listed above. IHCP policies and guidelines can be found in IHCP provider reference modules, banner pages and bulletins available on the Provider Reference Materials page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

The temporary policy changes documented in the following IHCP bulletins are no longer effective as of March 31, 2022.

**Table 1** – Temporary COVID-19 policies announced in bulletins with an end date of March 31, 2022

Bulletin	Policy Start Date	Policy End Date
<b>BT202174:</b> IHCP temporarily reinstates revisions to PA process for acute care hospital non-elective inpatient admissions	8/30/22	3/31/22
<b>BT202178:</b> IHCP temporarily revises time frames for certain PA approvals	9/1/21	3/31/22
<b>BT202179:</b> IHCP reinstates inpatient SUD and psychiatric admission policy changes	9/8/21	3/31/22
<b>BT202180:</b> PA changes temporarily reinstated for some DME/HME supplies and services	9/8/21	3/31/22
<b>BT202181:</b> IHCP reinstates temporary PA changes for managed care SNF admissions	9/8/21	3/31/22
<b>BT202182:</b> IHCP temporarily reinstates PA policy for LTAC and AIR facility admissions	9/8/21	3/31/22



## Transportation

Transportation to and from a facility where medically necessary covered services are provided is a necessary condition for access to care. MDwise has a transportation broker that arranges for non-emergent transportation services for the members of the MDwise Hoosier Healthwise program, who are covered under Package A. Non-emergent transportation is a covered benefit for Healthy Indiana Plan members who are in a HIP Maternity, or a HIP State Plan.



Transportation is not a covered benefit under HIP Basic and HIP Plus. Members needing transportation services, or providers who are looking to schedule transportation for a member, are instructed to call MDwise Customer Service. When a member or provider calls, they are prompted to select the “transportation option.” They are then connected with a transportation specialist who can schedule their transport to and from a covered service.

Non-emergent transportation is defined as a ride, or reimbursement for a ride, provided so that an MDwise member with no other transportation resources can receive services from a medical provider. Non-emergent transportation does not include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations. To assist a member in arranging a ride, please call MDwise Customer Service at [1-800-356-1204](tel:1-800-356-1204).





# Improving Culturally and Linguistically Appropriate Services (CLAS) to Members

MDwise, Inc. will provide culturally and linguistically appropriate services that are equitable and respectful to diverse cultural beliefs, languages, and communication needs that reduce disparities and enhance our members' health status in the communities we serve.

## Core Concepts

- Health equity embedded as central component to organizational quality
- Structural processes rebuilt with forcing functions placed upstream to encourage health equity work
- Organizational examination and action institutionalized in policy to root out any bias in policy, practice, or sponsorship
- Interventions reimaged & retooled, based on analysis & conceived with strategy, to address unequitable health determinants
- Partnerships continuously fostered with likeminded community groups and organizations to synergize equity efforts

## Reporting Relationship of Staff that Provide CLAS

MDW staff that interact with members or providers are responsible for delivering or facilitating member interactions and services that are culturally and linguistically appropriate, and that are equitable and respectful to the diverse cultural beliefs, languages, and communication needs.

### This includes all staff in the following departments:

- Customer Service – Reports to the Director of Customer Service
- Medical Management – Reports to the Director of Medical Management
- Provider Services – Reports to the Director of Provider Services
- Quality and Outreach – Reports to the Director of Quality

Full Membership Data for October 2021 is below.

Race	Total	%
Total Members	381,230	100%
American Indian or Alaskan Native	414	0%
Asian or Pacific Islander	7,530	2%
Black	66,724	18%
Hispanic	44,111	12%
Not Provided	69,622	18%
White	192,818	51%

Race	Members	Percent
Caucasian/White	22,121	5.80%
Black/African American	7,388	1.94%
Other	5,574	1.46%
No Race Selected	1,254	.33%
Asian	981	.26%
American Indian or Alaskan Native	124	.03%
Native Hawaiian or Other Pacific Islander	55	.01%



Language	Members	Percent
English	33,376	8.75%
Spanish	2,345	.61%
No Language Selected	536	.14%
Burmese	196	.05%
Arabic	137	.04%
Creole	134	.04%
Other	123	.03%

## Alternate Language Translation & Interpretation Services

MDwise strives to adequately serve a culturally and linguistically diverse membership. Annually, the cultural, ethnic, racial and linguistic characteristics of the membership are assessed to determine if adjustments in the availability of practitioners within the network are needed to ensure that these diverse needs are addressed.

To address the cultural and linguistic needs of its membership, MDwise uses several sources, including U.S. Census Data, data on gender, race/ethnicity and languages spoken of members and practitioners by county, as well as language and hearing interpretation data from member requests and Language Line activity reports.

MDwise addresses the communication needs of its members and ensures the availability of interpretive services to optimally engage, direct and support each member and his/her family and/or support systems. MDwise respectively observes, follows, and oversees the Principal, Governance, Leadership, Workforce, Communication and Language Assistance, Engagement, Continuous Improvement and Accountability Standards under the National CLAS guidelines. Our strategy for serving a culturally and linguistically diverse membership include:

- Providing education and training on diversity for all new staff.
- Ensuring that data on the individual member's race, ethnicity, and spoken/written language are collected in health records, and/or integrated into the management information systems and periodically updated.
- Providing member educational materials developed to be sensitive to an ethnically diverse population.
- Improving quality of care and reducing health care disparities by providing bilingual staff and interpretive services free of charge, such as sign language, foreign language for those with limited English proficiency (LED) and use of TDD/TTY lines for members with hearing impairments, including contracting with a Language Line in a timely manner during all hours of operation
- Making available easily understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

MDwise works collaboratively in the development, coordination and evaluation of quality improvement (QI) activities that include identifying, and understanding healthcare disparities, Social Detriments of Health (SDOH), with multicultural initiatives that promote an equitable, and inclusive experience from end to end, quality and member safety of clinical care services are a top priority for MDwise members.

The QI program and MDwise policies and procedures and contract agreements indicate the dual involvement of MDwise administration and their providers in identifying and participating in the QI program activities and initiatives.

## Lead Screening

### LEAD The Way on Testing

The State of Indiana continues the focus on the risk of lead poisoning in children and has passed new legislation that will be effective 1/1/2023. Please review the new legislation at [Health: Lead & Healthy Homes Division: Testing Requirements](#).

Additionally, MDwise is focused on helping providers increasing the reporting of blood lead results to CHIRP. It is often found that blood lead levels are underreported.



## Managing Airway Disease

Help us help your patients have better control of their airway disease. Together, we can ensure they are on appropriately prescribed asthma controller medications (e.g., long-acting inhaled corticosteroids) and they remain on the appropriately prescribed medications during the treatment period. Please note that our preferred inhaled corticosteroid product is ALVESCO (ciclesonide).

MDwise Members who are identified with certain medical conditions, including Asthma and COPD, are eligible for our Medication Therapy Management (MTM) program. These two conditions are among the most common diseases in which our members could improve their medication adherence. MDwise analyzes adherence using Proportion of Days Covered (PDC) for our population. Review of PDC for members who take part in education and intervention programs for airway disease shows adherence improvement of about 10%. This improvement in adherence helps reduce members need to visit an Emergency Department for airway issues, as well as improves their overall health.

Providers are encouraged to educate members about appropriate use of their airway disease medications. To aid in education, the National Heart Lung and Blood Institute (NHLBI) has some great resources available online. Resources can be found at [nhlbi.nih.gov](http://nhlbi.nih.gov).

Additionally, educational videos on the proper use of an asthma inhaler with and without a spacer can be found on the website of the Centers for Disease Control and Prevention (CDC) at [cdc.gov/asthma/inhaler\\_video](http://cdc.gov/asthma/inhaler_video).

For additional resources, please see the MDwise website: [mdwise.org/for-providers/pharmacy-resources](http://mdwise.org/for-providers/pharmacy-resources).



## Tobacco Cessation

Help Your patients Quit Smoking - Indiana Tobacco Quitline

MDwise covers smoking cessation services for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW) members. These services, in coordination with pharmacotherapy available under the Indiana Medicaid pharmacy benefit program, can be very effective in helping MDwise members quit smoking. It is important that as a provider you discuss the risks of smoking at every encounter with your patient. Providers should use the “5 As” model as a tool to discuss tobacco cessation:

- Ask
- Advise
- Assess
- Assist
- Arrange

Refer patients for tobacco cessation counseling to the Indiana Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669), or for mobile phone users, Text2Quit. Convenient “Quit Now” business cards and educational materials can be ordered for free from the Indiana Tobacco Quitline website.

Refer MDwise members via fax by using the form on the MDwise website at [www.mdwise.org/SMOKE-free\\_Resources](http://www.mdwise.org/SMOKE-free_Resources).

MDwise helps educate the community by hosting various tobacco cessation events around the state. For information about tobacco cessation events in your area, please visit [MDwise.org/events](http://MDwise.org/events).

Sources:

Agency for Healthcare Research and Quality.  
Five Major Steps to Intervention (The “5 A’s”).  
Indiana Tobacco Quitline

## FSSA extends postpartum coverage period to 12 months

Effective April 1, 2022, the postpartum coverage period for Healthy Indiana Plan (HIP) Maternity and Hoosier Healthwise members will be extended from 60 days to 12 months of continuous eligibility, regardless of change in circumstance that would otherwise result in loss of eligibility.

The FSSA is making these changes to comply with sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP), which gives states a new option to provide 12 months of extended postpartum coverage to pregnant individuals. There are no changes to the benefits covered, and members will continue to be exempt from cost-sharing during pregnancy and the postpartum coverage period.

The postpartum coverage period is available to an individual who meets one of the following criteria:

- Becomes pregnant while already enrolled in HIP or Hoosier Healthwise.
- Applies for Medicaid while pregnant and is eligible on the date pregnancy ends (by birth or other means).
- Applies for Medicaid after the child is born (or the pregnancy is terminated by other means) and was both pregnant and financially eligible in the month of application or one of the three retro months prior to the application month.

For pregnant individuals who were eligible and enrolled (including retroactive enrollment) on the date their pregnancy ends, the agency must provide coverage described through the last day of the month in which the 12-month postpartum period ends.

The postpartum coverage period is not available to members in Emergency Services Only (ESO) categories of coverage:

- Individuals in ESO Coverage with Pregnancy Coverage (Package B) still receive 60 days postpartum coverage.
- Individuals in ESO (Package E) do not receive any postpartum coverage.

During the 12-month postpartum period, HIP Maternity members will continue to receive full benefits that cover all the same services as the HIP State Plan. Hoosier Healthwise members in the 12-month postpartum coverage period will continue to receive full benefits under Package A – Standard Plan. The small number of pregnant members who are covered under Traditional Medicaid (fee-for-service, full coverage) or Hoosier Care Connect when their pregnancy begins will also receive the 12 months of postpartum protection and coverage.

If, at the end of the 12-month postpartum coverage period, the member is no longer eligible in their previous category of coverage, the Division of Family Resources (DFR) will review for eligibility in any other Indiana Health Coverage Programs (IHCP) benefit plan before disenrolling. Members who are eligible for HIP coverage when their postpartum period ends will start out in HIP Basic and be given an opportunity to pay their first Personal Wellness and Responsibility (POWER) Account contribution and move to HIP Plus.





## POWER Account Education

The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at minimum, be funded with State and individual contributions. POWER accounts give participants a financial incentive to adopt healthy behaviors that keep them from developing chronic illnesses.

The Healthy Indiana Plan (HIP) provides health insurance for uninsured adult Indiana Hoosiers who are legal US residents between the ages of 19 and 64 and whose family income is up to 133% of the FPL.

A POWER Account is valued at \$2,500 per adult to pay for medical costs per calendar year or benefit period. If the member leaves the plan early in the year and returns prior to the end of the calendar year the original POWER Account continues to be tracked for the remainder of the year. One hundred and twenty days (121 days) after the benefit period ends, the POWER Account is reconciled so MDwise can share with the State how the POWER Account funds for each HIP member were utilized.

### HIP Plus

HIP Plus or HIP State plus members are required to help fund their \$2,500 deductible by contributing to their POWER Account monthly. Required contributions will be roughly equivalent to 2% of the household income on a tiered basis per the below table.

FPL	Monthly PAC Single Individual (2% for top of band)	Monthly PAC Spouses (1% each for top of band)	PAC with Tobacco Surcharge (2.5% for top of band)	Spouse PAC when one has tobacco surcharge	Spouse PAC when both have tobacco surcharge (each)
<22%	\$1.00	\$1.00	\$1.50	\$1.00 & \$1.50	\$1.50
23-50%	\$5.00	\$2.50	\$7.50	\$2.50 & \$3.75	\$3.75
51-75%	\$10.00	\$5.00	\$15.00	\$5.00 & \$7.50	\$7.50
76-100%	\$15.00	\$7.50	\$22.50	\$7.50 & \$11.25	\$11.25
101-138%	\$20.00	\$10.00	\$30.00	\$10.00 & \$15.00	\$15.00

Employers and Non-Profit Organizations may contribute some or all the member's portion of required payment.

### HIP Basic

HIP Basic or HIP State Plan Basic members are not required to make monthly contributions to their POWER Account but are required to pay copayments at the time HIP covered services are rendered.

- No copayment is required for preventive care, maternity services, or family planning services
- Four-dollar (\$4.00) copayment is required for outpatient services.
- Seventy-five-dollar (\$75.00) copayment is required for inpatient services.
- Four-dollar (\$4.00) copayment is required for preferred drugs.
- Eight-dollar (\$8.00) copayment is required for non-preferred drugs.

### HIP Members Exempt from Cost Sharing

Pursuant to federal law, MDwise will not collect POWER Account contributions or impose any other cost-sharing, including co-payments for non-urgent use of hospital emergency departments, on pregnant members, members who have reached their 5% cost sharing requirement, or American Indian/Alaska Native members as they will be exempt from all billing and collection procedures.



## Fight Readmissions with Good Transitions

“The Centers for Medicare and Medicaid Services (CMS) define a transition of care as the movement of a patient from one setting of care to another.” Poor transitions from an inpatient level of care lead to higher rates of readmission in the first 30 days.

What is important to remember about transitions of care?

1. Identify members at Risk  
What members have a risk of readmission or lack of follow up care?
2. Perform an Assessment  
Comprehensive or Social Determinants of Health screenings  
What gets in the members way of adherence to the follow up plan?
3. Perform Medication Reconciliation  
Reconciliation to home meds and home prescriptions  
Does a member know what medications to stop and start?
4. Set up a Plan  
Develop a Collaborative Care Plan  
What Follow up is needed? What is the Member willing to do?  
What can MDwise do to help?

Care Management Services are available to all MDwise members. Our Care Management Team supports members in developing goals to self-manage their conditions. Refer members to the MDwise Care management team by calling 800-356-1204 or submit a referral electronically to [CM/DM Referral - MDwise Inc.](#)



**1-800-356-1204 or 317-630-2831**

Hoosier Healthwise and HIP

[MDwise.org/providers](#)



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