PROVIDER ENROLLMENT AND CREDENTIALING

2021 Annual IHCP Works Seminar

Agenda

- MHS Provider Enrollment
- Request for a New Contract
- Add Provider to Existing Contract
- Non-Contracted Provider Enrollments
- Demographic Updates
- Provider Directory Requirements
- Credentialing and Re-credentialing
- MHS Team

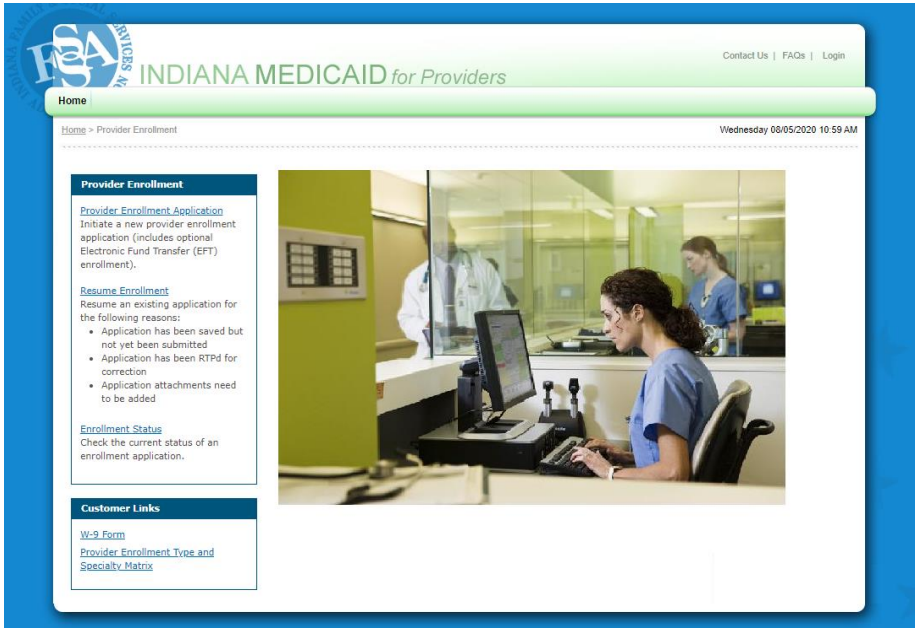
MHS Provider Enrollment

- MHS offers most provider enrollment processes via the MHS website mhsindiana.com including:
  - Request for a new contract
  - Enrolling a practitioner to an existing contract
  - Demographic updates, including address changes, panel updates, terminations, etc.
  - Non-contracted enrollments
- A provider must have a current IHCP provider enrollment number before beginning the process of enrolling with MHS.

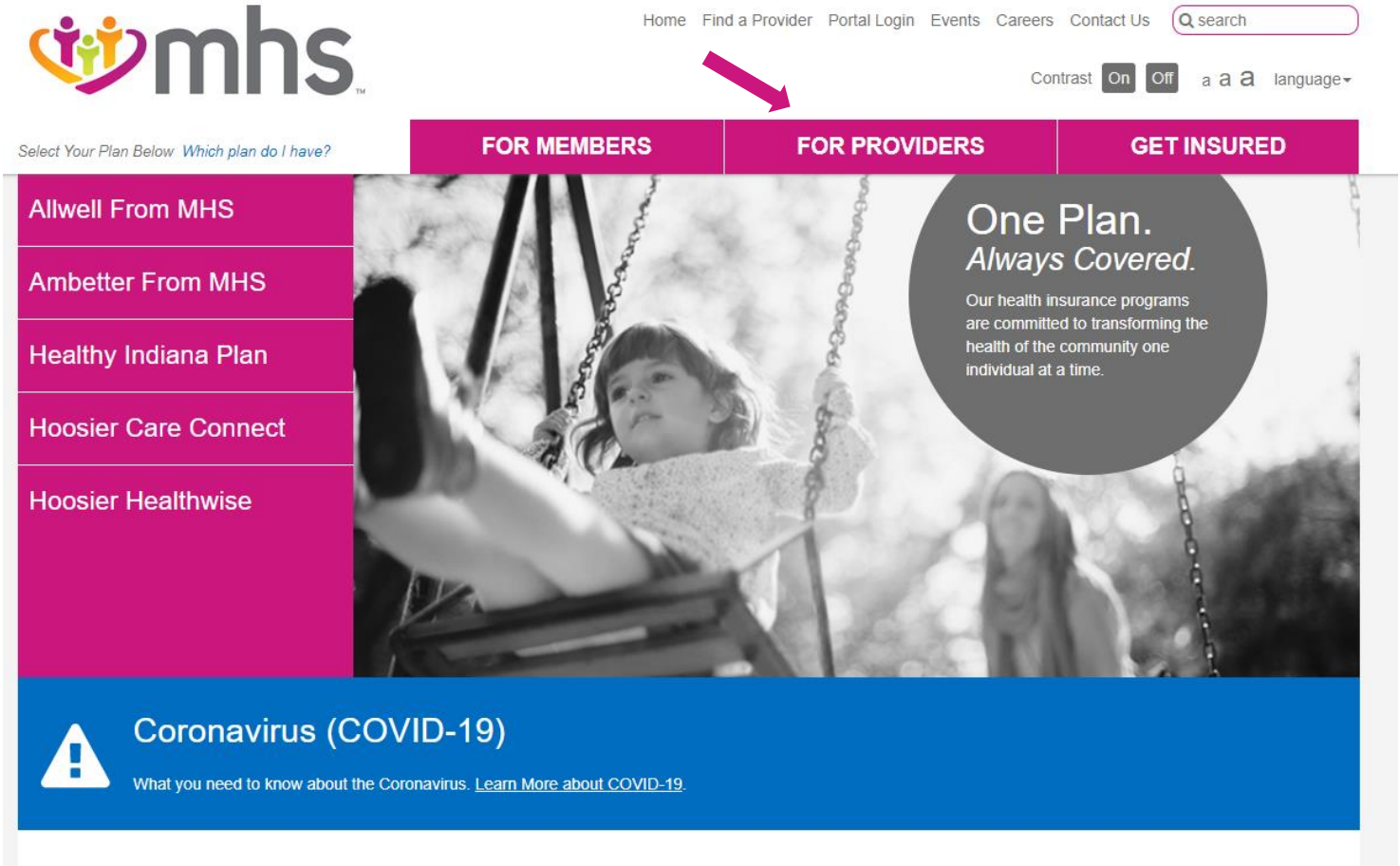
MHS Provider Enrollment

- IHCP Provider Enrollment Link

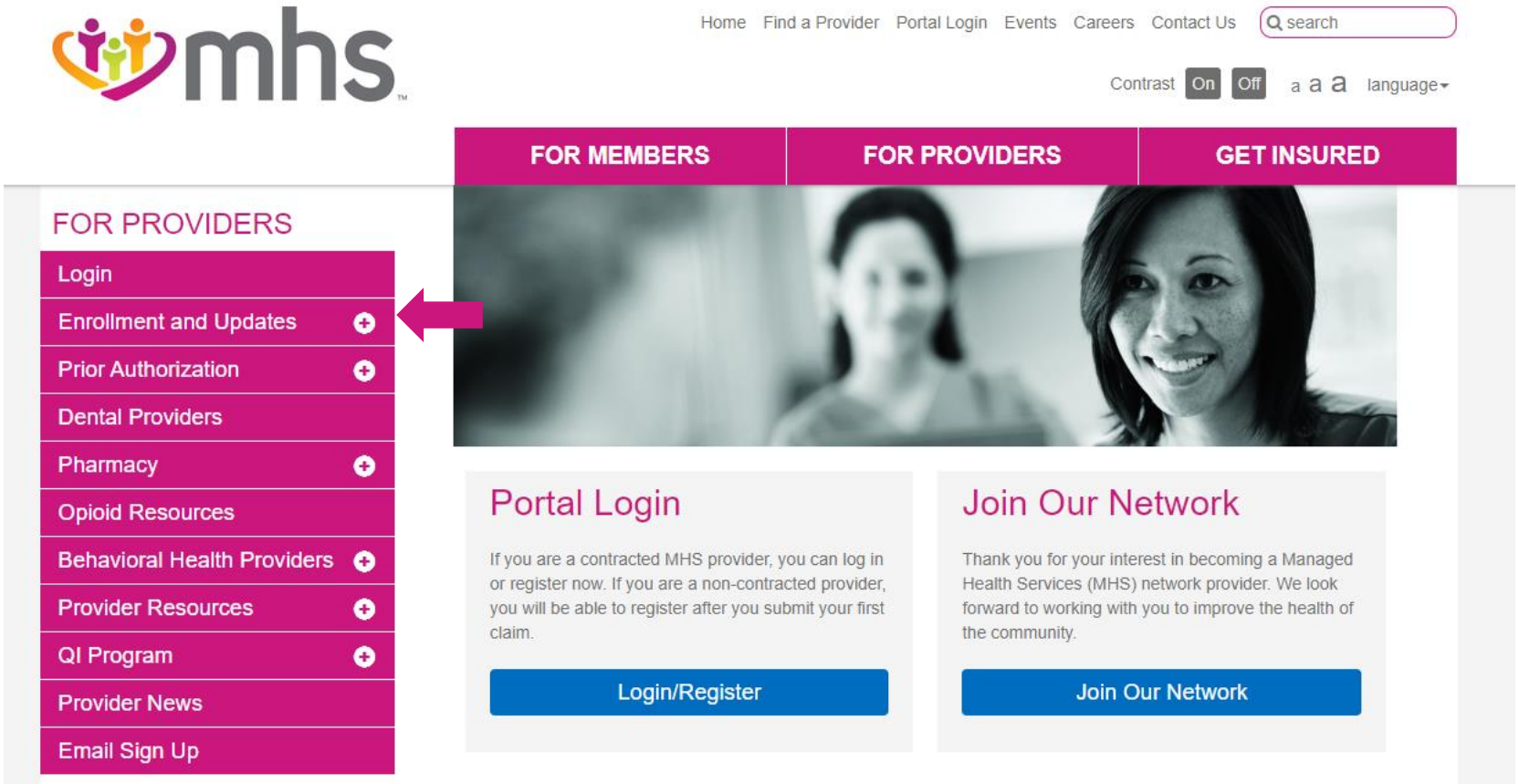
https://portal.indianamedicaid.com/hcp/provider/Home/ProviderEnrollment/tabid/477/Default.aspx



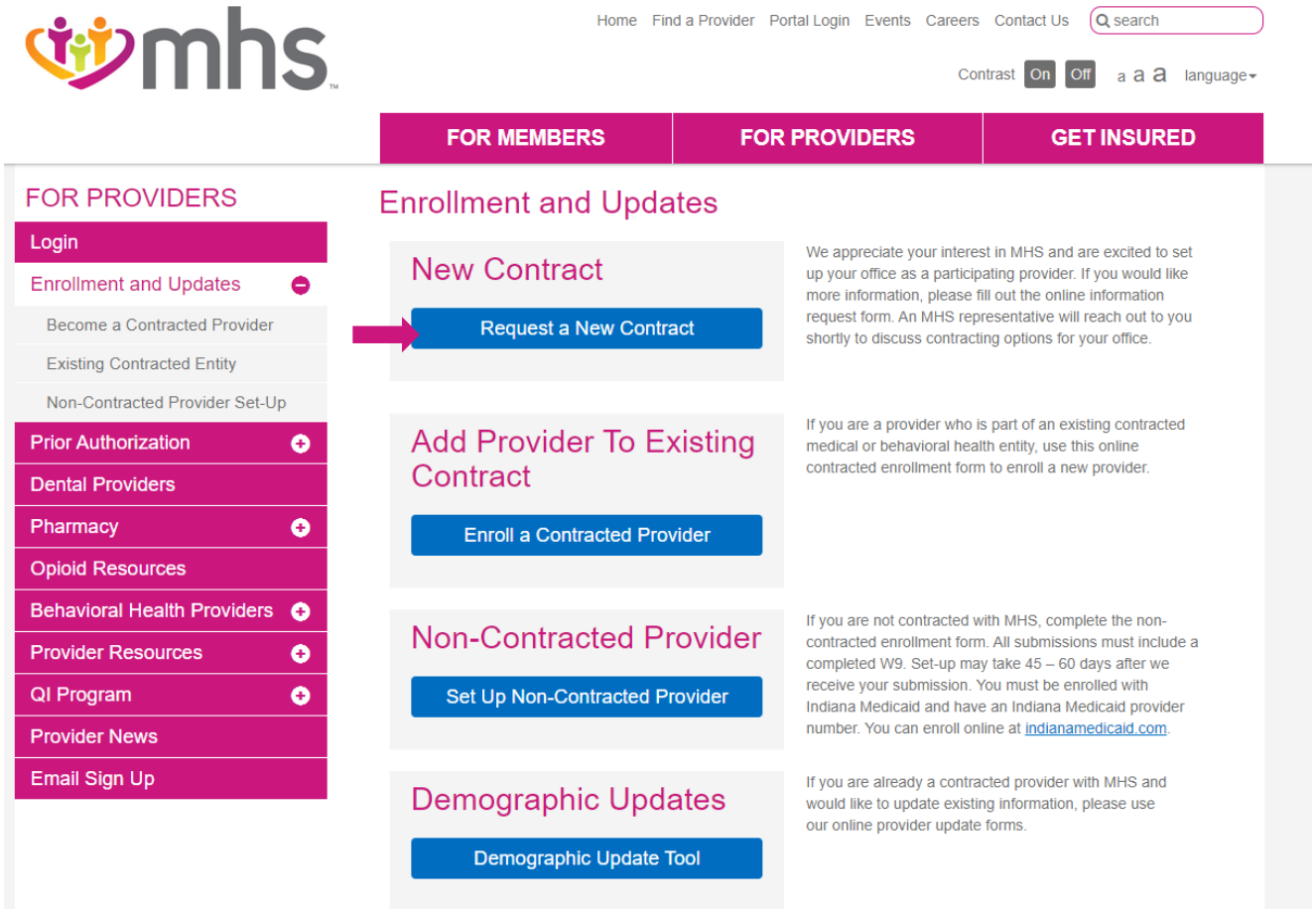
MHS Provider Enrollment



MHS Provider Enrollment



MHS Provider Enrollment



Requesting a New Contract

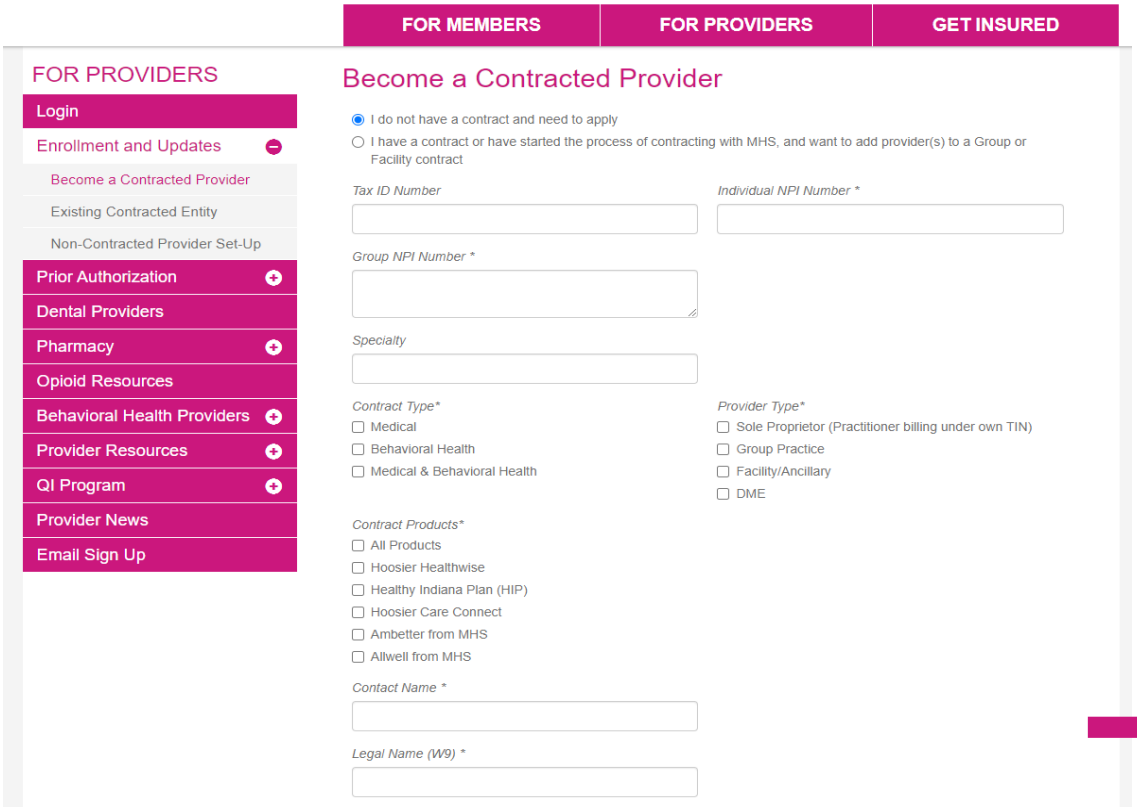
Requesting a New Contract

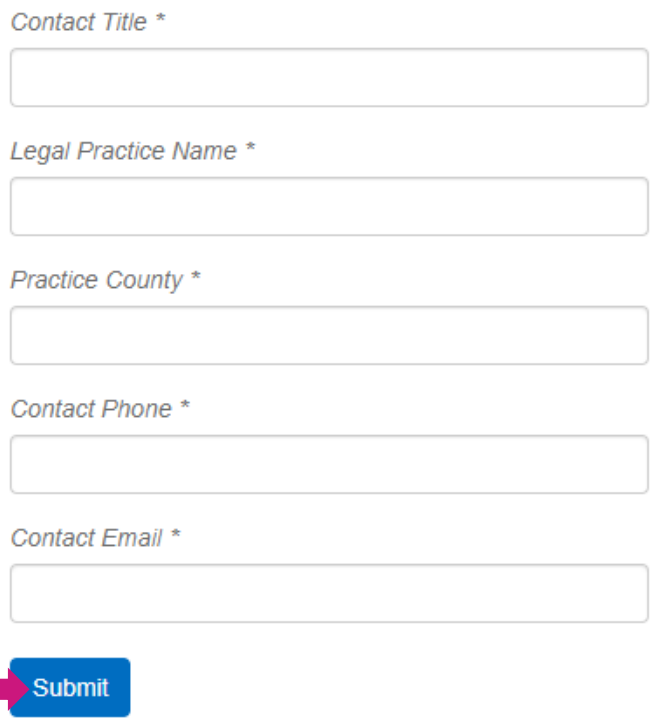
- If your provider group or office is not contracted with MHS, the following screens will guide you through the online process of contacting the MHS Contracting Department to request a new contract.

Request a New Contract

Please complete the online submission form and click submit.

This request will then be sent to the MHS Contracting Team and a Contract Negotiator will be in touch.



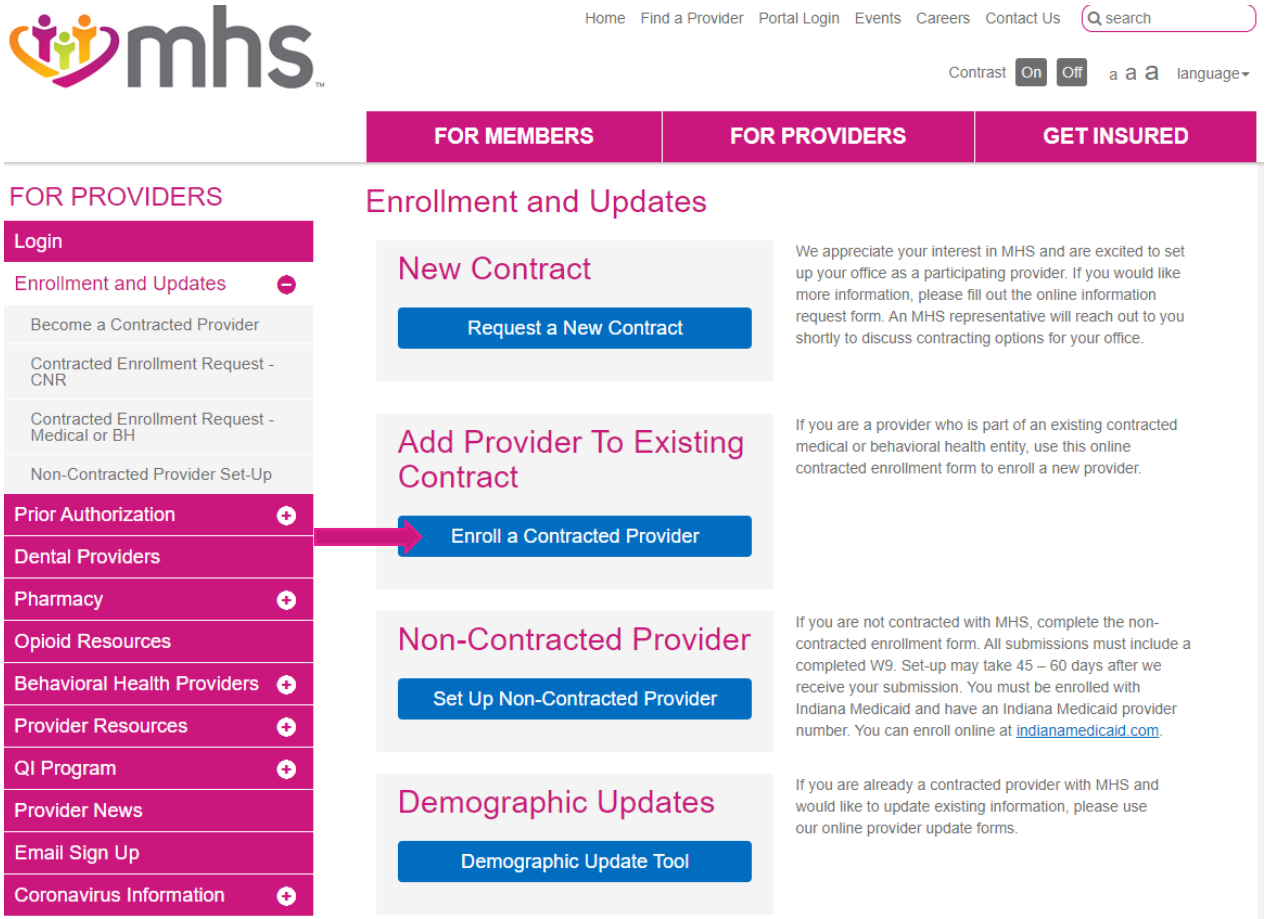


Add Provider to Existing Contract

Add Provider to Existing Contract

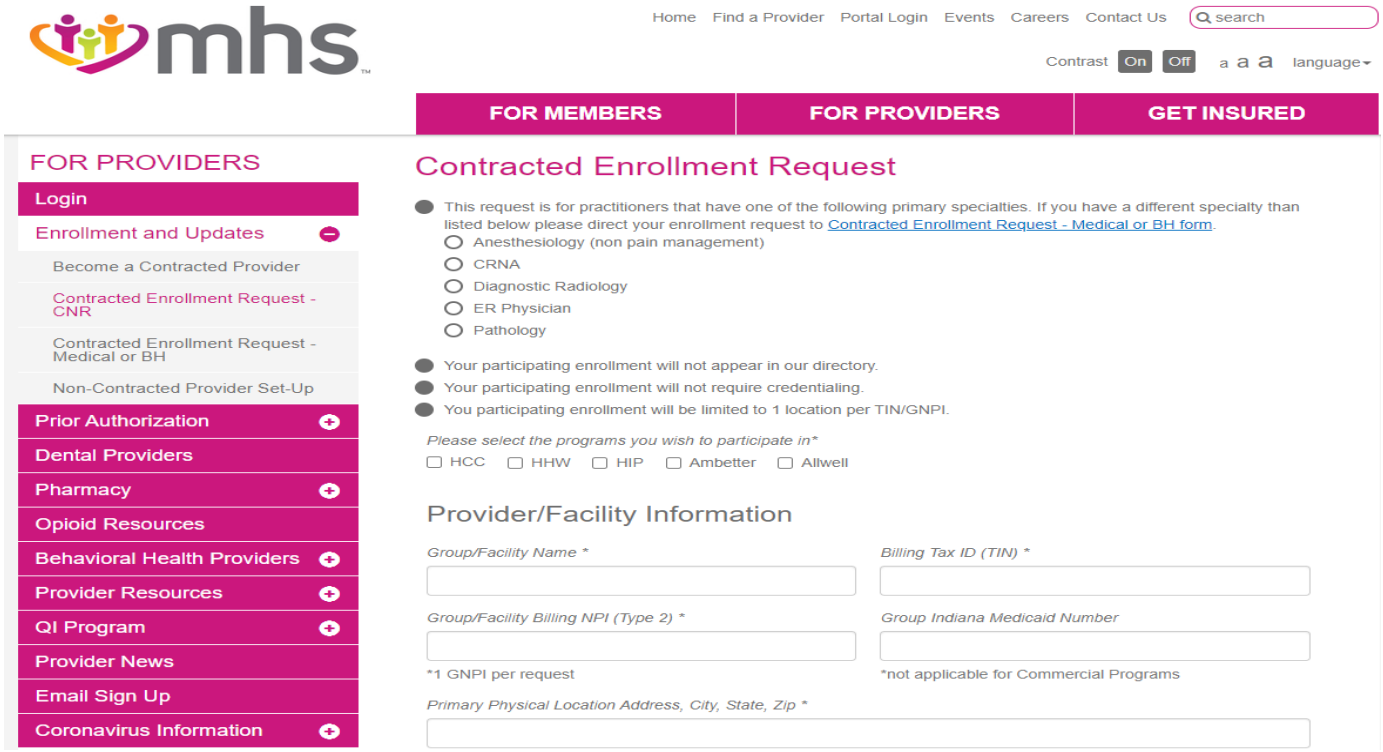
- If you are a provider who is part of an existing contracted medical or behavioral health entity, you will use this online contracted enrollment form to enroll a new provider.

Add Provider to Existing Contract



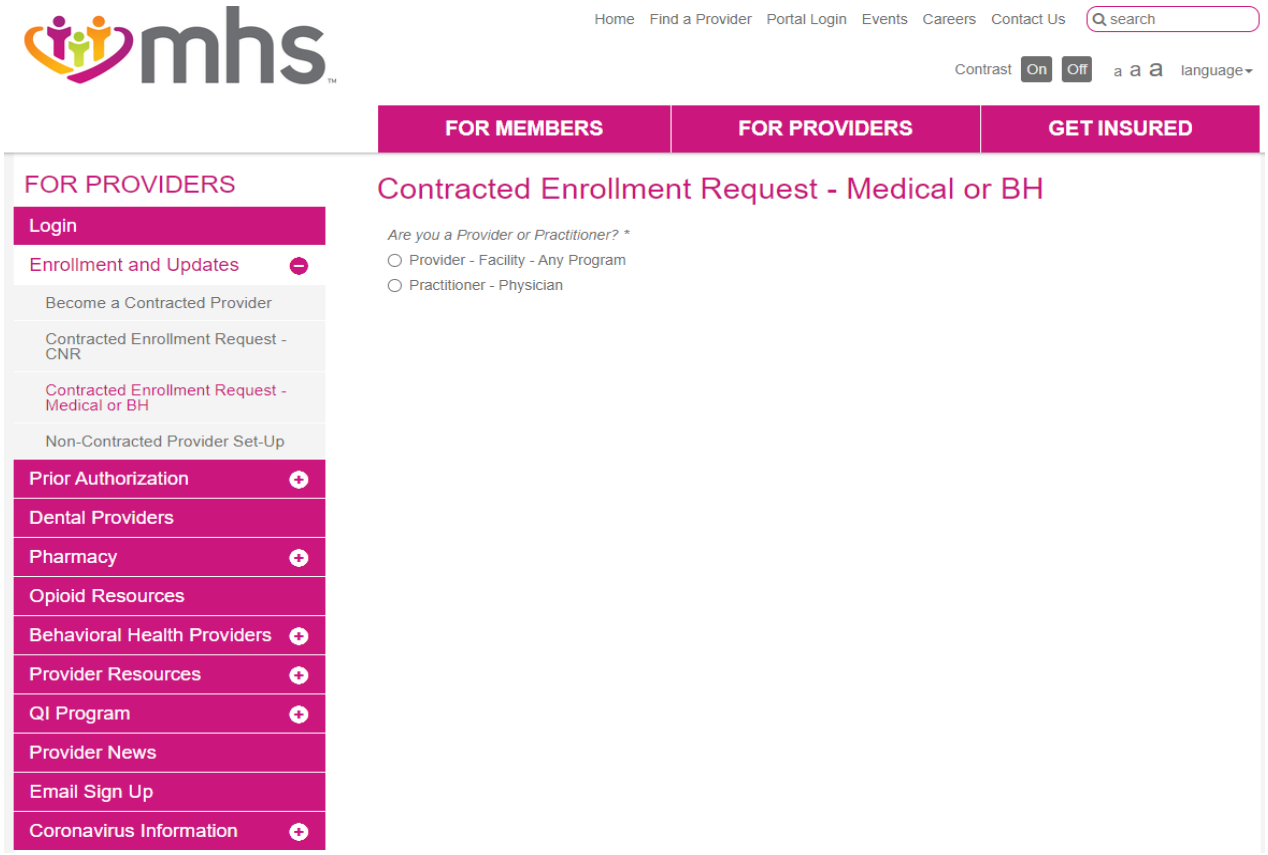
Add Provider to Existing Contract

- From this screen you will need to choose your provider specialty type.



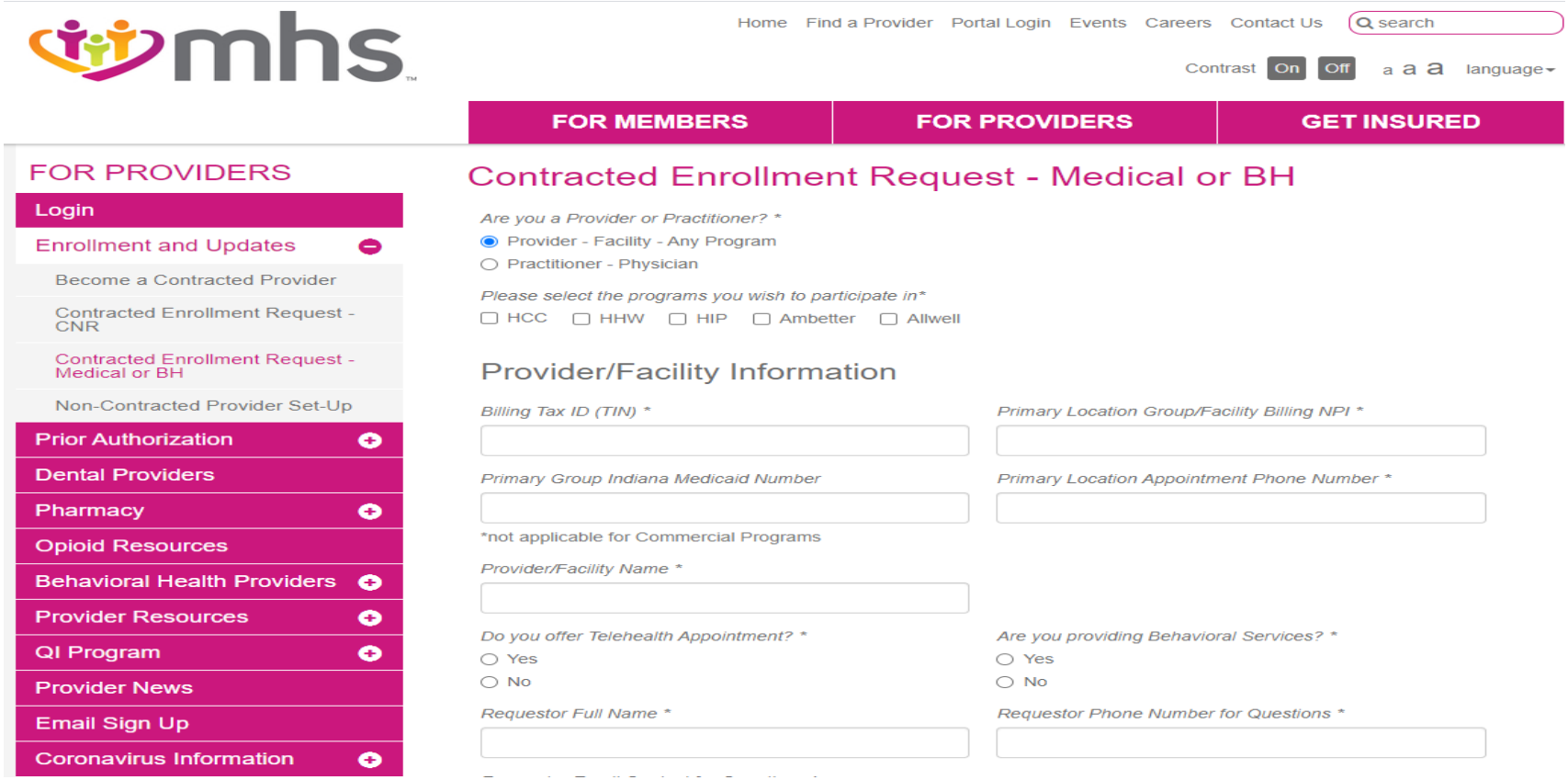
Add Provider to Existing Contract

- From this screen you will need to choose your provider type.



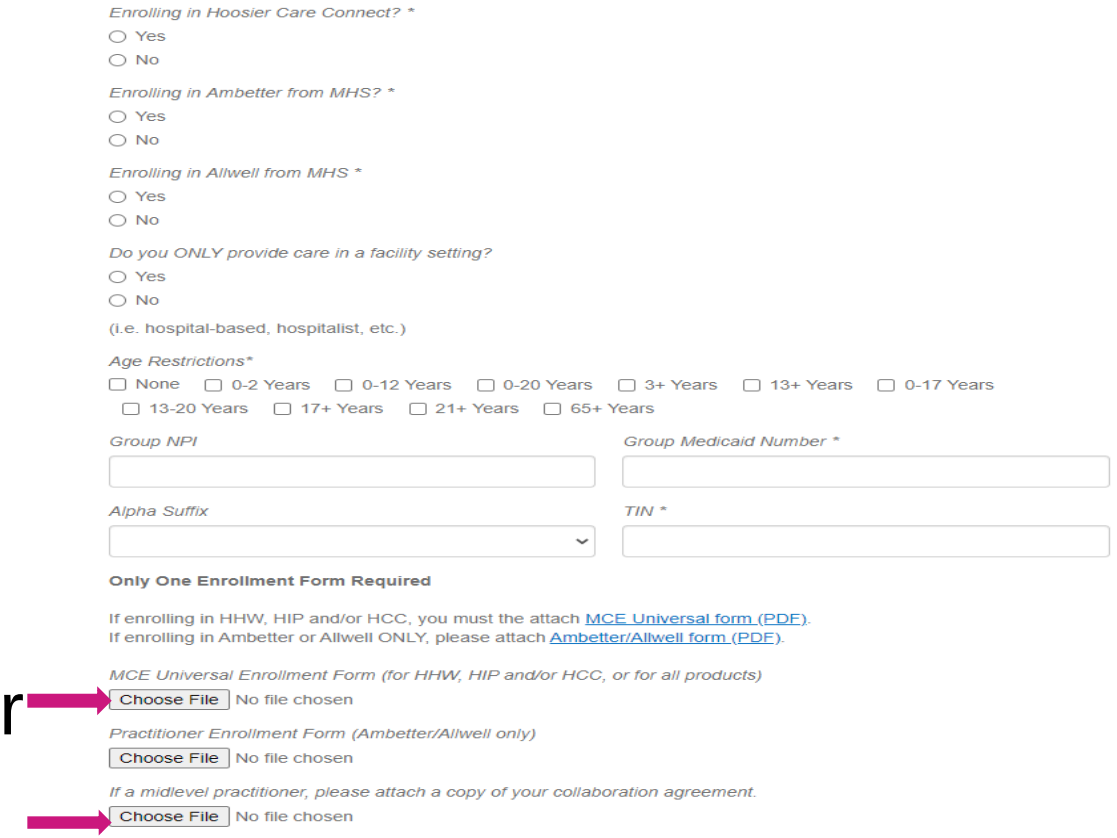
Add Provider to Existing Contract

- You will need to make sure that you complete the entire online submission form, including uploading the required attachments prior to clicking Submit.



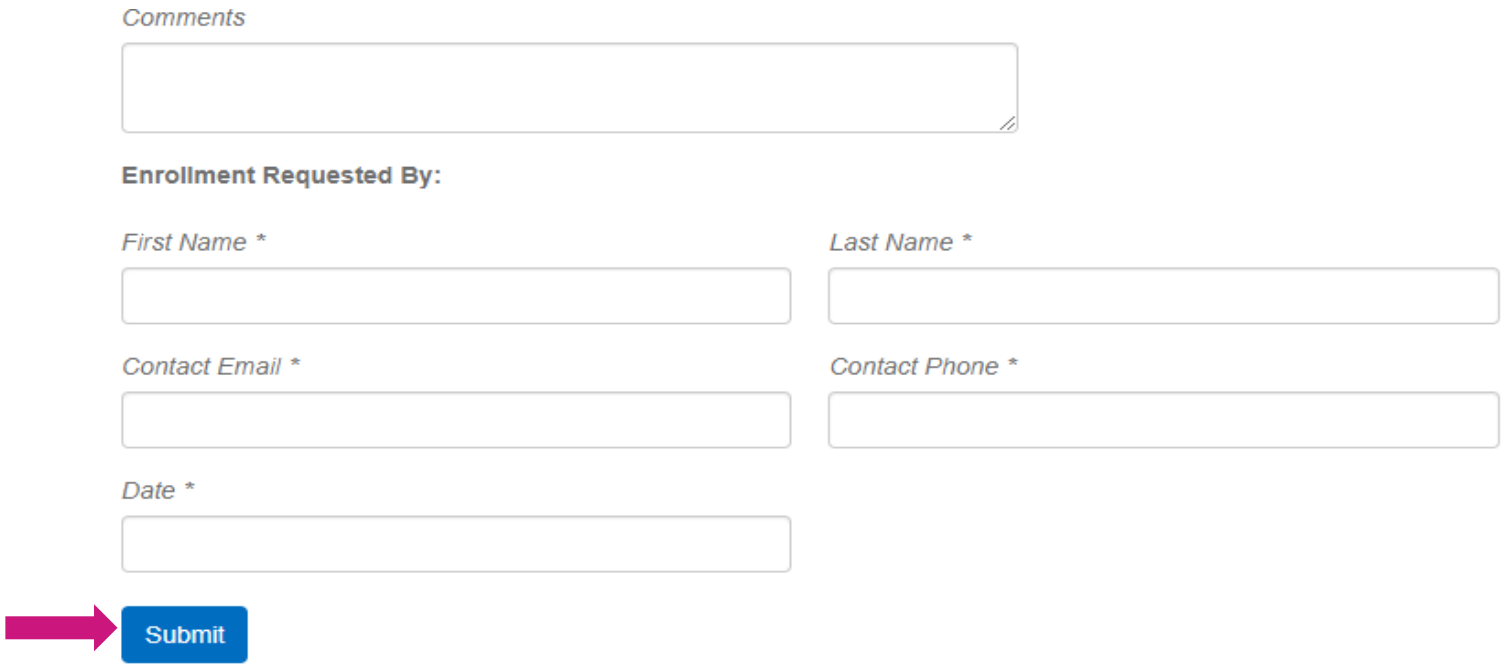
Add Provider to Existing Contract

- It is imperative that you upload and attach the MCE Universal Enrollment Form and the Collaborative Agreement for Midlevel Practitioners.



Add Provider to Existing Contract

- Once the form has been submitted it will be sent to the MHS Enrollment Team to begin the enrollment process.

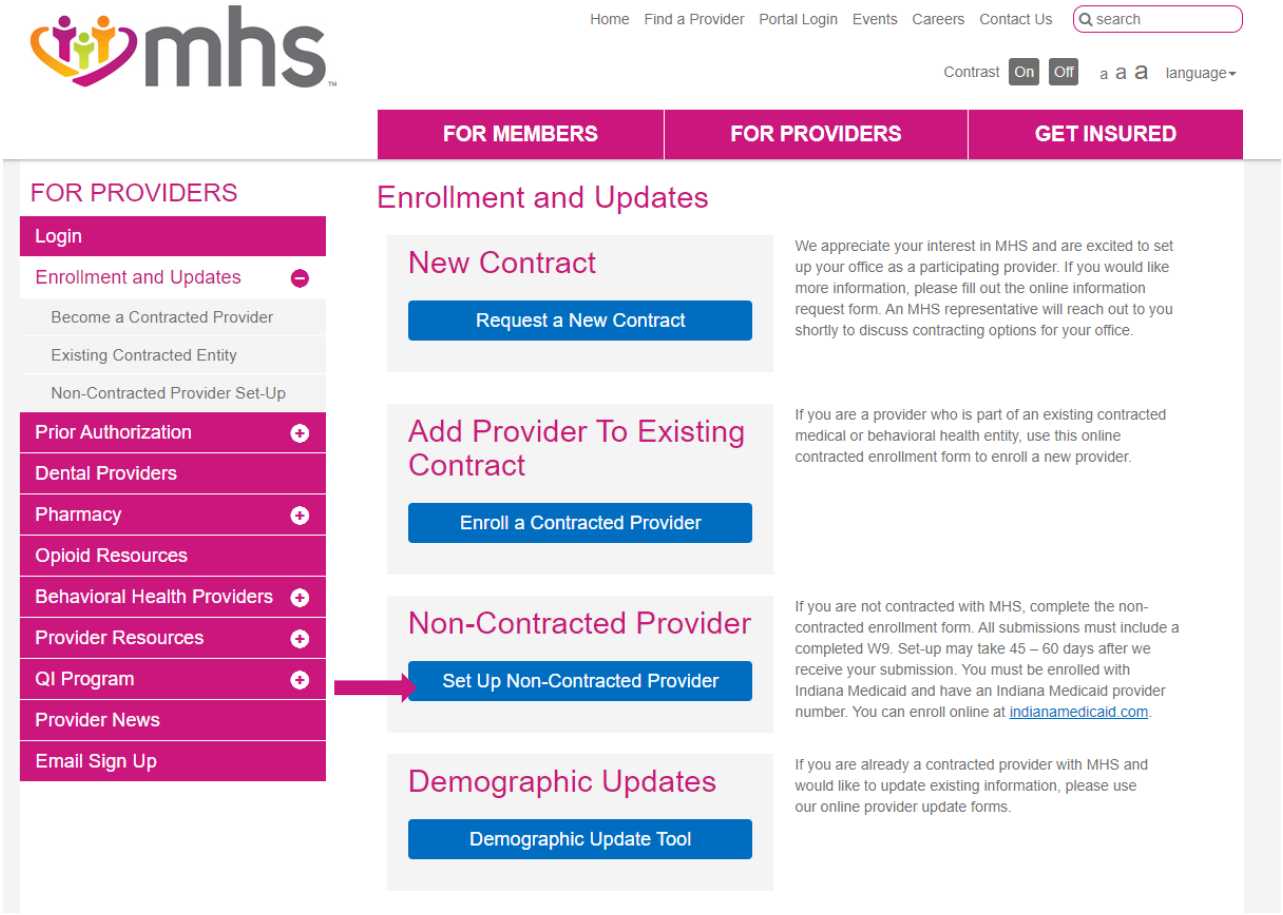


Non-Contracted Provider Enrollment

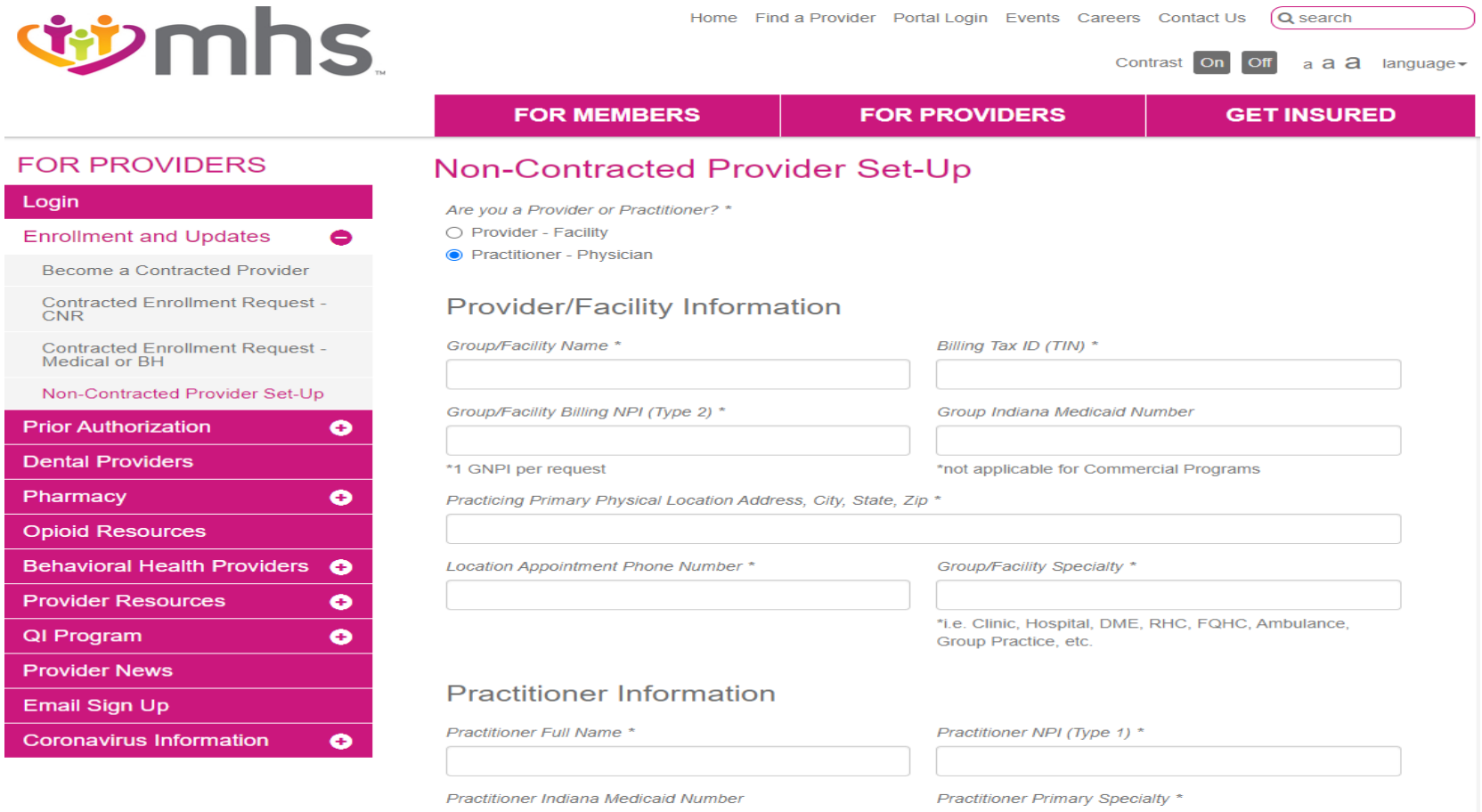
Non-Contracted Provider Enrollment

- If you are not contracted with MHS and do not wish to become contracted, complete the non-contracted enrollment form. All submissions must include a completed W9. Set-up may take 45 – 60 days after we receive your submission. You must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number.

Non-Contracted Provider Enrollment

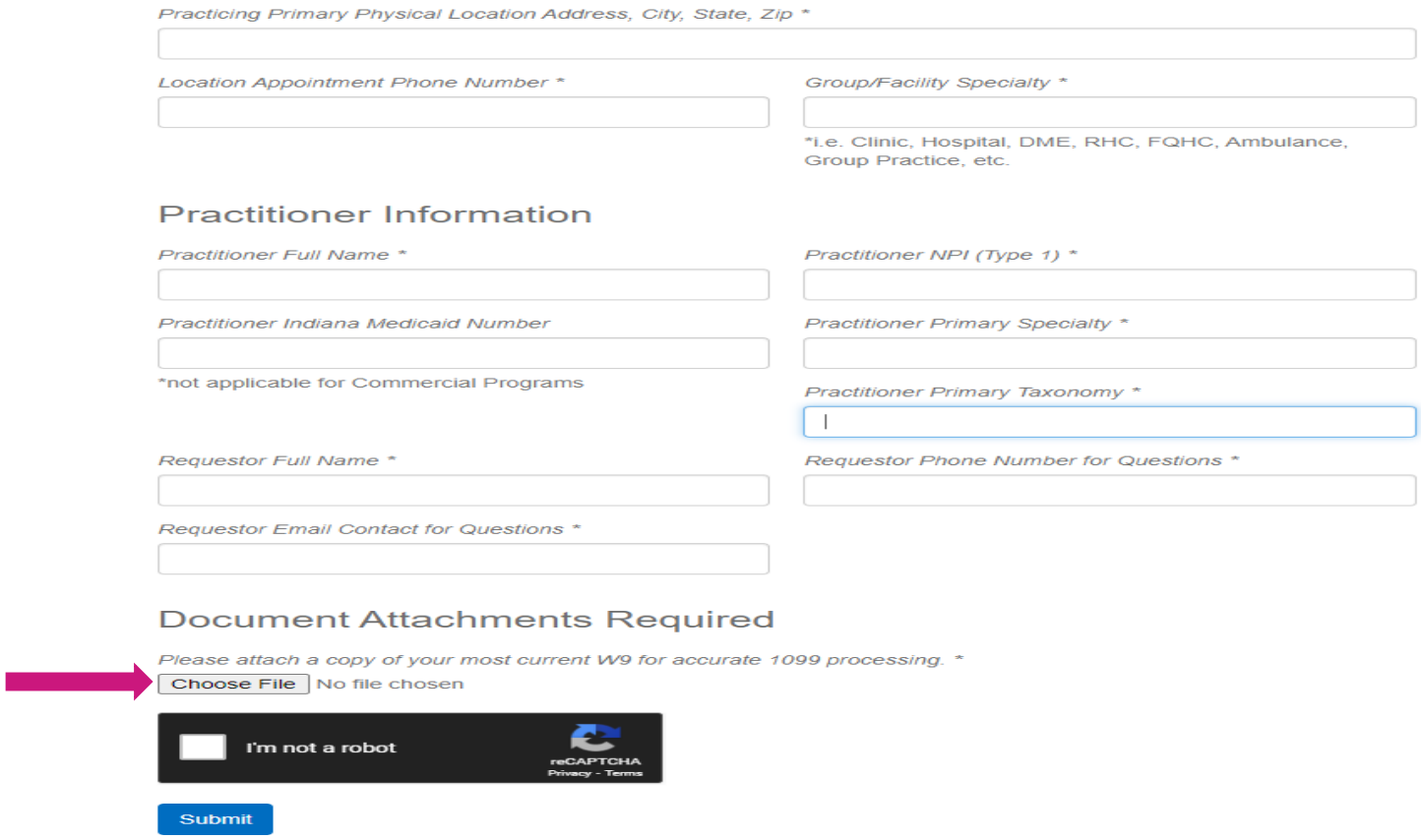


Non-Contracted Provider Enrollment



Non-Contracted Provider Enrollment

- Once the form is completed and you have uploaded the W9 Form, click Submit and this will be routed to the MHS Enrollment Team.

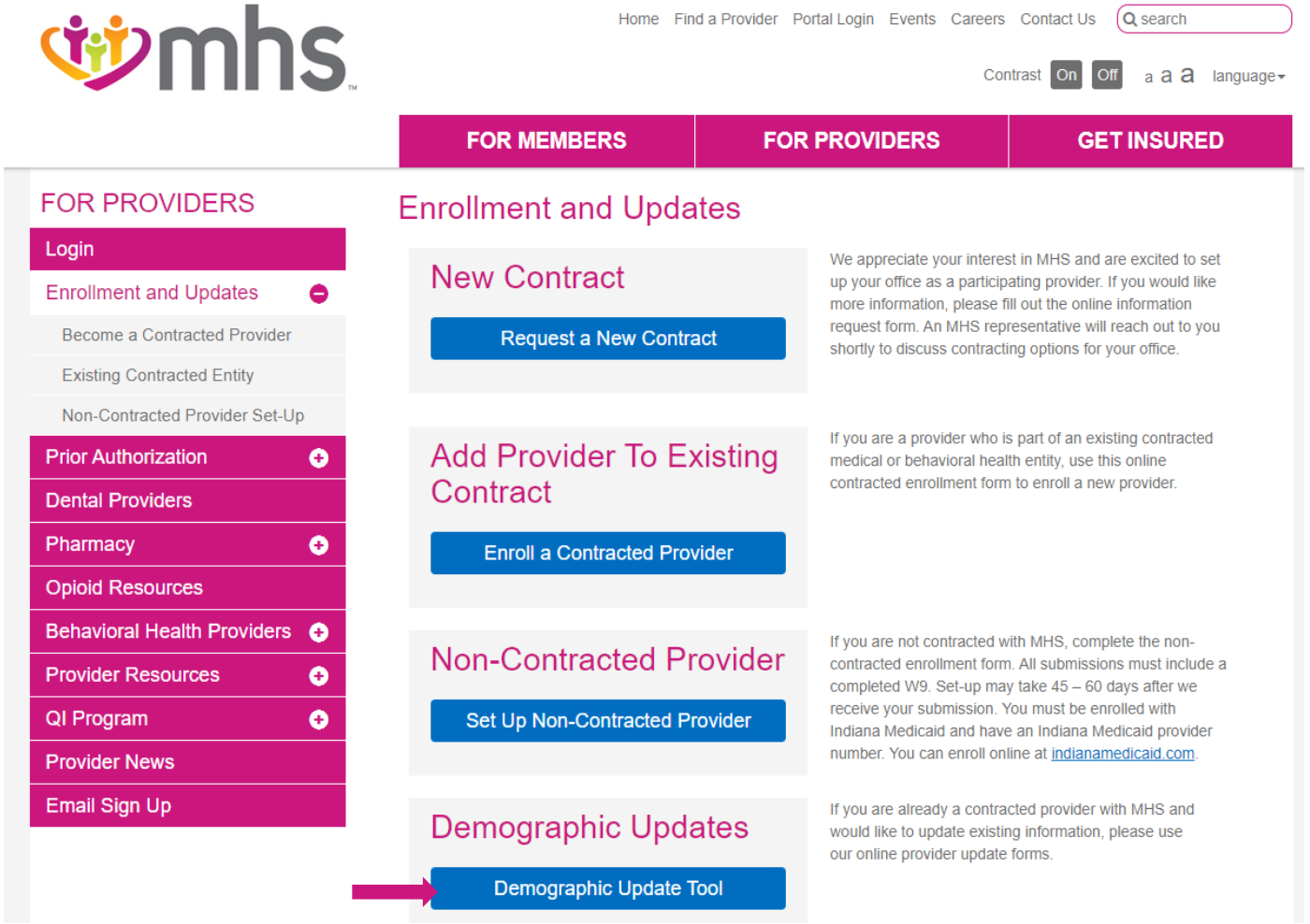


Demographic Updates

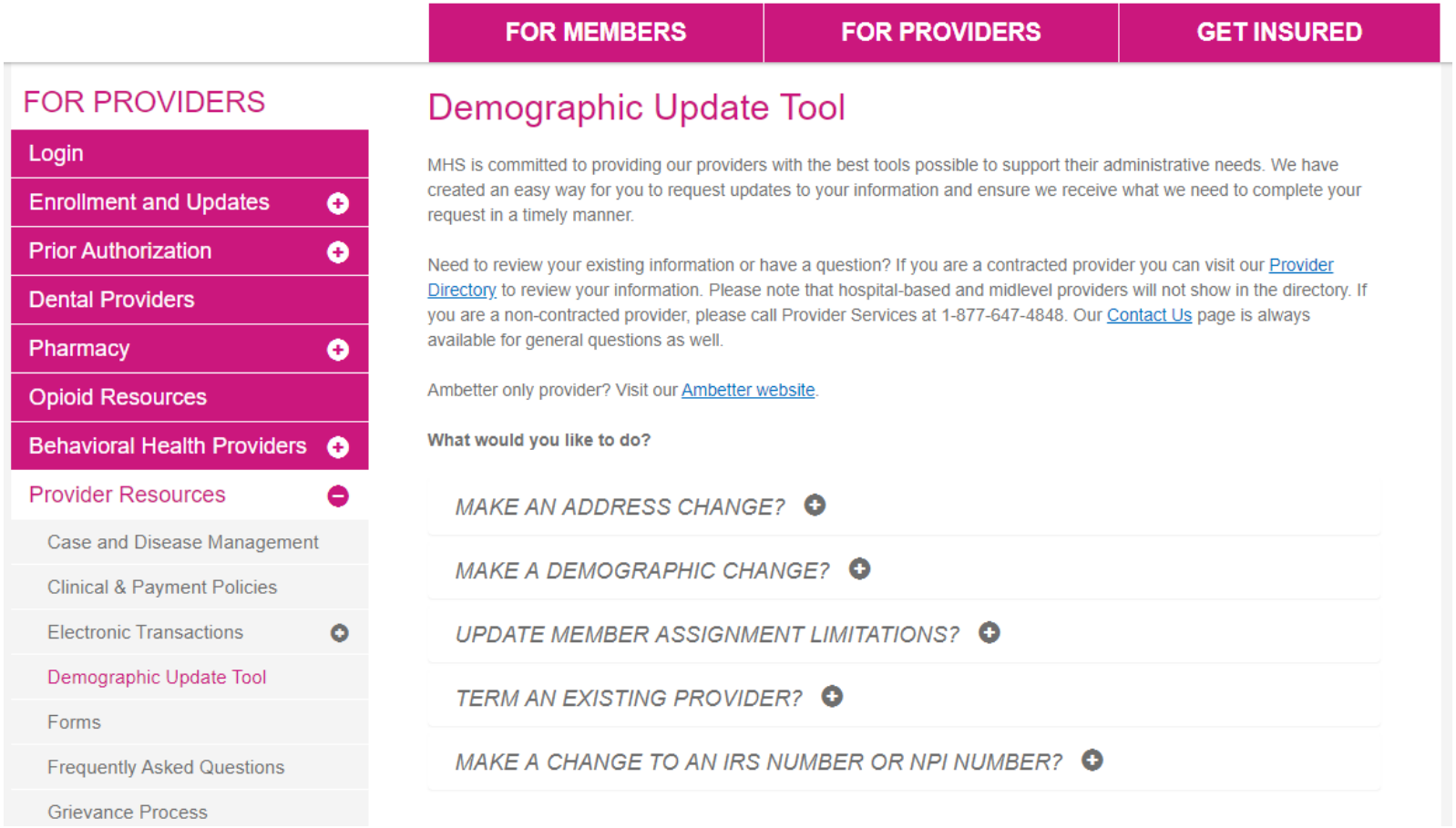
Demographic Updates

- MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

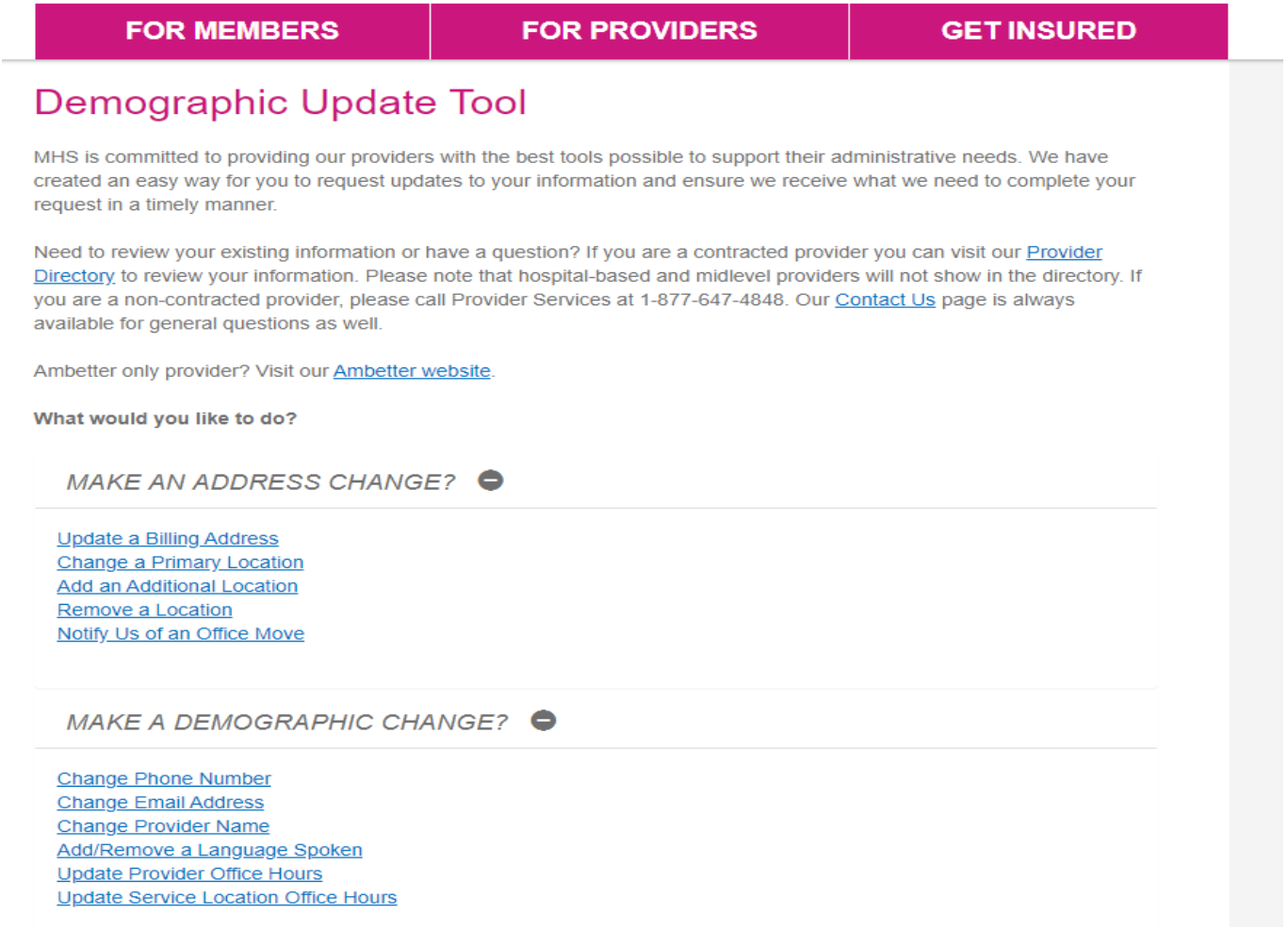
Demographic Updates



Demographic Updates



Demographic Updates



FOR MEMBERS | FOR PROVIDERS | GET INSURED

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our Provider Directory to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our Contact Us page is always available for general questions as well.

Ambetter only provider? Visit our Ambetter website.

What would you like to do?

MAKE AN ADDRESS CHANGE?

Update a Billing Address
Change a Primary Location
Add an Additional Location
Remove a Location
Notify Us of an Office Move

MAKE A DEMOGRAPHIC CHANGE?

Change Phone Number
Change Email Address
Change Provider Name
Add/Remove a Language Spoken
Update Provider Office Hours
Update Service Location Office Hours

Demographic Updates

UPDATE MEMBER ASSIGNMENT LIMITATIONS?

Change Accepting New Members Status
Change Panel Size (PMP Only)
Change Age Restrictions

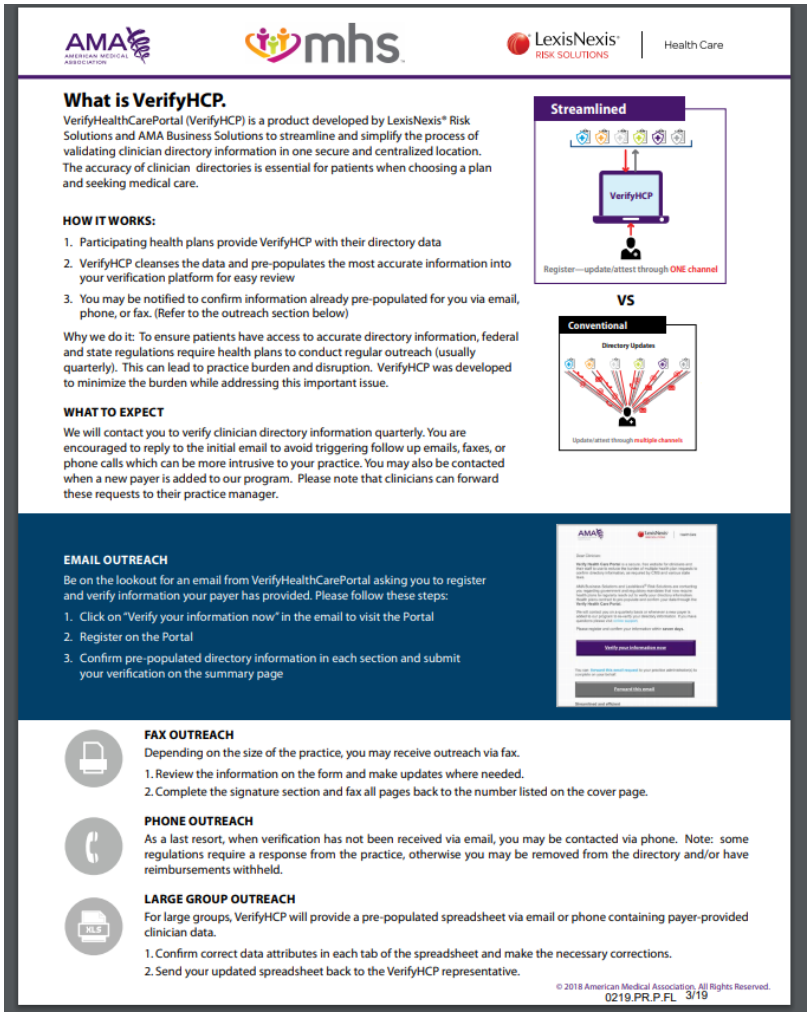
TERM AN EXISTING PROVIDER?

PMP
Specialist

MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER?

Change an IRS Number (TIN)
Change an NPI Number
Update an IRS Address

Demographic Updates



AMA AMERICAN MEDICAL ASSOCIATION | mhs | LexisNexis RISK SOLUTIONS | Health Care

What is VerifyHCP.

VerifyHealthCarePortal (VerifyHCP) is a product developed by LexisNexis® Risk Solutions and AMA Business Solutions to streamline and simplify the process of validating clinician directory information in one secure and centralized location. The accuracy of clinician directories is essential for patients when choosing a plan and seeking medical care.

HOW IT WORKS:

1. Participating health plans provide VerifyHCP with their directory data
2. VerifyHCP cleanses the data and pre-populates the most accurate information into your verification platform for easy review
3. You may be notified to confirm information already pre-populated for you via email, phone, or fax. (Refer to the outreach section below)

Why we do it: To ensure patients have access to accurate directory information, federal and state regulations require health plans to conduct regular outreach (usually quarterly). This can lead to practice burden and disruption. VerifyHCP was developed to minimize the burden while addressing this important issue.

WHAT TO EXPECT

We will contact you to verify clinician directory information quarterly. You are encouraged to reply to the initial email to avoid triggering follow up emails, faxes, or phone calls which can be more intrusive to your practice. You may also be contacted when a new payer is added to our program. Please note that clinicians can forward these requests to their practice manager.

EMAIL OUTREACH

Be on the lookout for an email from VerifyHealthCarePortal asking you to register and verify information your payer has provided. Please follow these steps:

1. Click on "Verify your information now" in the email to visit the Portal
2. Register on the Portal
3. Confirm pre-populated directory information in each section and submit your verification on the summary page

FAX OUTREACH

Depending on the size of the practice, you may receive outreach via fax.

1. Review the information on the form and make updates where needed.
2. Complete the signature section and fax all pages back to the number listed on the cover page.

PHONE OUTREACH

As a last resort, when verification has not been received via email, you may be contacted via phone. Note: some regulations require a response from the practice, otherwise you may be removed from the directory and/or have reimbursements withheld.

LARGE GROUP OUTREACH

For large groups, VerifyHCP will provide a pre-populated spreadsheet via email or phone containing payer-provided clinician data.

1. Confirm correct data attributes in each tab of the spreadsheet and make the necessary corrections.
2. Send your updated spreadsheet back to the VerifyHCP representative.

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- MHS has partnered with LexisNexis to assist with keeping our Find A Provider online directory current. It is very important to keep provider information updated and most current.

Provider Directory Requirements

Provider Directory Requirements

- Health plans/issuers are required to **establish a provider directory on their public website** that contains a list of providers and facilities they have a direct or indirect contractual relationship with for furnishing items or services under the plan.
- Additionally, plans/issuers are required to:
  - Establish the required verification process:
    - Verify and update the provider directory information every **90 days**
    - Establish a process to remove providers that are unable to be verified during a timeframe established by issuer
    - Make updates within 2 business days of receiving updates from a provider
  - Establish the required response protocol:
    - If a member requests information on whether a provider is in-network through a telephone call or electronic, web-based, or internet-based manner, the issuer must:
    - Respond as soon as practicable but **not later than 1 business day** after a request is received, through a written electronic or print communication (as requested by the member)
    - Retain communication in the member's file **for at least 2 years** following the response

Provider Directory Requirements

- **Effective date**: Plan years beginning on or after January 1, 2022
- **Impacted lines of business:** Group plans and individual market issuers
- **Mandates information to be included in directory**
  The following information must be included in the provider directory:
  - Name
  - Address
  - Specialty
  - Telephone number
  - Digital contact information on each health care provider or facility for which a plan/issuer has a contractual relationship for furnishing items and services
- **Print directory disclaimer**: With respect to a print directory containing provider directory information, a notification should be included that the information was accurate as of the date of publication and that members should consult the online database or contact the plan/issuer to obtain the most current information
- **State Preemption**
  The No Surprises Act does not preempt state laws related to healthcare provider directories.

Provider Directory Requirements

- Cost-Sharing for Services Provided Based on Reliance on Incorrect Provider Network Information

  If a member receives services from an out-of-network provider/facility, but received information through a provider directory or the response protocol stating that the provider/facility was in-network, **the member should not be responsible for cost-sharing beyond what they would pay if they had received services from an in-network provider**. In this situation, the in-network deductible or out of pocket maximum will apply.

- Disclosure on Patient Protections against Balance Billing
  EOB updates needed: Plans/issuers must make publicly available, post on a website, **and** include **on each EOB** the following in plain language:

  - The requirements and prohibitions on balance billing in the No Surprises Act and any applicable state laws that include requirements on providers regarding amounts they may charge a member for an item or service not covered under the member's plan
  - Information on contacting applicable State and Federal agencies if an individual believes a provider has violated any balance billing requirements

Credentialing and Re-credentialing

Credentialing and Re-credentialing

- The purpose of the credentialing and re-credentialing process is to ensure all practitioners and organizational providers initially meet and continue to meet the established criteria for participation in the MHS provider network. In order to participate in the MHS network, all licensed physicians, healthcare professionals and facilities must meet minimum requirements as set forth by MHS.

Credentialing and Re-credentialing

- The minimum requirements for participation in the MHS network are available in the MHS Provider Manual, Chapter 16.

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider_Manual_2020.pdf

Credentialing and Re-credentialing

- MHS requires practitioners to enroll with the Council for Affordable Quality Healthcare (CAQH).
- CAQH is a practitioner database website where practitioners can register their credentialing information for any and all organizations to which they want to apply.
- It is free to practitioners and is convenient because you only have to submit information to one place one time (and, of course, as it gets updated) rather than to each MCE, hospital or network you wish to join.
- It is also secure, as only authorized credentialing organizations may access your information with your permission.
- Please visit their website at caqh.org.

Credentialing and Re-credentialing

- MHS Credentialing will ensure the provider has met all federal and state regulatory requirements by reviewing the submitted information.
- Once the application is reviewed, the Credentialing Committee (CC) will render a final decision on acceptance within 60 calendar days.
- MHS will send the practitioner a letter notifying the practitioner if he or she is approved by the CC as well as identify the effective date the practitioner can begin to see MHS members.

Credentialing and Re-credentialing

- The MHS CC consists of MHS staff physicians and other physicians in the MHS network.
- The CC is supported by MHS Credentialing, Provider Relations, Compliance and QI staff.
- This committee reports regularly to the MHS Senior Executive Quality Improvement Committee.
- It has the responsibility to establish and adopt, as necessary, criteria for physician participation and termination, and to direct the credentialing procedures, including physician participation, denial and termination.
- Committee meetings are held once a month or as deemed necessary.

Credentialing and Re-credentialing

Re-Credentialing

- MHS conducts the re-credentialing process for practitioners and providers at least three years from the date of the initial credentialing decision.
- The purpose of this process is to identify any changes in the practitioner's facility, license, sanctions, certification, competence or other related information that may affect their ability to perform the services for which the practitioner or provider is contracted to provide.
- This process includes all practitioners (PMPs and specialists), ancillary providers and hospitals previously credentialed to practice within the MHS network.

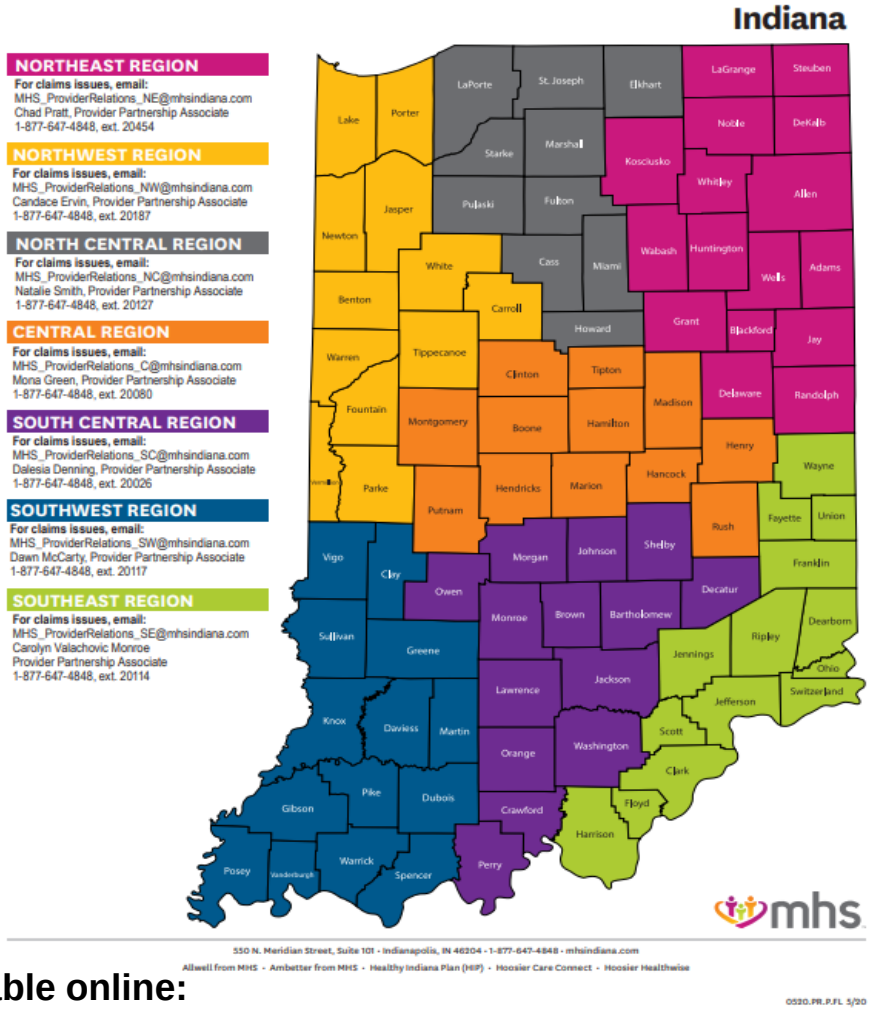
MHS Team

Provider Relations Regional Mailboxes

Regional Mailboxes

- Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
- North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
- Central Region: MHS_ProviderRelations_C@mhsindiana.com
- Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
- Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
- Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
- South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
- Tier 1 Providers: IndyProvRelations@mhsindiana.com

MHS Provider Network Territories



Available online:
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

NORTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
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NORTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION
For claims issues, email:
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SOUTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
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SOUTHEAST REGION
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Provider Partnership Associate
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MHS Provider Network Territories

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Provider Partnership Associate II
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tdanzie@mhsindiana.com

PROVIDER GROUPS

- Beacon Medical Group
- Franciscan Alliance
- HealthLinc
- Heart City Health Center
- Indiana Health Centers
- Lutheran Medical Group
- Parkview Health System
- South Bend Clinic

JENNIFER GARNER
Program Manager,
Provider Engagement
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PROVIDER GROUPS

- American Health Network of Indiana
- Columbus Regional Health
- Community Physicians of Indiana
- HealthNet
- Health & Hospital Corporation of Marion County
- Indiana University Health
- St. Vincent Medical Group

ENVOLVE DENTAL, INC.

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Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

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Yojani Benitez
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Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

Network Leadership

NETWORK LEADERSHIP

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Questions?

Thank you for being our partner in care.