**Physician-MCO Focus Group**
**Chicago, October 14, 2015**

**List of Issues/Questions in black**
**HFS and MCO Responses in red**

1. Is there a centralized formulary database of Medicaid Managed Care Organizations (MCOs) similar to the Medicaid Fee for Service on the HFS Website? Can those formularies be displayed side by side?

   All MCOs have their own formulary which is accessible on their own websites:

   - https://www.aetnabetterhealth.com/Illinois/
   - http://www.bcbsil.com/family-health-plan/
   - http://www.bcbsil.com/mmai/
   - http://www.bcbsil.com/icp/
   - https://www.ccaillinois.com/
   - www.countycare.com/
   - www.fhnchicago.com/
   - https://www.wellcare.com/en/Illinois
   - http://medicaid.healthalliance.org/
   - http://www.specialcareil.com/
   - https://www.humana.com/medicaid/illinois/icp
   - www.illinicare.com/
   - www.mhplan.com/il/
   - www.molinahealthcare.com/members/il

   We are not sure if a side by side display of various formularies can be arranged but will take that part of the question under advisement.

2. How can physicians be notified timely of patient plan changes?

   Physicians should check MEDI for member's most recent MCO. The Illinois Client Enrollment Services (ICES) sends eligibility files to HFS daily and it takes approximately 24 hours (may take longer over a weekend) to update the HFS system and MEDI. If physicians find that MEDI is incorrect, please notify HFS including details such as a print out of the MEDI screen.

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3. How can physicians get more frequent up to date information from care coordinators and care plans?

   Care coordinators should be sending care plans to the PCPs via provider portal, fax, or mail. If a PCP is not receiving those care plans or if the care plans are incorrect or inaccurate, the MCO Medical Director should be contacted:

   a. Aetna – Bruce Himelstein, MD, HimelsteinB@aetna.com
   b. BCBS – Anita Steward, MD, Anita_Steward@bcbsil.com
   c. CCAI – Tariq Butt, MD, tbutt@ccaillinois.com
   d. CountyCare – Elmer Abbo, MD – eabbo@cookcountyhhs.org
   e. FHN – Susan Oyetunde, MD, soyetunde@fhnchicago.com
   f. Harmony – Traci Ferguson, MD – traci.ferguson@wellcare.com
   g. Health Alliance – Robert Parker, MD – Robert.parker@healthalliance.org
   h. HealthSpring – Melanie Hunter, MD – Melaine.hunter@healthspring.com
   i. Humana – Neal Fischer, MD – nfesicher@humana.com
   j. IlliniCare – Angela R. Perry, MD – ANPERRY@illinicare.com
   k. Meridian – Cynthia Sanders, MD – Cynthia.sanders@mhplan.com
   l. Molina – Traci Powell – Traci.Powell@MolinaHealthcare.com

4. A recommendation was made to continue with regular meetings between physicians and the MCOs going forward, possibly with select topics.

   HFS will try and coordinate periodic meetings of physicians and MCOs and would be more than happy to participate in similar meetings organized by membership organizations or MCOs.

5. Providers would prefer a 'one-stop shop' of information for all MCOs in one place (possibly on HFS website) including PDLs, pay for performance info, patient panel roster, etc.

   HFS will discuss this with the Illinois Association of Medicaid Health Plans (IAMHP) to evaluate the possibility of a one stop shop approach.

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6. How can we address the problem of emergency room claims denials by MCOs?
    a. MCO representatives noted that all emergency room claims are mandatorily covered by law. Specific examples of denials should be presented to MCOs so they can determine the cause of those denials.
    b. Out of network emergencies are covered at the Medicaid FFS rate.

7. A health plan had notified physicians that because the state had not paid them, they would be unable to pay physician claims.

MCOs have a timely payment provision in their contract as follows:

Contractor must pay 90 percent (90%) of all Clean Claims from Providers for Covered Services within thirty (30) days following receipt. Contractor must pay 99 percent (99%) of all Clean Claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of this Section, a "Clean Claim" means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of the service or from a Third Party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee's admission to a NF, a "Clean Claim" means that the admission is reflected on the patient credit file that Contractor receives from the Department.

8. Claims are being denied for care of babies seen in the first 90 days who should still be covered under mother's MCO.
    a. MCO representatives recommended proactively reaching out to the MCOs for denied claims.
    b. Physicians requested that MCOs reach out to them proactively as well when patterns of repeated denied claims are recognized.
9. HFS systems seem to be creating some issues, and a recommendation was made that the department should be included in future meetings, and inquired as to how much HFS is willing to come to the table to make system changes.

It was noted that HFS is somewhat limited by legislation, but will continue to make efforts to improve the current systems within those restrictions. HFS understands there are system limitations and is in the process of updating its systems.

10. Travel distance for in-network referrals was raised, and an inquiry was made as to what mileage restrictions are in place.
    a. Mileage restrictions may vary per MCO. MCOs are responsible for transportation for covered services no matter how far the in-network provider's distance is.
    b. MCO representatives noted that there is a lack of some specialists to serve the Medicaid population. MCOs do actively recruit physicians, but requested that if PCPs know of a specialist who is not with a patient's MCO, they recommend enrolling that specialist. A comment was made that physicians may not want the hassles of signing up for additional plans, and MCOs should ease the process of enrolling.

11. An inquiry was made as to whether MCOs have reviewed the HFS Healthy Kids Handbook as claims for required services have been denied.

    MCOs have access to all HFS handbooks and should be familiar with the Healthy Kids Handbook. If providers run into such a situation, please contact the provider relations department of an MCO. Provider relations contacts are on the HFS website at:
    http://www2.illinois.gov/hfs/SiteCollectionDocuments/ContactListAllMCEs.pdf

12. Can APNs, NPs, PAs and Psychologists carry their own panels?

    MCOs are allowed to follow the same guidelines as the Medicaid FFS for their panels. PAs and Psychologist are not enrolled with the Department. States allow Advanced Practice Nurses (APN) who are licensed as a registered professional nurse, hold a valid license in the state of practice and is legally authorized under state law or rule to practice as an advanced practice nurse, so long as that practice is not in conflict with the Nurse Practice Act [225 ILCS 65], the Medical Practice Act of 1987 [225 ILCS 60], the Podiatric Medical Practice Act of 1987 [225 ILCS 100], the Dental

Practice Act [225 ILCS 25] and implementing rules is eligible to be considered for enrollment to participate in the department's Medical Programs.

Categories of APNs include:

a. Certified Registered Nurse Anesthetist (CRNA);
b. Certified Nurse Midwife (CNM);
c. Certified Nurse Practitioner (CNP); and
d. Clinical Nurse Specialist (CNS).

13. Could general guidelines on performance incentive information be provided?

    This is specific to each health plan; however, it should be included in the contract MCOs have with their providers. If there are any questions please contact health plan directly. Meetings and trainings are typically provided by the MCO provider services. This information cannot be shared publicly due to antitrust concerns.

14. Credentialing is sometimes lengthy and difficult and is different for each MCO. Could a grace period be offered as HFS has?

    Due to NCQA accreditation, credentialing cannot be backdated; however MCOs do have workarounds in place such as provisional credentialing. CAQH is the preferred system for submitting credential paperwork and can greatly ease process.

15. County Care has stopped credentialing providers for a 3 month period, what can be done in the interim?

    The pause in credentialing is temporary and due to a back-office upgrade which will greatly improve the process going forward. While this is occurring, County Care has said they can work with individuals on a case-by-case basis.

16. Physicians are still seeing underpayment on some claims which are being paid at the previous rates?

    Some health plans were late changing their internal systems and are working to address underpayments.

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17. Billing is being done on two different systems; please clarify why this is the case.

    APL should bill on UBO40, Non-APL on CMS1500.

18. Inpatient addiction services are not being covered, or covered as observation only.

    Inpatient addiction services are covered by the Medicaid health plans. If providers are experiencing problems getting the health plans to cover these services, the Department can look into the issues but will need examples (member names, recipient identification numbers, dates of service, procedure code/service provided, and health plan(s) involved).

19. There have been difficulties finding placement for hospital patients such as post-acute care. Some patients are reaching the in-stay hospital limit and still have not found placement. As a result, claims after the max period are being denied. Who is responsible for covering these claims?

    It was recommended that in these cases, physicians contact the health plan who have discharge specialists and can assist in finding a placement for the patient.

20. What is the next step if the MCO covered formulary drug is known not to be effective for patient?

    If a drug is not known to be effective, the provider can request a different drug in the same class. It may require prior authorization.

21. How does mental health parity law apply to MCOs?
    a. Mental health parity does not apply to Aces and CCEs, however as those plans are in transition to an MCO partnership or MCCN, parity will apply after the transition.
    b. Parity is based on percentage of the HFS Medicaid rate, a minimum rate of 100% of Medicaid rate is in compliance.

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22. There is a concern that behavioral health is not being integrated with medical care.

    Some health plans have a model that includes integrating behavioral health specialist into a medical home. Several health plans have contracted with FQHCs that have behavioral health services integrated.