HFS - Behavioral Health Providers and MCOs Meeting in Springfield
-Meridian Health Plan Responses

Topic	Vendor	Issue/Question	Answers
Audits	ALL MCOs	Where can we find your auditing policies and does it include interpretive guidelines?	Meridian Health Plan audit requirements are outlined in individual provider contracts.
Billing	All MCOs	MCO paper remittances vs Electronic remittances – this is a huge imposition and requires enormous staff time. What is MCOs doing to offer electronic remittances?	If this is happening with Meridian Health Plan claims, please reach out to provider representative to address this issue. The Payer Id # for the Contracted Vendors is: 13189. Electronic remittances can be processed through our provider portal.
Billing	Meridian and Molina	We would like an 835 return file for larger payers (that do not currently provide it). What is your reason for not offering this or are you in the process of developing it?	Meridian Health Plan makes EFT and ERA available. Please contact your provider representative for more details on this.
Claims	HFS	We would like all payers to have the same submission timeline as IHFS/IDHS (180 days). Is this possible?	
Claims	Health Alliance	Health Alliance is still requiring paper claims which cause unnecessary administrative work. When will Health Alliance improve its system to accept electronic claims?	
Contracts	All MCOs	If a consumer has an MCO and moves to a non-MCO county, what happens? Do they stay on the MCO? This is an issue because we have facilities in MCO communities and outside them	Meridian Health Plan can only have members assigned in their service area.
Credentialing	ALL MCOs	Where can we find your credentialing criteria?	Initial credentialing is done using CAQH. Please contact your provider representative for details. Meridian Health Plan requires credentialing every 3 years..
Customer Service	ALL MCOs	Is there a provider advocate, above the front line staff, that we can call if needed?	Kim Gallaher Colleen Dore
Enrollment Process	HFS	Providers spend prolong periods of time trying to find out who people are enrolled with. What would HFS recommend providers do to help people find out who they are enrolled with?	

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Enrollment Process	HFS	I find it difficult to correctly identify what insurance carrier is handling a member/patients' plan. Members have 90 days to change their plan after being auto or voluntarily assigned a plan. I have seen members in plans for 30 days and even 1 day – that is very hard to track. It can take up to one hour to find information on one client. We Checked Medi, Automated Voice Response System, Connex, and Advantage plan and still did not get an answer to what plan a patient is enrolled in for all dates. Medi provide basic info like the client has dual coverage. However, many times it doesn't show which plan is handling the member's benefits. Also, info is received in 3 months date range only, requiring several checks for one client to find out when the client's plan changed. What can be put in place to address the issue?	
Manuals	All MCOs	What resources are available to learn the policies and procedures of each MCO? A manual online?	Meridian Health Plan website is www.mhplan.com

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Medications	Molina	Our psychiatrist sees MCO clients in St. Clair County. He has a concern with Molina and their medications rules; here is his complaint… He prescribes antipsychotic medications for schizophrenic and other clients in need. When these individuals moved from fee-for-service Medicaid to Molina managed care he was told by Molina that he could not keep them on their existing drug, Latuda. They said he needed to use Step Therapy and that he must move these individuals to step one drugs. The step one drug is Risperdal. The physician does not want this drug to be used for two reasons: it has side effects including breast enlargement in males, and there are numerous lawyers trolling for patients on Risperdal so they can file lawsuits on their behalf. If after four weeks the client fails to benefit from Risperidal, then he must move them to Seroquel or Zyprexa. He does not want to use these drugs because both are associated with weight gain and his clients are for the most part African Americans with high blood pressure and perhaps diabetes. If clients fail on these drugs then he can move them to either Invega or Latuda. Apparently Latuda is on the Medicaid formulary and this is his drug of choice for these clients. These are established clients that he had on Latuda for a reason and Molina wants him to move them to other drugs with known problems. When he told them he had tried some of these clients on the step one or two drugs before and they did not do well, Molina told him they have no records of that, too bad. He must prove that the client has failed on these drugs, it's not good enough to just use the rational that these drugs are poor choices based on the characteristics of the client or based on their past treatment history pre-Molina. To argue this through with each case is very time consuming and his time and that of the nurses who assist him is limited.	

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Medications	All MCOs	In regards to medication – in many cases the doctors are choosing to go with older antipsychotics that are cheaper and have less likelihood of major health issues for the patients – weight gain; diabetes; heart issues. However they are not approving the medication that counteracts side effects even though the two drugs are known to work best in conjunction, for instance Prolexin and Cogentin – so Cogentin gets denied and we have to have staff spending time to call for appeal (these drugs combined are considerably cheaper than the newer atypicals). What is the reasons for denying this medication?	This sounds like a specific case and should be addressed with the MCO directly. Faxed to MeridianRx at 855-580-1695 for PA forms. In emergency situations, please phone MeridianRx at 855-580-1688, and report the urgency so that PA can be processed immediately. MHP Formularies are on MHP website, www.mhplan.com
Medications	Molina	We recently were told that upon denial of a medication that it was not approved – not in Molina's formulary (we don't have and haven't been able to locate their formulary to even know what options are available) and previously we had been told the doctors would have up to 90 days to make a transition to another drug. When our staff person pressed they were told well that is the way we had been doing it but we changed our procedure. Staff person said they were unaware of this change and shouldn't we be informed before something like this went into effect, MCO staff said she had a point but still denied the claim. How can we be held accountable for procedures/protocols that have changed without our being informed in advance? What is Molina's process in informing providers of policy changes? Also, where can we find your formularies?	
Labs	Molina	Some providers who have primary care clinics embedded within their agencies and who provide laboratory services are required to send their patients outside to local hospitals for lab work. This policy means that a majority of our clientele we will need case managers to get them to the hospital labs to ensure they labs get drawn. This policy does not seen to be cost effective for the patient, Molina and the providers. What are Molina's reasons for not using these labs within agencies if it will reduce everyone's cost and add to patient satisfaction?	

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SASS	ALL MCOs	For SASS what are the standardized assessments that will be required? Will that be changing moving forward? Can we arrange a secure upload site or portal to e-mail SASS screenings on weekends? We cannot fax on weekends due to the nature of our communities, and the fact that screens are performed far from our offices and fax machines. For SASS, do the MCOs have the same age guidelines as those we currently operate under? Are the MCOs planning to contract CARES? Who is and who is not? If not, what is the plan of actions – how will it work? If they are contracting with CARES – will they be giving RIN #'s still or any form of authorization #? What about eligibility dates? How long will they be covering a SASS consumer for services? Are eligibility dates going away since Medicaid covered services provided after the 90day SASS coverage when needed? When we have a walk in consumer who needs a SASS screen do we (MH agency) call it into CARES like we always have in the past with Medicaid or do we need to call the MCO? Some MCO's seem to be going back and forth with this. If the above answer is that we need to call the MCO's then what number do we call and what about after hours? What is their solution to transportation? Seems that some may be working on contracts with specific organizations for transportation? What are the official contact numbers for after hours for the MCO's? Or do they not have an afterhours contact for SASS agencies? Sometimes we receive instructions from the MCO's to call specific numbers with final dispositions but when trying to contact those numbers they are non-working during after hours. It would be good to have a list of Q&A's from each individual MCO for future references.	Meridian Health Plan follows the same CSPI assessment that the state of IL is requiring. Meridian Health Plan has the same age requirements for SASS, provides transportation and follows the same billing codes as the State of IL. Upon calling SASS agency for a screener, we provide the SASS agency with dates of eligibility/auth #, crisis situation, and demographics on member.

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Psychiatry	ALL MCOs	Some of the MCO's contracts indicated you may not subcontract services. Does this mean all psychiatrists must be employees of the provider agency? Can you use contractors who work at your site? Can you use a locum tenens to fill needed psychiatry time?	All contracts are negotiated between provider and Meridian Health Plan.
Psychiatry	ALL MCOs	What are the plans to increase reimbursement rates for psychiatric benefits to reasonable rate rather than the community agencies absorbing these costs?	All contracts are negotiated between provider and Meridian Health Plan.
Rule 132/2090	ALL MCOs and HFS	We understand that your behavioral health benefits are to be inline with Rule 132 and Rule 2090 services. Is every MCO required to offer these services and are all MCOs using the same behavioral health benefits and where can providers get a list of them?	Meridian Health Plan does cover Rule 132 services and Rule 2090 services.

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Utilization and Authorization	Health Alliance	Health Alliance has a repetitive pattern of approving only 14 days in detox and rehab together. They have said on numerous occasions that detox and rehab are "not differentiated", hence the approval of "14 days in detox and rehab". After 14 days, they require a "peer to peer" review with doctors (. Their doctor is quite condescending and will sometimes call me doctor when I continuously state I'm not a doctor. They will inquire about issues and make comments that are irrelevant to requesting further days in rehab, such as noting that our "agency is enabling the client" . When we have these Peer to Peer reviews, it can be 2-5 days later we are told by the Health Alliance contact that we were denied additional days due to the rehab not being medically necessary so we are not paid for the days/nights of care provided and denied. There are a couple issues here: There seems to be a set policy of offering only 14 days of detox/rehab. National research and best practices indicate higher adherence (less relapse with longer care – 30 days) and the MCOS are only authorizing 8-14 days for detox and rehab the likelihood for relapse is quite high – which poses issues from an ethical standpoint and perhaps even a compliance concern – putting someone in a level of care that is more costly and which they will not be able to get enough coverage to potentially address the issues (similar to knowing a standard course of treatment for a particular disease is say 14 days of an antibiotic but you only are given 7 days worth and as a result the person still has the illness). There are also liability concerns with then discharging someone before he/she is stable – we have many individuals that have dual disorders mental illness and SA. We urge you to reconsider this policy? Is Health Alliance aware of the fact that their contracted or outsourced "Peer to Peer" organization (Prest Associates) are rude, unprofessional and does not appear to be following "medical necessity" when making continuing care decisions? Please see example below: (under Utilization and Authorization)	

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Utilization and Authorization	Health Alliance	**Example:** **Patient- Bipolar D/O, GAD, Alcohol Dep, Opioid Dep, Cannabis Abuse; Hx of eating fentanyl patches, IV drug user. Drug use since age 17.** **Peer Review:** Peer Review doctor contacted provider and asked how client was doing. Clinician noted that client is still struggling with anxiety, depression, and addiction issues. Writer noted that he was checking medication and providing this to another client and both were on the cusp of being terminated, but due to the nature of their illness, they were given the opportunity to be placed on a behavior contract and if one term of the contract was not followed, they would be discharged immediately. Peer review doctor inquired as to why the police were not contacted for consequences and also noted that it sounded like the agency was only enabling his behavior. Clinician noted understanding this and identified that this client was very ill and it comes with the nature of his disease, noting that the client is well aware of the consequences he will face if he does not follow his contract. Peer review doctor reported that he would provide this information to Health Alliance and they will contact me if further days are approved or denied. Next day, Health Alliance staff left a voice mail reporting that the Dr from the peer review deemed Jeff's stay at Heritage "medically unnecessary" beginning today. The patient is still unstable.	
Utilization and Authorization	All MCOs	Are MCOs using the ASAM placement criteria? If not, What placement and continuing care criteria are being used for patients with a substance use conditions?	Meridian Health Plan follows Medicaid guidelines, and utilizes Mihalki Medical Necessity Criteria and ASAM criteria to determine medical necessity.
Utilization and Authorization	ALL MCOs	Where can we find all MCOs' appeal process on authorization?	Meridian Health Plan has these details in our provider orientation packets and when a denial is issued a letter is sent. The appeal process is also detailed in the letter.

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Utilization and Authorization	Meridian	Molina has an online form for pre-authorizations for residential group homes; Meridian does not. Can there be a pre authorization, in writing, for Meridian? A verbal authorization is hard to substantiate after the fact.	Meridian Health Plan does have an authorization form online that can be utilized and we are working on developing a BH specific authorization form. Authorizations can be completed on provider portal, over the phone, and via fax.
Utilization and Authorization	ALL MCOs	If the MCO does not have 24 hour/7 day a week prior authorization capabilities – how are we to handle prior auth of an off-hours admission? We do not want to admit someone in the evening/overnight/over a weekend only to get a retro denial of the admit on the next business day. Especially, IP SA detox and Crisis admits.	Meridian Health Plan BH provider line is 24/7/365