

QUESTIONS/ANSWERS
FROM TOWN HALL MEETING ON MEDICAID MANAGED CARE
Thursday, January 24, 2013

I. Services/Consumer Rights

- 1) What will happen to the Home Services Program? Will consumers still be able to hire and fire their own personal assistants?

All Medicaid clients enrolled in managed care who qualify for the Home Services Program will continue to be able to hire and fire their own personal assistants. The State believes in consumer-directed care.

- 2) For home-based service waivers, are members enrolled in an ICP with developmental disabilities included in Phase II?

Persons with developmental disabilities will not be enrolled in long-term supports and services (considered Phase III) until 2014.

- 3) Can consumers opt out of these programs and use their Medicaid benefits without Managed Care? If not, why? Where is the right to choice?

The Integrated Care Program is mandatory for Medicaid clients who reside in the affected areas. It will be mandatory in other areas of the state as coordinated care/managed care is rolled out. Consumers will the right to choose between different plan options and can switch plans during the first 90 days of enrollment and annually during open enrollment.

- 4) Please define who is dual-eligible and who establishes the combined Medicare-Medicaid rate.

For purposes of the Medicare/Medicaid Alignment Initiative (MMAI), a dual eligible is someone who is eligible for full Medicaid benefits (not through spend down) and who also has Medicare Parts A&B. The rates have not been set yet.

- 5) Does a consumer have the right to appeal the number of hours of home care in the service plan (as consumers currently can in HSP)?

Consumers retain all current appeal rights and gain the right to first appeal through an internal MCO appeal process. For acute medical services, consumers can also appeal a service denial to an external independent review organization certified by the Department of Insurance.

- 6) How do you ensure that sign language interpreters are provided for primary care?

ADA regulations apply to healthcare providers regardless of whether a person is in an MCO or not. ICP health plans are also contractually required to provide ASL interpreters during key face-to-face oral contacts and to ensure that consumers have primary care providers that are culturally and linguistically appropriate.

- 7) Many deaf people had a difficult time reading the material for open enrollment and it wasn't until after the fact that they realized that they didn't have the choice of their primary doctor and it's too late to change until next open enrollment. How do you ensure they have access and understanding of materials?

First, consumers have the right during the first 90 days of enrollment to switch plans. Second, consumers can switch their primary care physician (PCP) within the plan every month. With respect to the communication of choice information: written material is reviewed by the Department's Consumer Education Subcommittee of the Medicaid Advisory Committee to try to ensure it is clear and understandable. The written material directs consumers to call the Client Enrollment Services Contractor to enroll. The consumer service representatives at this number can more fully explain the program and the consumer's choices, including ensuring a desired PCP is in the plan selected. Client Enrollment Services has a TDY number.

- 8) To MCOs: How do your plans address the needs of Medicaid clients who speak a primary language other than English?

From Aetna Better Health (ABH): it currently uses a translation service "Akorbi" for over the phone and in-person translation needs. "Akorbi" provides translation services for a vast number of languages for their members. For Waiver services, ABH is contracting with existing DRS and Aging Homemaker agencies that have been providing caregivers in the members' native language. This group of Homemaker Providers includes the CLESE group of providers. In addition, ABH is working to procure a contract for CLESE to provide in-home translation services for the LTSS Case Managers as they have been doing for the Department on Aging. These efforts are to help minimize disruption to the member, keep their caregivers who speak their language in place, and provide translation for accurate assessments to ensure the Plan is meeting the member's needs.

All ABH members have the right to receive information in the language of their choice. Printed member information is available in English and in Spanish and information can be made available in alternative forms (i.e. large print, braille, audio cd, etc.) upon request. Additionally ABH provides Interpreter Services for member free of charge. These services include language interpretation, sign language and tactile interpretation. Language Services can be arranged by contacting their Member Services Department at

1-866-212-2851. The plan has hired care coordinators who are fluent in languages other than English. The Plan also has a translation service it uses to support members in their interactions with their providers and the Plan.

- 9) Are pharmaceutical services covered by managed care? Do clients have to go to a pharmacy that's in a specific managed care network?

Pharmaceuticals are covered by the MCOs and consumers must go to a network pharmacy. However, all plans have open networks allowing all pharmacies to join.

- 10) How will you ensure that people with disabilities have a voice in determining the services that consumers will get? And how those services will be delivered? What role will centers for independent living have?

Consumer self-direction is a guiding principle of the reformed health care delivery system. MCOs have consumer advisory councils that have CILs represented on them. The advocacy role of CILs will not be diminished by managed care.

- 11) In promoting independence, will the MCOs provide peer services, programs, supports? Does the MCO "person-centered" model contemplate that the person will partner with providers in development of care plans?

MCOs are philosophically committed and contractually bound to consumer participation in care plan development. The MCOs are discussing peer services with CILs.

- 12) For the State and MCOs: how is this transition being communicated to the Hispanic community?

Written materials are provided in Spanish. MCO and Client Enrollment Services have bi-lingual operators.

- 13) Is there going to be geographic overlap between ICP and the dual-eligible program? How will that be handled? Will there be clients who will not be in managed care, i.e., Medicaid only in Chicago.

Yes, ICP and MMAI will have significant geographic overlap initially and complete overlap when ICP moves into Chicago next year. Medicaid only clients in Chicago will not be mandated into managed care until 2014.

- 14) Clients from the former Soviet Union who are on Medicaid Part B only and Medicaid have been considered Dual Eligible up to this point. Will they no longer be Dual Eligible? Will they have to be in the Medicaid-only MCO system?

Individuals without Medicare Part A are not eligible for the MMAI demonstration, but remain eligible for Medicare Part B coverage in the Fee-For-Service system.

15) Will the state revise First Transit?

Each MCO will be responsible for scheduling and approving non-emergency transportation. They may contract with First Transit for these services or with other companies.

16) Currently, ILHIE Direct is not compatible with Explorer 9. Is this being addressed for providers that have more recent versions of Explorer?

The ILHIE Direct web portal is compatible with Explorer 9. Please contact the Illinois Health Information Exchange (ILHIE) for technical assistance.

17) Are emergency services required to remain in network?

No.

18) Will the MCOs formularies be the same or different from the existing Phase I formularies?

Nothing about Service Package II should change the MCO formularies.

19) Since the desired and documented outcome is “improved health”, what specific services will HMO’s provide to address spiritual, recreational, political and community well being? We’re only been told of plans for physical and mental health.

All the same services covered by Medicaid today will be covered by the MCOs.

20) Will the State or MCOs continue to partner with the disability community to deliver peer support?

MCOs are in discussion with the community on how to partner to deliver these services.

21) What if a needed behavioral health and substance abuse service doesn’t exist or serve an area covered by the MCOs or, later, by other managed care entities (MCEs) in other regions? Or the capacity of provider is inadequate to meet BH/SA treatment needs of clients? Will the coverage of medical services or pharma vary at all within various management entities or all through HFS directives?

Lack of capacity in the community for certain services is a problem the state is acutely aware of and is working to address. All Medicaid covered services are covered services

under the MCO contracts. Utilization policies may differ among plans and be different than the state's policies. Plans are working together to be as uniform as possible.

22) How do these changes affect recovery homes and substance abuse treatment?

Service Package II does not change substance abuse services, which were included in Service Package I. Service Package I caused providers to begin billing the MCOs and working with the MCOs on service plans and authorizations.

23) Will local DHS offices be required to use ILHIE?

DHS offices will not use ILHIE. ILHIE is intended to allow for the exchange of clinical records among healthcare providers to be able to provide the best possible treatment and clinical care to patients. DHS offices are not involved in the clinical care of Medicaid clients.

24) How will HFS and the MCOs participate in compliance with the Ligas/Williams consent decrees? MCO's will conduct assessments-is this redundant with assessments required by the consent decrees and contractors who are executing them?

HMOs are responsible for honoring the care plans developed by the Williams contracted providers and paying for covered services in those plans. In addition, MCOs provide comprehensive care plan development focusing on the consumer's entire needs, including the extremely high incidence of serious physical health co-morbidities. These more comprehensive assessments are not redundant.

25) Will IMDs be included in Phase II? If so, will Chicago IMDs also be included?

Yes, IMDs in the ICP service area are included in Phase II. Chicago IMDs will not be included until 2014.

26) How will waiver services coordinate with Title III, Older Americans Act services? Will two separate assessments be necessary one for waiver and one for Title III? Who will complete assessments and who will pay for those?

MCOs will be required to make referrals to non-waiver services such as Title III Older Americans Act services when those are needed. The plans will make those referrals directly to the Title III providers and will be responsible for ensuring that these providers have the information they need to initiate services for the client.

II. Provider/Plan Relationships

27) What are the plans to coordinate between providers and MCOs to ensure seamless transition?

A list of current Service Package II providers has been given to the MCOs so that they know who is serving a consumer at the time of transition of those services to managed care. The MCOs have been given current service plans and have pre-authorized those services. During a 180 day transition period current service plans will remain in place unless a change is agreed to by the consumer.

28) How are providers going to know which of their customers are going to receive their services through the Integrated Care Program? When will providers begin receiving authorizations from MCOs for active customers?

All current eligibility verification systems indicate MCO enrollment. Further, plans have been given current waiver service plans, including current providers. Plans are reaching out to providers and authorizations have already been put into their systems.

29) What system is in place for consumers to review their electronic records to find and correct errors and omissions?

Consumers have access to their own records at the health plans through an on-line consumer portal and may request any corrections in those records they think are appropriate. Consumers also have a right to see their medical records at their providers' offices and correct those records.

30) When a member shows up for behavioral Health or Substance abuse services, will the provider call their case manager for approval or just render services based on assessment findings?

Members can self-refer for substance use disorder treatment and mental health treatment. For providers participating or contracted in the Aetna Better Health (ABH) network, prior authorization (PA) requirement is determined by the code used to bill the service. No Rule 132 services require prior authorization at this time for participating/network community mental health centers. Non-participating providers need to prior authorize all services. Prior authorization is performed by the PA/Utilization Management team, not Case Managers/Care Coordinators.

31) Are there plans to work with providers (and DCEO) to identify current workforce capacity and skills and proactively develop training/retraining programs to meet the needs of Integrated Care?

Yes. The Governor's Healthcare Reform Implementation Council has established a workgroup on workforce development, chaired by Dr. LaMar Hasbrouck, Director of the Department of Public Health.

32) How does the ICP Program plan to manage utilizations (brand vs generics)?

Aetna Better Health's formulary is available on its website. It affords providers access to a wide range of drugs. Where clinically effective, they substitute a generic equivalent drug on their formulary if an "A" rated generic equivalent is available. Lower cost drugs are selected only when their clinical benefits for a substantial group of patients are established as equal to, or better than, other agents in the class.

33) Will the managed Medicaid organizations be required to follow the State Drug Formulary & Covered Medical Benefits or can each managed Medicaid organization develop their own criteria?

Plans must cover all Medicaid covered drugs, but may have their own Preferred Drug Lists and other utilization control policies.

34) If a client is determined to be ineligible retroactively and the MCO recovers payments made to the provider, will the provider be able to recover those costs?

In the very rare instance that a client is retroactively disenrolled from an MCO and a provider's payment is recovered by the MCO, the provider may bill the state through the fee-for-service system. The MCO will be required to inform the provider of that opportunity.

35) What is Aetna Better Health doing for LTC residents in group and nursing homes? I am a nurse working in LTC pharmacy in prior authority department.

The question at hand references the prior authorization process for pharmacies not contracted with the Plan's Pharmacy Benefit Manager. Aetna Better Health of Illinois members should receive specialty pharmaceuticals purchased through this channel. The plan has "any willing" provider approach and will engage the pharmacy to get them the information they need to start the contracting process with the PBM.

36) What are the MCOs doing to ensure that they utilize the disability experience in managed care model?

The MCOs are interviewing persons with disabilities to serve as transition coordinators in the ICP program. The Plans are in discussions with several Centers for Independent Living on how to best collaborate in the care of these members.

III. Contracts/Billing

- 37) Providers are going to have to deal with from two to ten MCOs each with different billing procedures. Is there any consideration by HFS of a universal billing form?

MCOs are forming an organization that will work with a state committee to attempt to streamline and standardize contract provisions, billing forms and utilization control policies.

- 38) For patients enrolled in hospice: Currently, we bill for routine care and LTC. We then pass through LTC monies to nursing home will we continue to do this? How will we know which Nursing Homes are part of MCO?

Hospice providers will bill MCOs in the same manner. It is not a matter of which nursing home is in an MCO, it is a question of whether the client is enrolled. All eligibility verification systems indicate MCO enrollment.

- 39) Do Hospice Services need to be pre-authorized? If yes, what services need to be preauthorized?

Yes, hospice services are authorized upon receipt of a certificate of terminal illness from the member's physician. Upon receipt of the certificate, all covered hospice benefits are authorized.

- 40) If a patient is covered by Medicare for Hospice Services but resides in a LTC facility: does the hospice still bill for room and board charges? If yes, do the charges get submitted to the MCP (Managed Care Program) or still submit to Springfield?

The Integrated Care Program does not cover individuals with Medicare coverage.

- 41) Eligibility applications for nursing home residents are 6 to 12 months behind. Will this improve under managed care? How will the bills be paid to nursing facilities: fee-for-service or via the MCO?

The state is working on the issue of delayed processing of admissions. MCOs will not be required to pay nursing facilities until the admission is recognized on HFS systems and sent to the plans on the patient credit file.

- 42) For nursing home residents with income that is applied to their nursing home bill. How will this work in managed care? No change, or will MCO be involved?

No change. The MCOs will receive a monthly patient credit file from the state.

- 43) For providers: will there be billing software provided and from whom? Will the referrals still come to the providers from the case coordinating units or from the MCOs?

MCOs will not provide billing software to providers. Plans have on-line direct data entry billing systems that do not require software if providers want to use that method. Otherwise, claims are electronically sent through standard clearinghouses.

- 44) Are there new billing requirements for providers providing Behavioral Health or Substance abuse services?

Behavioral health and substance abuse services were included in Service Package I and are not changing now, with the exception of substance abuse residential services which are now covered by MCOs so that providers do not have to bill two entities. This may cause a switch from the 837P to the 837I for one of the plans.

- 45) How will payments to pediatric subspecialists treating members with congenital diagnosis be handled going forward in this new model? These patients are 18 and older.

Providers must bill the MCO for MCO enrollees.

- 46) Can or could other funding sources pay for services and receive Medicaid reimbursement?

MCOs are the only source of payment for services covered by their contracts for their enrollees. For services not included in the MCO contracts (e.g., LEA services) payment continues to be existing funding sources.

- 47) What billing system will be mandatory starting February 1st? Form 1500 or IDOA system UMRP?

Standard HIPAA compliant forms will be required and the exact form will depend on the provider and service type being billed.

- 48) I represent a Medicare Part A certified Home Healthcare Agency. We currently do not accept Medicaid. Can the agency contract with Aetna and Centene to provide services for their members?

Yes. But the home healthcare agency must be certified as a Medicaid provider by HFS.

- 49) Do providers have to contract with CCEs, or will payment still be fee-for-service? If, contracting is required, when will CCEs begin contracting?

CCEs will be organizing networks of care for their clients. Providers within their networks will be paid on a fee-for-service basis for Medicaid services.

- 50) Should behavioral health organizations that only serve children, adolescents and families be contracting with Aetna and or Centene or will there be other managed care entities that focus on pediatric behavioral health?

The Integrated Care Program (Aetna/Centene) serves only adults. A solicitation is pending for CCE/MCCN entities to provide care coordination for children with complex health needs. In 2014 all children in most areas of the state will be moved to

coordinated care/managed care and pediatric providers will need to contract with one or more managed care entities.

51) Please explain the payment process. How about late payment fees?

MCOs are contractually obligated to the state to pay their providers timely. This means that 90% of clean claims must be paid within 30 days and 99% of clean claims must be paid within 90 days. Contracts between MCOs and providers can have terms for faster payment, but not slower. Interest is determined by the contractual terms between the MCO and the provider.

52) MCOs are being guaranteed prompt payment by the state and in turn are guaranteeing prompt payment to their providers. The concern is that this will delay even further payment to providers for services for non-Medicaid eligible clients. What guarantee of prompt payment will be afforded to the non-Medicaid contracts?

We acknowledge that payment of state bills are a problem. However, payments to Medicaid providers, including MCOs, do not slow payments to non-Medicaid providers. The Comptroller must balance and juggle all the outstanding bills.

53) What should we do if a billing agency calls repeatedly? What should we do if the bill goes to a collection agency?

Clients are not responsible for bills for MCO covered services. If a provider is seeking payment from a client, he/she should notify the member benefit representative at the MCO.

54) How can we register with the MCOs to be able to bill for our services?

Aetna
Office: 866-212-2851
Prompt for Providers (press 2) and then can select 5 to speak to a
Provider Services Representative

IlliniCare(Centene)
PrestonMedranoDirector,NetworkDevelopment
Office:866-329-4701ext.47824
pmedrano@centene.com

IV. State Oversight

55) How will you meet your goal of 1,000 people moved out of institutions by the end of 2013?

The Colbert and Williams Consent Decree Implementation Plans require the State to transition 300 people each (600 total) from nursing homes/IMDs into the community in 2013. The State does plan to meet this goal.

56) Will pay-for-performance incentives be tied to any quality indicators? Will MCO quality results be made available in the public domain? If so, when?

Yes. Pay-for-Performance incentive payments are tied to hitting targets on specified quality indicators. The P4P indicators can be found in the chart at the end of Attachment XI to the ICP contracts found on the HFS website at: <http://www2.illinois.gov/hfs/ManagedCare/Pages/default.aspx>. Quality results will be posted on the Department's website. Calendar year 2012 results are expected this summer.

57) Regarding the "Health and Quality of Life Performance Measures": will these apply for ICP, or all managed care initiative in Illinois?

These performance measures will apply to all "managed care entities" providing services for the Seniors and Persons with Disabilities. The draft "Health and Quality of Life Performance Measures" are available on the HFS website. Please submit your comments by close of business on February 22 at HFS.ICP@illinois.gov.

58) Do managed care entities have any obligation to publicly solicit community partners or do they get to sole source select without oversight?

Managed care entities will build networks of care around their Medicaid clients, including "any willing provider" for waiver services. However, the managed care entities will be held to key performance measures, as will their providers. MCOs are not required to maintain contractual relationships with all of the providers in their networks if there are concerns based on performance.

59) Are the proposed performance measures for year one only? If so, when will HFS draft performance measures for later years? If not, why does #37, regarding movement between HCBS & institutions only require reporting and not meeting a benchmark (like maintaining baseline) as in other proposals?

The performance measures will continue. They are not for one year only. Although not shown in the chart, all measures will have baselines and targets developed, including #37.

60) Will the managed care companies comply with the parity requirements under federal laws and regulations as well as our State Parity Act in the Insurance Code?

MCOs are responsible for complying with all state and federal laws.

61) How do you authorize a service which you have no responsibility or authority to authorize, e.g. home delivered meals?

There is a distinction between the Plans requirement to "authorize" a waiver service (i.e., HDM under DRS), and their obligation to make a "referral" to a non waiver service

(i.e., HDM under Title III). As part of their obligation to coordinate care, MCOs are responsible for making referrals to non-waiver services such as home delivered meals. For Aging, the MCO is only making a referral to a non-waiver service and is not “authorizing” that service to be paid through the existing provider system. The non-waiver service provider determines whether the consumer meets the eligibility for that service and whether they have the capacity to serve them.

62) As MCOs have a case management system, will clients still be assessed by current CCUs for CCP services?

CCUs will continue to perform waiver eligibility determination. Plans will perform care planning and case management.

63) To MCOs: What is total number of staff doing direct care? How many of them are people with disabilities? How many clients does each case manager handle?

MCO staff members do not perform direct care. The role of the Care Coordinator is to assess and stratify members based on their individual needs and identified risk. Through this process, MCOs identify members who have special health care needs and collaboratively develop an individual member Care Plan and work closely with members, their caregivers and their providers to facilitate the coordination and delivery of care. The Care Team includes RNs and LCSWs. These team members are responsible for facilitating the approval of required services as well as the development and/or monitoring of the member’s Care Plan. Caseloads are based upon members’ risk stratification categories. In compliance with the MCO contracts, caseloads for High/Intensive risk members are no more than 1:50 managed by licensed clinicians; Moderate/Supportive 1:150 managed by non-licensed professionals.

64) Will we get new Medical cards?

MCO enrollees get ID cards from the plans and all state eligibility verification systems show MCO enrollment.

65) If nursing homes only receive public aid cards 1x/year, how is a facility supposed to know when a resident becomes a new enrollee in one of the HMOs?

Nursing homes will continue to receive a monthly file with an indicator of MCO enrollment.

66) Why are MCO staff qualifications for MFP less stringent than for current MFP coordinators and staff?

They are significantly more stringent and require a significantly higher degree of education and expertise.

67) When will we know who the other Insurance companies will be for Medicaid contracts for Chicago – 2014?

The plans awarded contracts for MMAI in the greater Chicago area will also serve Medicaid Seniors and Persons with Disabilities in Chicago. Other entities, including CCEs and Cook County's CountyCare system may also serve this population.

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