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

Topic	Vendor	Issue/Question	Response
Audits	ALL MCOs	Where can we find your auditing policies and does it include interpretive guidelines?	**As Harmony is an MCO, Harmony is responsible for any auditing, but the state also retains the right to conduct an audit as necessary. As an MCO, we may conduct medical necessity reviews and chart audits.**
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?	Harmony encourages providers to submit claims electronically via electronic data interchange (EDI) or direct data entry (DDE). Both are less costly than billing with paper and often enable quicker claim processing. The following link provides additional information on Electronic Claims Submission: https://harmonyhpi.com/provider/electronic_claims_submission
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?	
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	Harmony members will be serviced until the member is no longer effective on the Harmony plan, regardless of where the member resides within the State.
Credentialing	ALL MCOs	Where can we find your credentialing criteria?	Information about provider credentialing can be found on the Harmony website in the provider manual https://www.harmonyhpi.com/provider/resources Written requests for information may also be emailed to credentialing@wellcare.com.

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

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Customer Service	ALL MCOs	Is there a provider advocate, above the front line staff, that we can call if needed?	Harmony offers a Provider Escalation Team (PET). This team is made up of tenured representatives with a wide variety of provider experience. At any time during a call, the provider can ask for their call to be escalated to the PET.
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?	
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?	

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

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Manuals	All MCOs	What resources are available to learn the policies and procedures of each MCO? A manual online?	Harmony offers a wealth of information via the Harmony website https://harmonyhpi.com/provider/default. This information includes the provider manual, Clinical Practice Guidelines, Clinical Coverage Guidelines, provider forms, a Quick Reference Guide, and bulletins on benefit and contract updates.

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

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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	

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

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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?	For Harmony, Medicaid, Cogentin (Benztropine) is a covered medication that does not require a PA. The Harmony Preferred Drug List (PDL), as well as additional information regarding the Harmony Pharmacy Program can be found at the following link: https://harmonyhpi.com/provider/pharmacyservices

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

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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?	

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

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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?	

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

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SASS	ALL MCOs	1. For SASS what are the standardized assessments that will be required? Will that be changing moving forward? 2. 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. 3. For SASS, do the MCOs have the same age guidelines as those we currently operate under? 4. 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? 5. How long will they be covering a SASS consumer for services? Are eligibility dates going away since medicad covered services provided after the 90day SASS coverage when needed? 6. 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 medicad 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? 7. What is their solution to transportation? Seems that some may be working on contracts with specific organizations for transportation? 8. 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. 9. It would be good to have a list of Q&A's from each individual MCO for future references.	1. The CSPI and the standard documentation that you use as a SASS provider. We cannot answer as to what changes HFS may require in the future 2. Until the SASS worker is able to get to a location to fax the paperwork to us, they can call our 24-hr toll-free confidential voicemail at 877-706-9507 and leave us disposition information 3. Yes, we are following the SASS provider handbook and overall guidelines 4. Harmony is in the process of contracting with the CARES line. All current processes as they are now for fee-for-services clients will remain the same for us. -Again, the CARES line follows the same process. No authorization #'s are needed to provide crisis services. 5. We will follow the general 90 days, but if clinically warranted and appropriate, SASS services can continue beyond the 90 days. 6. Follow the current process and contact the CARES line --N/A 7. Follow the current process and use your current vendors 8. Call our 24-hr toll-free confidential voicemail at 877-706-9507 and leave us disposition information 9. We believe this is referencing a request for a FAQ document. Harmony has created and will distribute via its website.
8 | Page			

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

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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?	Harmony does not require all psychiatrists to be employees, however, we do require there be a contract in place between the contractor, the locum tenens and the local provider. The downstream contracts have to hold the provider to the same requirements as a participating provider agreement.
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?	Harmony currently is reimbursing all community mental health services at the Illinois Medicaid fee schedule rates as established by HFS. We are required to contract for no less than the published, Medicaid FFS rates, and cannot discuss specific rates due to anti-trust concerns
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?	Harmony has recently adjusted its benefit package to be inclusive of the Rule 132 and Rule 2090 services. Harmony has published an update to its Prior Authorization Grid that reflects these services. https://harmonyhpi.com/provider/behavioral_health

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

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		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: 1. 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	
Utilization and Authorization	Health Alliance		

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

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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.	

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

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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?	Harmony is using ASAM placement criteria.
Utilization and Authorization	ALL MCOs	Where can we find all MCOs' appeal process on authorization?	This can found on the Harmony website.
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.	
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.	Harmony does not require prior authorization for emergency behavioral health services, including crisis admissions. Harmony does require notification of an inpatient admission on the next business day following admission.