HFS - Behavioral Health Providers and MCOs Meeting in Springfield
-Molina Healthcare Responses

Topic	Vendor	Issue/Question	Molina's Response
Audits	ALL MCOs	Where can we find your auditing policies and does it include interpretive guidelines?	Care Access and Monitoring (Molina Utilization Management) department is responsible for assuring that decisions are made timely and communicated appropriately. Reports are available from Molina's UM module that can measure when a request was received against when a determination is due (based on the request status of routine vs urgent). UM auditors run reports daily to monitor the request queues and remind staff to prioritize those due the same day. Retrospectively, the supervisors run reports at the end of every month to assure that we maintain overall compliance. Corrective action plans are devised when cases are identified that did not follow UM policy for compliance.
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?	Information is provided to each of our providers at the time of orientation to the Molina Network. Additionally, the orientation information is available for professionals along with our provider manual on our website: MolinaHealthcare.com - Provider Manual & Orientation For electronic remittances, providers need to register and complete the form at: ProviderNet.AdminiSource.com **Electronic Funds Transfer (EFT)** • Molina Healthcare has partnered with Alegeus ProviderNet for Electronic Funds Transfer (EFT) and Elec Advice. Access is free for participating providers. • Go to https://providernet.adminisource.com to register after getting first check from Molina Healthcare • Call (877) 389-1160 or send an email to WCO.Provider.Registration@alegeus.com if you have questio the registration process.
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?	Same as above.
Claims	HFS	We would like all payers to have the same submission timeline as IHFS/IDHS (180 days). Is this possible?	N/A
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?	N/A
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	If a member moves into a non-MCO county, they will drop from MCO coverage once their new address is provided to Illinois Department of Human Services. Eligibility is controlled by DHS; health plans are not able to discontinue covered services while they are enrolled with the plan. If a

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			member is out of the service area, health plans are responsible for all emergent services and will work with the member on obtaining elective non-emergent services.
Credentialing	ALL MCOs	Where can we find your credentialing criteria?	Molina follows the state of IL, CMS and NCQA credentialing guidelines. Our credentialing forms, as well the state's application is available at our website: MolinaHealthcare.com - Provider Credentialing Forms
Customer Service	ALL MCOs	Is there a provider advocate, above the front line staff, that we can call if needed?	Molina has a Director of Behavioral Health, Kathleen Jones, MSW, LCSW, under the direction of the VP of Healthcare Services, Catherine Schilling, RN. They are available via email at Kathleen.Jones@MolinaHealthcare.com and Catherine.Schilling@MolinaHealthcare.com. Molina has assigned a Provider Services Representative to work with all Behavioral Health providers, Aissa Bell, available at Aissa.Bell@MolinaHealthcare.com. Molina also provides support for affiliated providers, assigned according to the county in which the provider resides. Attached is a map of the Molina service area which designates the assigned territories for our Provider Service Representatives. All Provider Service Representatives are under the direction of Michelle Roan, Manager of Provider Services, available at Michelle.Roan@MolinaHealthcare.com. Additionally, provider materials including a manual and orientation are available at our website: MolinaHealthcare.com - Provider Materials
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?	N/A
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	N/A

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		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?	Our Provider Service Representatives are available to meet any provider in person. The Molina Healthcare Medicaid Provider Manual and Orientation are both available at our website: MolinaHealthcare.com - Provider Manual & Orientation Additional forms and guides are available at our website: MolinaHealthcare.com - Frequently Used Provider Forms
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 Risperdal, 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	Enrollees new to the Plan are grandfathered or life on behavioral health medications (including antipsychotics) if they were previously on the behavioral health medication, as determined from prescription claims experience, medical records submitted, etc. Please note that for enrollees new to the Plan, we do not always have the prescription claims history available for review so it is helpful when a provider submits the member's medication history on the prior authorization (PA) form. For enrollees who are newly started on an antipsychotic medication that requires a PA (e.g., Latuda and Invega), the PA criteria includes documented trial; failure; contraindication; intolerance to preferred agents such as generic Risperdal, generic Zyprexa, generic Seroquel, generic Geodon. The PA requests are reviewed on a case-by-case basis by a pharmacist and we ask for supporting documentation (e.g., medical records) when we do not have any prescription claims experience on our members (often happens with members new to the plan). Molina Preferred Drug List (i.e., Formulary) is available to our providers and our members, at: MolinaHealthcare.com - Provider's Preferred Drug List MolinaHealthcare.com – Member's Preferred Drug List Molina Preferred Drug List (PDL) is updated quarterly so we encourage our providers to check online for the most current PDL.

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		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.	
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 Prolixin 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 are the reasons for denying this medication?	Molina IL Preferred Drug List includes anticholinergics, like Cogentin, and various antiparkinsonian agents for management of side effects of the older antipsychotic agents, such as Prolixin. These agents do not require a prior authorization. Medications on the preferred drug list have been chosen based on their clinical merits, among other criteria, including impact on medical services. A preferred drug list is utilized to ensure proper utilization of medications. Providers can consult the Preferred Drug List available at our website: MolinaHealthcare.com - Provider's Preferred Drug List
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?	Molina Preferred Drug List (i.e., Formulary) is available to our providers and members at: MolinaHealthcare.com - Provider's Preferred Drug List MolinaHealthcare.com – Member's Preferred Drug List There has been no change in Molina's 90 day transition of care exception for new enrollees to the plan. New enrollees with the Plan who were previously (as determined from prescription claims experience, medical records submitted, etc.) on a non-Formulary (NF) medication are allowed to stay on that medication for 90 days. Please note that for new enrollees with the Plan, we do not always have the prescription claims history available for review so it is always helpful when a provider is able to submit that medication history on the PA form. Upon the expiration of the 90 day period, for continuation of therapy with that non-Formulary medication, Molina asks for documentation of trial/failure/contraindication/intolerance to a Formulary drug, and documentation around other criteria that may apply to a NF/PA drug, etc.
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.	As long as the clinic is contracted with Molina and bills with the covered NPI and Tax ID, the labs will be reimbursed for covered services.

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		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?	
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 Medicaid 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 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? 7. What is their solution to transportation? Seems that some may be working on contracts with specific organizations for	1. SASS Screening results (CSPI) should be sent to secure email address. (*See attachment*)  9.23.14 SASS Providers Memo.pdf 2. Same as 1. 3. Yes. Under 21 are eligible for SASS-like services. 4. Molina – Yes. (*See attachment*)  Family Health Plan - Children's Mental Hea RIN # given for FFS SASS service only and will include the FFS SASS eligibility dates only. (HFS will address this.) 5. Minimum of 30 days. (*See attachment*)  CMHI Deliverables for MCO Agreements 6. Molina – Yes, call CARES as usual. We are mirroring the existing system of care, deliberately, during the crisis stabilization phase of the SASS-like services. Simply send CSPI results (see answers to 1.,2.). 7. Molina – currently working with AMT to develop secure BH transport for youth, pending secured contract, will pilot services

		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.	with a gradual rollout. 8. CARES Line. Molina Nurse Advice Line also works with CARES, meaning that the NAL team is aware of the CARES Line, the role/function of this specialized service, and will refer to CARES Line when appropriate.
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?	Molina will contract with BH providers, who meet contracting and credentialing guidelines, directly and as part of a group. It is contingent on how the provider is established and how they wish to participate. We are able to accommodate requests for contracting from providers in a myriad of fashions. Some requests are situational and will need to be vetted with detailed information for an appropriate response on how the terms and relationships would exist. However, Molina currently does not carve out functions that the health plan is expected to administratively execute per our contract with the State/CMS. Locum tenens and contractors can be used to provide covered services (provided they meet program rules), but Molina does not contract or credential these providers directly as they do not meet contracting and credentialing guidelines.
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?	Managed Care Plans receive an actuarial sound premium from the State/CMS based on 100% of the Fee Schedules (Medicaid for Medicaid program and Medicare and Medicaid for MMP). The health plans do not receive additional dollars for increased rates for any covered services.
Rule 132/2090	ALL MCOs and HFS	We understand that your behavioral health benefits are to be in line 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?	Molina Healthcare provides same level of coverage as the State for all medically necessary Medicaid covered services, including Rule 132 and Rule 2090 services. Refer to the HFS Community Mental Health Providers Reimbursement Guide, which is posted online: Illinois.gov - HFS CMHP Reimbursement Guide
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	N/A

		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 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? 2. 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)	
Utilization	Health	**Example:**	N/A

and Authorization	Alliance	**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?	Molina follows ASAM placement criteria (to place individuals in the appropriate level of care in the most appropriate settings). **POLICY:** Inpatient admission for intoxication withdrawal is limited to the medically necessary, medical treatment of withdrawal symptoms associated with drug or alcohol detoxification only. A. Admissions for medical detoxification are subject to Molina Healthcare prior authorization criteria which specify that emergency inpatient admissions require notification to Molina Healthcare within 24 hours or the next business day and all elective admissions require prior authorizations. Elective admissions for medical detoxification require prior

			authorization. B. All admissions are subject to medical review for appropriateness of admissions and continued stay. C. An admission for inpatient detoxification is limited to those individuals with an immediate safety risk and severe withdrawal potential; those individuals with severe addiction to substances where sudden withdrawal may have significant negative health consequences. Inpatient admission must meet InterQual criteria to qualify for authorization. InterQual criteria for intoxication/withdrawal are available upon request from Molina Healthcare.
Utilization and Authorization	ALL MCOs	Where can we find all MCOs' appeal process on authorization?	This policy is to help Molina comply with NCQA Utilization Management standards for appropriate professional review of appeals. This policy focuses on two key issues: the identification of the appropriate professional to review the appeal and the use of a same-or-similar specialist reviewer for appeals. **Definitions** **Identifying the Person or People Deciding the Appeal** NCQA requires that: "The organization must appoint a person not involved in the prior adverse decision to review the appeal. The appointed person must be neither the individual who made the adverse determination that is the subject of the appeal nor a subordinate of (i.e., directly supervised by) such individual, although the practitioner who made the initial adverse determination may review the case and overturn the previous decision. As with initial UM denial decisions, a physician or other appropriate clinical peer must evaluate medical necessity decisions for adverse appeal decisions." (*2014 Health Plan Standards and Guidelines, Explanation; UM Standards 8 and 9, Factor 5).* **Using the Same-or-Similar Specialist Review of Appeals** "For appeals involving clinical issues, including appeals about whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care practitioner who has appropriate training and experience in the field of medicine involved in the case must review the appeal. NCQA refers to this practitioner as a **same-**

			or-similar specialist. • The *same specialty* refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. • A *similar specialty* refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems." (*2014 Health Plan Standards and Guidelines, Explanation; UM Standards 8 and 9, Factor 6).* **POLICY** The following process is to be implemented when dealing with appeals across Molina Healthcare plans. 1. The appeal will be reviewed by a person not involved in the prior adverse decision subject to the appeal and who is not directly supervised by the individual who made the prior adverse determination. 2. The appeal will be reviewed by a practitioner with same or **similar** credentials and licensure as those who typically treat the condition or health problem that is in question. A same or **similar** specialty is a practitioner who has experience treating the same problems as those in question in the appeal and experience in treating **similar** complications of those problems. a) A physician with primary care training and experience, such as an Internist, Family Practitioner, Pediatrician, Emergency Medicine Physician, General Surgeon typically treats general conditions or health problems no matter the age of the patient, if the health condition has criteria that can be applied to both adults and children. Therefore, this type of physician can review most appeals. b) A physician or a pharmacist can review pharmacy appeals. c) A physician can review chiropractic, physical therapy, speech therapy, or occupational therapy appeals. **PROCEDURE** Using the above guidance: 1. An appeal will be reviewed by a person not involved in the prior adverse decision and who is not directly supervised by the individual who made the prior adverse determination.

			a) Example: Doctor A is a medical director in a specific state plan and makes an initial adverse determination. The appeal can be reviewed by any other medical director in that state plan, the CMO of that specific state plan, a medical director in another state plan, a CMO in another state plan or a corporate medical director. b) If a CMO in a specific state plan made the previous adverse determination subject to the appeal, the appeal will need to be done by a corporate medical director or a CMO at a different state plan. c) In these situations listed above, all appeal reviewers will still need to meet the same-or-similar specialist requirements listed in this policy. 2. The majority of appeals can be reviewed within the structure of the state specific appeals process by a physician with primary care training (Internist, Family Practitioner, Pediatrician, Emergency Medicine Physician or General Surgeon). a) **Example:** an appeal for a sleep study could be reviewed by a primary care practitioner as sleep apnea is a common condition treated by primary care practitioners and occurs in all age groups. b) **Example:** an appeal for an MRI for low back pain can be reviewed by a physician with primary care training as this is a common condition treated by primary care practitioners and occurs in all age groups. c) **Example:** An appeal by an orthopedist for knee surgery can be reviewed by a physician with primary care training as knee pain is a common condition treated by primary care practitioners and occurs in all age groups. 3. In cases where the appeal involves a specialty that is not available within the state specific appeals department but the condition for which the appeal is being requested is truly common, the reviewing physician with experience in treating the condition, will meet the same-or-similar specialist NCQA definition and can do the review.

			a) **Example:** an appeal for spine surgery by a neurosurgeon can be reviewed by a physician with primary care training as chronic back pain is a common condition treated by primary care practitioners. b) **Example**: an appeal for prostate surgery by an urologist can be reviewed by a physician with primary care training as prostate problems are common conditions treated by primary care practitioners. 4. In cases where the appeal involves a specialty that is not available within the state specific appeals department and the condition is uncommon it may be possible that elsewhere within the company there is a practitioner that would meet the definition of same or similar who may be able to do the review. a) **Example:** an appeal for an off label use (non FDA approved) of a drug to treat an unusual ophthalmology condition could be done by an ophthalmologist within Molina Healthcare Inc. 5. In cases where there no practitioner within Molina Healthcare Inc. who can meet the same or similar definition and the condition is uncommon then an external review will be required.
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.	N/A
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.	Molina plans to initiate rollout of the after-hours PA program on November 15, 2014.