Q&A Summary for Marketing Your HIV Program's Services to Insurers, 02/25/16

#	Questions	Answers
1.	When will the webinar slides be available? Where can I access the entire webinar archive?	This webinar and others produced by CRE are available on the TARGET Center website at: https://careacttarget.org/cre/resources
2.	What are some specific examples or strategies to identify insurer's needs?	There are several ways to identify insurers' needs. (1) Insurer's commonly list the types of healthcare facilities and clinicians needed in their networks in their "Join Our Network" websites. The American Academy of HIV Medicine maintains a list of those websites for Medicaid MCOs and ACA Qualified Health Plans. The website can be found at: http://aahivm.org/chapter/exec/healthreformbystate Click on the state of interest to get the website URLs. (2) Member handbooks summarize covered benefits being offered to their members. The handbooks are commonly found on the insurers' websites. (3) There are several sources of information for Medicaid MCOs. In some states, the Medicaid program summarizes required covered benefits and disease-specific requirements, including HIV and preventive services, in their Request for Proposals (RFPs) for MCOs. Those RFPs are commonly posted on the Medicaid program's website. They may be archived if procurement has closed and MCOs already selected. State Medicaid programs often use "model contracts" to summarize their requirements. Those model contracts are commonly posted on the State Medicaid Program's website. On occasion, you may have to request the model contracts if they have not been posted. In a few instances, the full MCO contract has been posted on the State Medicaid Program's website.
3.	How can we speed up the process of credentialing? For brand new LPCs or LCSWs getting Medicaid (or Care for LCSWs) numbers it has taken us 6-9 months. The same has been true for us with commercial insurance - it takes 6 months or more to get through the process.	This is reported to be a challenge for many clinicians and other healthcare providers. Several strategies might be used. Often the delay is caused by missing paperwork or because the clinician is too busy to follow-up. An administrative staff person might be tasked with tracking all submissions to ensure that your staff complete and submit their materials on a timely basis. The staff person might also verify that all materials have been received and no additional items are needed, such as records of licensure or other credentials. All confirmations of receipt should be gathered and recorded in case submitted documents are lost. If unnecessary delays occur, it might be helpful to file a formal letter of complaint with the State Medicaid Program director and medical director. Such correspondence commonly must be addressed

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		within a specified time frame. If one type of clinician is most commonly found to experience delay, the complaint letter might be copied to the State trade association representing those clinicians and licensure board.
4.	How do we address concerns, which may be implied rather than stated, that people living with HIV are high users of health care, especially medications?	Health insurers are correct in their perceptions that HIV+ individuals are high users of healthcare services relative to healthy HIV seronegative individuals. What is important to educate insurers about is that current HIV treatment regimens have been greatly simplified, resulting in much greater adherence to medications, improved health outcomes, and longer life. HIV+ individuals adhering to their ART commonly have far fewer inpatient stays and ER visits for HIV-related treatment. Their use of specialty clinical services is also reduced substantially because they do not need specialty diagnostic and treatment services. Treatment is then normalized and the costs can be well predicted and controlled. Regardless of the perception of the cost of HIV care, insurers cannot systematically discriminate against them due to the perception that they are high cost or frequent users of care.
5.	We are paneled with four insurance providers and have submitted applications to two more. Do we need to make a pitch to them too?	Joining FFS provider networks does not require a pitch to insurers. Pitches are particularly important if provider networks, as demonstrated on the insurers' provider networks, do not include an experienced HIV clinical provider or do not include agencies that can offer important services that address insurers' legal, regulatory, ethnical, or financial interests. Pitches are also helpful if your agency or HIV care network would like to educate insurers about the array of services that might be offered through contract. Finally, most insurers have disease care management groups that arrange for services in the community to address individuals with chronic diseases and other expensive care. The care management programs might be very interested in learning about your services if they can help them prevent disease, reduce morbidity and mortality, meet clinical and other performance standards, and improve their financial bottom line.
6.	I bring a different skill set – Certified Case Manager, a mental health license, as well as a MPH in infection control and Dr in behavioral health. I have been asked for counseling license over and over again to	We recommend that you check with the relevant State licensure board that issued the license to determine if you are appropriately licensed to contract with insurers of interest.

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	provide care. What are my options to get around this?	
7.	We are finding it impossible to identify a psychiatrist who will work with our mental health clinic. Most don't accept insurance and we can't afford their salary. Are you aware of others experiencing a similar problem?	This is a persistent and growing problem in the U.S. It is recommended that you check with the medical school closest to you to determine if fellows and faculty might provide services. Telehealth is increasingly being used to address this issue in psychiatric shortage areas, with insurers increasingly willing to support that model to maximize the availability of their members to get needed services.
8.	How do we get pitch meetings with insurers? Does it really result in higher pay outs? Also, is much travel is involved?	Pitch meetings with Medicaid MCOs might be facilitated by State HIV and/or Medicaid program staff. They might also be facilitated by the insurers' medical director or the director of disease care management. You might send a letter requesting a meeting, and then follow-up telephone to reiterate your request. It is often helpful to have a team of HIV providers request meetings so that the insurer is not inundated with requests. Regarding payoffs, pitches are particularly helpful in educating insurers about the HIV epidemic in the communities in which they operate, as well as informing the insurers about the availability of high quality, experienced providers that can help them meet their legal, regulatory, ethical, and practical interests.
9.	If we become approved as a specialty provider so that we get a potentially higher pay out, how do we balance the risk of the client then having a higher co-pay for seeing a specialty provider?	State Part B ADAP and Insurance Continuation Programs, as well as many Part A programs are shifting their funds to address the needs among HIV+ individuals for co-pay assistance. Consider checking with the Part A and Part B recipients in the state in which you reside.
10.	Is there any way to negotiate a higher rate for Medicaid MCOs? Traditional Medicaid pays pretty poorly.	Yes, negotiations may yield higher payment levels. Such payment models may also require an organization such as yours to accept some financial risk. We discussed such capitated, sub-capitated, and pay-for-performance models in earlier CRE webinars available on the TARGET Center website at the URL mentioned above.
11.	Are there any resources to inform ASO and CBO leaders of state-by-state differences in what Marketplace insurance will cover? Do you have guidance for how folks in non-Medicaid expansion states should address this issue? What about state vs. federal insurance Marketplaces?	You might start with the comparative analyses conducted by the Harvard Center for Law and Policy Implementation at: http://www.chlpi.org/plan-assessment/. State HIV policy groups operate in some states and may have helpful resources. Variability in coverage occurs regardless of whether a state has expanded Medicaid eligibility. While some variability is allowed under the ACA and state health insurance

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		regulations, some policies are not allowed. Check with your State Medicaid Program and Insurance Commission, which regulates insurers in your state. The list of State insurance commissioners can be found at the website of the National Association of Insurance Commissioners at: http://www.naic.org/state_web_map.htm