BHA/MA/Beacon Health Options, Inc.
Provider Quality Committee Meeting Minutes

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, August 09, 2019
10:00 am to 11:30 am

In attendance: Tammie Parrish, Donna Johanson, Gelisa Christian, Barry Waters, Barbara Trovinger, Cynthia Petion, Shannon Hall, Stacey Diehl, Lakia Thompson, Enrique Olivares, Jessica Allen, Jenny Howes, Susan Steinberg, Mary Viggiani, Joana Joasil, Roxanne Kennedy, Scott Gloefler, Robert Canosa, Gloria Reeves, Cory Francis, Evette Griffin, Rebecca Frechard, Abigail Baines, Daniela Relf, Tiffany Hebron, Shavandriah Godet, Sharon A. Jones, Josh Carlson, Suequethea Jones, Denise Eangleheart, Dierre Dikaha, Tyra Lorenzo, Cynthia Roberson, Stephanie Clark, Donna Shipp, Steve Reeder

Telephonically: Andrew Sacchetti, Eulanda Shaw, Andrea Fenwick, Leona Bloomfield, Seven Sahm, Ashley Hipsley, Kristen Rose, Anne Armstrong, Beth Waddell, Abiba Wynn, Aisha Harris, Christopher Steel, Kwante Carter, Lauren McCarthy, Mariel Connell, Danica Thornton, Tim Santoni, Faye Fogle, Sheba Jeyachandran, Dorothy Lefore, Sonja Moore, Ashley Stewart, Joanne Reilly, Angela Ferro, Cathy Jones, Abby Appelbaum, Judy Tucker, Susan Gilmore, Lavina Thompson, Vonda Kendle, Rebecca Maloney, Sarah Petr, Geoff Ott, Sue Kessler, Jarold Hendrick, Barry Parker, Mark Greenberg, Joseph I. Monye, Cathy Murray, Jen Hodge, Jen Kihiko, Angela Williams, Paula Nash, Shanzet Jones, Daniel Watkins, Andrea Carroll, Mike Dunphy, Guy Reese, Michael Ostrowski, Mona Figuero, Belinda Strayhorn, Joan Sperlein, Elizabeth Hymel, Shaney Pendleton, Melissa Sinclair, Susan Gilmore, Robin Elchin, Betsy Nelson, Sandy Umbel, Angela Williams, Tiffany Rich, Fran Stouffer, Greg Warren, Gerrica Germany, Diana Long, Kelly Kalatucka, Melissa Sinclair, Kathy Kiselak, Tekeytha Fullwood, Rachel Wilson, Sheryl Neverson, Tammy Fox, Cynthia Pixton, Cynthia Middleton, Paris Crosby, Stacy Fruhling, Brooke Johns, Shu Zhushu, Austin McCool, Nicole Cooper, Yordan Mavrodinov, Connie Pippin, Elexus Snow, Joyce May, Jill Brown, Sylvia Delong, Jim Freeman, Deana Cookinfo, Michelle Rivera, Barrington Page, Nicholas Shearin, Lorraine McDaniels, Davy Truong, Christopher Steele, Deloris Watson, Bryce Hudak, Abiola Ward, Robert Dinkin, Kathleen Curry, Kristine Garlitz, Rebeca Gonzalez, Mary Blackwell

Topics & Discussion

BHA Update

- SAMSHA has allowed states to utilize one time only funding for training and technical assistance. As a result of the feedback from the June 2019 training on cultural and linguistic competency , BHA will be hosting a series of training sessions in September and October. These sessions will also include discussions on the use of CLAS standards and data driven approaches to address health disparities. Trainings will start on September 13, which will be followed up by webinars. More information will be shared regarding the opportunity to build capacity around cultural competency and diversity training.

- House Bill 1092/Senate Bill 703 created the Behavioral Health Crisis Response Grant program to award competitive grants to Local Behavioral Health Authorities to establish and expand behavioral health crisis response systems. $3,000,000 in dedicated funding was allocated to BHA for this purpose in Fiscal Year 2020. Funding is targeted to programs that facilitate access across the life span, meet national standards, integrate the delivery of mental health and substance use disorder (SUD) treatment, and timely connect individuals to community-based care. BHA is working with the jurisdictions that have been awarded the grants to expand existing services and to implement new programs The State has increased the availability and array of SUD services for individuals with opioid use disorder (OUD) through the use of the State Opioid Response (SOR) grant funds. This has included implementation of stand-alone crisis stabilization centers, OUD residential crisis services, and OUD-specific recovery residences, and the provision of Medication Assisted Treatment (MAT) in jails and detention centers. With the passage of the HB 116 this legislative session, local correctional facilities in certain jurisdictions will now be required, under certain circumstances,. to provide inmates with MAT, behavioral health counseling, and access to peer recovery specialists inmates.

Medicaid Update

On July 24, 2019, following approval with the Board of Public Works, Optum was awarded the contract as the next ASO for the Maryland Department of Health. MDH appreciates and thanks Beacon Health Options for their many years of service to Maryland, and specifically, BHA and Medicaid would like to thank Beacon Health Options on behalf of their work with Providers.

The official implementation of the new contract with Optum is set to begin September 1, 2019. However, implementation and transition discussions with the State, Optum and Beacon have already begun, focusing on system and infrastructure builds. The Department is working on a formal announcement regarding the change and will send this information out via transmittal. Over the next several months there will be more specific information shared with providers to prepare for transition, including information regarding trainings, authorizations and claims payments. The Department notes that although Optum is a subsidiary of United Health Group, an MCO in Maryland, the ASO model provided by Optum is a very distinct and separate line of business under United. Representatives from Optum will start attending Provider Council meetings, possibly as soon as September or October. At this time, it is not anticipated that the transition between Beacon and Optum will go past December 2019 and it is the Department's expectation that Optum is ready for go live on January 1, 2020.

Beacon Health Options Update

- Karl Steinkraus, who was the Director of Provider Relations, is no longer with Beacon Health Options. Donna Shipp is stepping into the role of primary contact for provider relations. Providers should still send questions to marylandproviderrelations@beaconhealthoptions.com, just as before, and the Provider Relations team will follow-up. If providers are experiencing issues with getting response to urgent issues, you may also email Stephanie Clark (Stephanie.Clark@beaconhealthoptions.com) or Roxanne Kennedy (Roxanne.Kennedy@beaconhealthoptions.com), to facilitate follow up.

  Beacon Health Options will set up an inbox specifically for transition questions. A Provider Alert will go out shortly with the following email-address. Questions sent to MRLD-ASO-Transition@beaconhealthoptions.com will be reviewed and disseminated to both MDH as well as Optum.

Provider Questions

1. **I heard that Beacon Health Options was not selected to continue as the ASO for MD Medicaid and that, as of January 1, 2020 there will be a new ASO. Is this true? If so, can you tell us who was selected for this role?**

   Please see the Maryland Medicaid update for more information regarding the new ASO transition.

2. **As more Spanish speaking families are seeking services in our area, does MD Medicaid have any benefits/funds to cover interpretation services?**

   Please contact your local CSA/LAA/LBHA to see if they can provide funding for this service. There is also limited amounts of Spanish speaking coordinators in each jurisdiction of the BH departments, so please contact them as well to find out what resources there are available.

3. **Perhaps I missed it, but I have not received an update on the new requirement for NPI numbers for individual providers in OMHCs. Has a new implementation date been seen?**

   A new date has not been set yet by the Department. Please continue to have your licensed providers enroll with Medicaid via ePrep. Medicaid will give a 60 day notice prior to go-live of this requirement, but given the challenges some programs are experiencing in the enrollment process, please continue the process now and follow up (remember you must log into the ePrep Portal for updates) to avoid issues once the requirement is live. OMHCs must continue enrolling your independently licensed providers - not licensed graduates - into ePrep/Medicaid enrollment.

4. **Is Beacon Health Options going to leave all the Grey Zone payments that have been showing up on the Medicaid check each week since July 9, 2019 for services after June 30, 2019 or will there be a change/reprocessing that Providers should know about, or are we just going to continue to receive our Grey Zone payments on the Medicaid check in the future?**

   This question is being researched by the Beacon Health Options finance team to identify if it is a wide-spread issue or a provider specific problem. If any other providers are experiencing an issue with the payment of their uninsured members, please email Marylandproviderrelations@beaconhealthoptions.com with your examples.

5. **FMCS status on active clients. We were told by Customer Service at the beginning of July that this would not affect our client services when we called immediately after the FMCS started to appear on the consumer insurance profiles. The Customer Service representative said FMCS said that this insurance only applied to two providers, Brooklane and Sheppard Pratt, for inpatient stays. When we tried to get Grey Zones for these clients because there is a MA lapse, the Beacon system will first now allow us to input a Grey Zone request online. When calling the 800 number we were told we had to do**

over the telephone, but they would deny our request because of the FMCS was active. Can we please understand more about this situation?

Answered below for both questions.

6. **New Medicaid Eligibility Codes: When verifying Medicaid eligibility for new customers, Provider Connect now lists FM1 and FM2 as funding sources for Medical Assistance. What is the funding source associated with each code, and what is the purpose of the new codes?**

   On July 1, 2019, Beacon Health Options launched the 4.0 expansion waver for the state. This particular waver allowed consumers receiving SUD services in an IMD to now be reimbursed through Medicaid. This fund is FMCS (FM2) and allows 15 days per month to be covered under Medicaid for individuals having this co-occurring disorder being seen at the IMD's. We are aware that this has caused some issues with some of the uninsured folks, everyone who has Medicaid is now eligible for this new fund, however, when the consumer's Medicaid terminates, the new funding was not terminating. So we expect this to be resolved within the next two weeks. Our eligibility team is working to identify all of the records that were affected by this error and manually update them.

7. **When a client is receiving services in the 3.7, or 3.7WM level of care, can an external lab bill medical lab charges, such as CBC and BMP, or are these considered part of the daily rate for SUD?**

   Only drug screening is included as part of the daily rate for adult residential SUD treatment.

8. **Workflow change for Lapsed Medicaid Eligibility? Two providers (Behavioral Health Partners of Frederick and Channel Marker) report an operational change for consumers when Medicaid coverage lapsed. Individuals used to be automatically enrolled in the uninsured eligibility category with 30 days of coverage to renew Medicaid. Now, individuals are identified as ineligible unless the provider manually enrolls them in the uninsured workflow, while simultaneously working on the Medicaid renewal. Is this an overall operational change in practice for individuals with lapsing Medicaid? If so, can operational changes like this be communicated to the field in advance of implementation?**

   Our system policies have not changed. Eligibility is handled through the Medicaid process. As consumer information is updated, it updates into the Medicaid system

and then feeds into the Beacon system. In instances where consumer's eligibility is terminated with a retroactive effective date, the process has always been to allow a 30-day grace period of uninsured benefits. This process allows consumers and providers the opportunity to update the consumer eligibility and to get their entitlements back in place. This is not a universal process; it only happens when retrospective eligibility is at play. Beacon receives an eligibility feed directly from Medicaid and in those instances where it is identified that a consumer has a retroactive termination, the 30-day span is added.

We do believe that the new IMD funding source that has been added may be causing issues for some eligibility spans. Consumers who had Medicaid coverage and then were terminated retroactively, are still showing the IMD funding source and preventing the uninsured authorizations to flow through as normal. Beacon is aware of this problem and we are working to fix this issue within the next 30 days. If providers believe that their files are affected, they may email provider relations at marylandproviderrelations@beaconhealthoptions.com.

9. **E&M rate increase – It appears that they were not given the 3.5% increase July 1, 2019. The increase was only pennies? Is there any reason?**

   E&M codes are managed separately that other rate increases and are aligned with the CMS rates. Each year CMS identifies a rate and the legislature will dictate that E&M's are paid at a certain percent of the Medicare rate. There was an increase from 90 to 93 percent in this last legislative session, however, that occurred separately from the process of 3.5% HOPE act increase, which is for community based services. E&M codes are evaluation management codes that apply across provider types, these are medically managed codes that are accessible by the behavioral health providers. Beacon Health Options has reviewed the rates in our system and they are in alignment with the approved increase. However, we recognize that with large scale rate increases that some providers can be inadvertently left off the update. If you believe that you are receiving the wrong rate for your E&M code, please send your provider information to Marylandproviderrelations@beaconhealthoptions.com and we will assist you in researching your file and having it updated as appropriate.

   Accreditation question – recently we moved. We notified the Joint Commission of our intention to move in April 2019. The Joint commission came to visit within 7 days of our move. They said it was because the State of Maryland required us to have the site visit immediately. I know many other agencies that are accredited by CARF, that when a move occurs, CARF issues a preliminary letter stating that the agency is accredited for the new location

and will be reviewed on the next site visit. What is correct, immediately or at next site visit?

Program licenses are site specific and cannot be transferred to another location. Medicaid numbers are also site-specific. In the event of a move, please advise BHA and the local authority at least 60 days prior to the move. Paperwork for a new license will have to be submitted. The accreditation agency is conducting site visits as quickly as possible for BHA, so that BHA can issue the new license.

Medicaid site visit occurs after the program is licensed both accredited and has received their BHA license. When programs move locations or are expanding, they need to plan in advance for the various entities that are involved. Medicaid site visit is the last step in that process. Providers remain at risk for any services provided without authorization. Even in emergency situations, it is very challenging to get all the parties to coordinate their efforts. It is something MDH is continuing to look into. Programs need to be very diligent in their work with ePrep and plan as far in advance as possible for moves.

ePrep provides a listing of what providers need before a site visit, so the best thing to do when getting ready for the BHA visit and your accreditation is to gather the documents that are necessary for the Medicaid site visit. For example, Medicaid site visit require an organizational board and requires verification of licensing for each provider. There are different requirements and if providers proactively review the requirements and prepare (and upload to ePrep) the process will be smoother.

Beginning in April 2019, our claims for OMHC services have been denied for patients who also receive ABA services from another provider on the same date of service due to the maximum sessions per day rule. These patients receive ABA services every day, therefore, we do not have the option to see them on a day they are not receiving ABA services. It seems the denials began after the new CPT codes for ABA services went into effect earlier this year. Each provider (OMHC and ABA) has received authorization to provide services to the child as they are different services and are both clinically indicated. Please advise if an exception can be made to the maximum services per day rule to ensure both providers can be paid for the services rendered?

This concern has been brought to the attention of the ABA team at Medicaid and will be further reviewed. Please share examples/scenarios of when this occurred for review by emailing Marylandproviderrelations@beaconhealthoptions.com

10. **This seems to be a problem for revalidation and other MA related issues. We applied in late April for a move to our new address. This process took 9 weeks to have the MA surveyor out to do a site visit which was fine. Our**

application appeared fine, all solid green dots. However, after the Surveyor did the site visit, they returned our application for a field that was not checked regarding DBA, which we do not have. Now we are again back to the beginning again. My question really is, once you fix something for something so minor as checking a box that wasn't required, why do we go back to the beginning of the queue again, basically starting all over instead of returning to the same place in the queue. I could go on and on about the whole ePrep thing for a lot of other reasons, disaffiliations that take months to occur, Revalidations gone awry, giving MA numbers to applicants that entered license info wrong, it just goes on and on.

11. **In the past, ePrep would send notifications emails to the provider stating that there was a message waiting to be reviewed. Revalidations are taking weeks and weeks and being denied for small errors without any contact with the provider including the lack of notification emails. This results in suspensions that cannot be reversed quickly. What can be done or is being done to avoid 12-15 week wait times? It is now understood that relying on any communication from ePrep or reviewers is not to be done but the wait times still are long.**

For the 2 questions above: ePrep – Unfortunately, we do not have a representative from Provider Enrollment at the Provider Council meetings, but we will convey the concerns providers have been sharing with the Provider Enrollment/Operations Division. We cannot speak to generalities but when there are specific issues, providers have been reaching out to the Medicaid Behavioral Health unit and my team has been assisting when possible. Providers should always document whom you are talking to as a lot of their work is verbal over the phone. Also, please keep checking your ePrep portal frequently, especially when you are in the process of enrolling a provider - to make sure to follow up. There are no email notifications sent out to say you have a message in ePrep, you must go into the portal for messages. The enrollment process, without any missing documents can take about 4 to 6 weeks. If there is an urgent reason in case something needs to be expedited please contact Mdh.bhenrollment@maryland.gov.

14. **What is the status of efforts to resolve with CMS the conflict between Medicare "incident to" billing rules and Medicaid rendering NPI rules? Is there an anticipated timeframe for resolution?**

    The remains under review. OMHCs need to continue to enroll their licensed providers as "rendering" under the OMHCs.

ASO Transition – We appreciate the comments submitted with regards to provider's interest in the pending transition. Please send questions regarding this transition to MRLD-ASO-Transition@beaconhealthoptions.com

MDH is working in collaboration with Beacon Health Options and the new vendor, Optum, on a communication plan for providers. Providers should expect to see department transmittal in the next few months that will outline the transition plan for all claims, authorization, and provider information. Please continue to share points of concern as they will be included in a future outreach meeting facilitated with Optum.

We will share the list of received areas of concern in the minutes and will include these items in future forums when the Optum ASO has their Maryland presence. As part of their work during implementation, they will be holding regional forums to introduce their key staff and mission in joining the Maryland system.

15. **Transfer of unresolved billing issues. How will unresolved billing provider issues be transferred to the new ASO vendor? Will there be a list of "open tickets" transferred from Beacon to Optum? If so, will providers have the opportunity to review it and identify any omissions? For example, Southern Maryland Community Network was awarded EBP status for Supported**

    Employment in May 2019, retroactive to October 2018. It hasn't yet received the seven months of payments. How will the status of pending issues like these be identified and managed during the transition period?

16. **Authorizations. Will open authorizations be transferred to the new vendor electronically? Will any textual clinical notes transfer with the authorization, such as those noting acuity or factors impacting medical necessity for individual clients?**

17. **Transfer of M-number. Clients who were initially uninsured are assigned an M-number instead of a Medicaid number. Even if the client becomes Medicaid-insured, Beacon continues to track them by the M-number. Will M-number assignments be transferred to the new vendor?**

18. **New Vendor's Payment System. The timing of payments is critical to providers' operational workflows. When will providers be oriented to the new vendor's payment processing system and learn the frequency, day of the week and duration of Optum's claims processing system?**

19. **Adequacy of Transition Period. If the new vendor is unable to start as anticipated on September 1, will the state delay the January 1 implementation**

date? If delays occur during the transition period, what processes are in place to allow evaluation of extending the implementation date?

20. Communication. What provisions does the new vendor anticipate having in place to ensure timely communication with the provider community?

21. Limitations on Cross-Vendor Take-Backs. In past ASO vendor transitions, the new vendor has recouped claims from providers without adequate notice or sufficient detail to identify impacted claims. We request that no payment recoupments or take-backs occur across ASO vendors unless the vendor has given 30-day notice of the anticipated take-back to the provider, describing the impacted claims by client number and date of services.

It depends on the reason for the take-back. If it is in regards to an eligibility issue, it would be helpful to know what the different scenarios are so the Department can review. In the past when a new program was launched, Medicaid has permitted a grace period. During that time providers are still responsible for correct billing but there is a temporary hold on retractions. This will be considered as we move closer towards implementation and in consultation with both Beacon and Optum.

22. For OMHCs, I understand that all LC's are not independent practitioners that you can add into the ePrep portal. As you hire more you continue through that process for the LM they are going to be working under the LC and they are put into the e-portal, correct? With practitioners trying to better their opportunities and advance their career, in that they would re-affiliate with another practice, how quick is that process? Is that process being expedited?

An LM is a licensed master social worker and refers to a graduate student, not an independently licensed practitioner. Ideally, the already licensed provider who wants to join your practice and who wants to be disassociated with a previous practice can take care of this themselves in ePrep. It does not account for the time it takes to get the license approved, but the actual association with the new practice is done by the program.
Providers should check their status when they leave a practice to make sure their license is no longer attached to the practice. There are situations where practices keep billing for providers that no longer work at their practice.

23. I would like to know when the combination of services will be reviewed or looked up. There is a lot of issues going on with all the business Beacon has taken over.
If a patient of a mental health group is coming to see me but on the same day has received therapy somewhere else, and that therapist does a family group session – we are not aware that this provider is conducting a family group

session and now we are not getting paid for what we do, as we have no idea what the other provider is doing as he is not affiliated with us.

There is a report that providers can run on the mental health side to see if there are any open authorizations for a patient with another provider. On the substance abuse side this is trickier because of the inability to disclose if the consumer is being seen somewhere else. The report will show a pop-up claiming that this consumer potentially has an authorization in the system that could affect the ability to bill for this consumer – if this pop-up appears, **please call the Beacon clinical department**.
Beacon Health Options will provide assistance by looking into our system if we can obtain an ROI for that consumer so we can communicate between the two programs and let you know if there is conflicting authorizations. The directions on how to get to the report can be found here. The report will not disclose who the other provider is, it will just state that there is another provider who is rendering services to a consumer.

24. Residential Crisis Services no longer receive their MA numbers through the state and these requests are now going through Beacon Health Options. Is that true?

Yes. They do not require a MA number because it is not funded under Medicaid.

25. We have heard from a number of Residential Crisis Services that they feel like that service in particular has been really disruptive switching between vendors.

Medicaid used to handle the non-Medicaid reimbursable services and assigned a non-Medicaid number to them. This function was transferred over to the ASO. This confused providers, as they assumed that it was a Medicaid number, therefore they are going through ePrep trying to obtain a Medicaid number for Residential Crisis Services, which are not reimbursable through Medicaid.

26. What are they going to back-pay Grey Zone for the consumers affected? Why are providers not affected still seeing FMS?

The FMCS funding source is assigned to any consumer who has FMCD, so even if providers are not providing IMD services it will still show that funding code on the consumers file. As far as backdating the Grey Zone individuals, it will be backdated to the date on which the new Grey Zone eligibility span was submitted. Please email Marylandproviderrelations@beaconhealthoptions.com in case there are any issues.

27. While I understand that there is a currently a lot of discussions that are taking place between Optum and Beacon Health Options, the providers are at a real

disadvantage since the January 1, 2020 deadline seems to be a hard deadline, and now we are not getting information until September. There is a lot of work that needs to be done on our end with our EMR systems to prepare for successful implementation. Can someone provide clarity in regards to the 2 Dollar co-pay? There seems to be no set rule to help clients determine whether a client is responsible for a 2 Dollar co-pay or not.

This is an uninsured issue – ANNE ARMSTRONG to confirm (just had an email about this) Anne Arundel County is the provider questioning this.

28. Who is contacted if another suite is added?

New suites have to get licensed so please initiate the BHA licensing process first. See answer to question 10.

29. Does Medicaid has to visit an expansion site of an existing MA provider before the new site is issued an MA number. We could not hear the answer.

For the BHA site for a license under COMAR 10.63, each site, whether it is a new suite or a new address, has to be seen and accredited. A Medicaid survey for programs always has to occur.

30. Can we have a direct contact for ePrep for application renewals? I tried to send messages via the inbox with no response.

Unfortunately, there is no direct contact. Providers have to go through the ePrep application process. In case of continuous problems, please email Mdh.bhenrollment@maryland.gov.

31. I was told that we can ask for our account to be expedited and if it has been sitting in review for over 30 days. I have done it and it works. ePrep is backed up for 6 months, what is the provider's office supposed to do if we continue to check and they are backlogged?

These concerns will be sent to the ePrep team.

32. My accreditation body has put in writing that they expect the provider to begin services upon accreditation and licensure. They expect providers to provide pro-bono service. Medicaid approval is no reason for the delay of starting services.

BHA will have a discussion with CARF about this.

33. ePrep process is not returning to provider for just documents but for minor items like checking a box. Once corrected, we are put back into the queue for another ten weeks.

Regardless of the reason, in case of two rejections, the process will go back into the queue. Sometimes there are exceptions. Please give specific situations so that this issue can be addressed and a request for expediting can be put in. Please email Mdh.bhenrollment@maryland.gov.