MHA/ValueOptions® Maryland
Provider Quality Committee Meeting Minutes

ValueOptions® Maryland
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, February 11, 2011
10:00 am to 11:30 am

In attendance: **In attendance:** Karl Steinkraus, Darlene Wehn, Spencer Gear, Jim Chambers, Elma Alston, Lissa Abrams, Carol Leeson, Kaleb Berhe, Sharon Ohlhaver, Jarrell Pipkin, Greg Burkhardt, Michael Schorr, Jamie Miller, Herb Cromwell, Mary Mastrandrea, and Candace King. **Telephonically:** Paulinus Okonkno, Missy Wilson, Irina Beyder, Donna Shipp, Shajuan Forsey, Andrene Jackson, Heather Barton, Terry Brown, Anita Clyburn, Pat DilFelice, Julia Myers, T. Williams, Marty Scanlan, Angie Kent, Teresa Fernandez, Agnes Parks, Toya Jackson, Dawn Beckett, Christa Taylor, Susan Wilkoff, Larry Abramson, Mary Brassard, and Mark Mowbray.

Topics & Discussion	Follow-Up Actions
Review and approval of Draft Minutes • January Minutes approved	
MHA/ValueOptions® Maryland Announcements	
MHA UPDATE – Lissa Abrams: • **MHA Staff Update:** L. Abrams gave some background information on MHA's new Secretary of Health and Mental Hygiene. Dr. Josh Sharfstein. DHMH has a new Deputy Secretary of Healthcare Financing, Charles Milligan and Deputy Secretary of Operations, Thomas H. Kim. • **FY 2011 Budget:** Most recent proposed rate cut would affect Community Providers. An increase of 1.13% increase was projected; however that was canceled out by a proposed 2.5% rate decrease for cost containment. MHA took targeted cuts; in predominate services paid with State general funds to eliminate the overall impact of this rate decrease. • **FY 2011 Budget Hearing:** State funds are continuing to be gradually decreased, we did have another pay cut to CSAs (Core Service Agencies). There are still no additional funds, and there's a still a deficit related to services and individuals paid with general funds. There were no new recommendations related to community mental health. However there were recommendations related to closures of beds at RICAs (Regional Institutes for Children & Adolescents), State operated RTC's to cut beds, cutting three Chaplin positions at two hospitals and setting aside funds to do a capitol campaign/review of capitol planning process to look at constructing new state hospitals. The department opposed all four recommendations. The legislature can only cut the executive budget, so this process is still in	

the beginning stages, there is another hearing scheduled for February 14th in the House.

Community Programs Oversight & Monitoring: The Secretary has charged Wendy Krommiller with reviewing oversight and monitoring of all community programs. Those programs will include community mental health programs. Wendy is in the process of reviewing all the various oversight and monitoring role of various State and local Agencies.

- **COMAR Amendments to COMAR 10.21.25:** After publishing the proposed amendments in the Maryland Registrar, DHMH received multiple comments from providers about the language used regarding individual practioners and documentation. DHMH is working on possibly modifying some of the language, because it reads as if you'd be subject to retractions, for any regulation that you are out of compliance. DMHM looking to add language that would say something more along the lines of "substantial compliance." Requirements for Partial Hospitalization Programs also need to be clarified. The expectation for PHP's if regulated under 10.21.02, a ½ day is a minimum of 4 hours, a full day is a minimum of 6 ½ hours, that did not include an outpatient mental health clinic. Some PHP call their ½ days an IOP but a ½ day of Partial is a minimum of 4, and an outpatient health clinic also has a rate of IOP which is a minimum of 3, received feedback that that was confusing.

- **New Rehab Rates**: DMHM coming up with new rehab rates, once they are in a better format, a group of Providers will be pulled to review them. The new rates will either be a daily rate or a 15 minute increment rate, with a bundle of units the Provider would get based on the level of care. The PRP for children would stay in the state plan and mobile treatment. Planning to add crisis services and peer support at a later date to the I-waiver. I-Wavier services are targeted for people with serious mental illness. This is process will take a year for proposal and approval process

- **CBH Regulatory Reviews**: Anything under licensing and monitoring is being addressed by Wendy Krommiller. DHMH is not in the position to make or agree on any changes as of yet that would reduce requirements. DHMH is willing to consider changes to requirements for mental health professionals, to serve as program directors, DHMH is also willing to look into and work with the boards to review the issue of psychiatric nurse practioners in lieu of psychiatrists at OMHCs . Suggestions to conduct Evidenced Based Practices/Fidelity Visits every other year instead of annually are being looked at now. DHMH is also open to reviewing with Medicaid the issue of having separate approvals for every site as well as the issues regarding advance directives for young adults, the age requirement is still being discussed. DHMH is willing to consider convening a workgroup to reduce paperwork, also Providers are still responsible for verifying through EVS that consumers are eligible for Medicaid, they are also responsible for completing the eligibility form and making sure all supporting documentation is included as well. Those

particular responsibilities can't be changed from the Provider to the ASO. Reviewing the requirements for 24/7 emergency response for PRP is also a future possibility. Regarding all the other items listed, at this time the elimination of these requirements isn't possible.

- **Authorizations**: At this point DMHM is not in a position to change the length of authorizations. DMHM is mostly being criticize for not adequately monitoring, there's an increase emphasis to assure that DHMH knows that the services authorized are services that have been provided to meet the needs of that individual. At the present time, the current restraints stay in place until further notice but won't make any changes to be more restrictive in the authorization process.

  PRP Management: It's been determined that ValueOptions was not over budget for Uninsured PRP. No changes to UM protocol at this time. VO and MHA will continue to monitor utilization throughout the fiscal year.
  ValueOptions® Update – Mary Mastrandrea

- **Authorizations for Secondary Sites:** The authorizations requirements are different from group practices vs. those that are more individual looking. While they get 12 OP visits, they're excluded from the OMHS bundle which results in having to request authorizations more frequently) There are other rules in play outside of accreditation.

- **Monthly Retro Eligibility Project** –Per M. Mastrandrea the MREP is scheduled for the February 16th voucher, the Provider won't see much negative financial consequence but they will see activity on their Provider Summary Voucher. Funding retracted and repaid under a different fund. There are many instances where VO is going to retract under the uninsured fund and pay it back under the Medicaid fund so we can go after the federal match. VO will also be paying retros for individuals who lost Medicaid under the uninsured fund granted it was an uninsured service. Provider will also see some activity where the individual is dual coverage, so they're dual eligible retrospectively. There will be some negative impact as a result of these MREPs but the majority of it will be seen as an increase in volume in you PSVs because of the retraction and then repayment under a different funding source.

- **Detail Denial Report:** Mosaic recommended we add HIPAA compliance codes to the DDR, in addition to the VO specific denial codes that are on it currently. A Provider Alert went out with the new file layout as well as information informing Providers that the HIPAA codes being added. Providers were given 60 day notice, with the imposed changes not being finalized until sometime in April.

Provider Issues

- **Medicaid Provider Files –** L. Abrams reminded Providers to keep their information in the Medicaid Provider Files updated and accurate. Any

information that needs to be correct/updated has to be changed with Medicaid.

- **Provider Reports (Clinical Information/Access) –** Per M. Mastrandrea the system is operating as it was designed to do. It's always been procedure that once you submit a authorization, you have the option to print it or save it and export it somewhere else. Once it's submitted, access to the authorization data is still accessible just not the clinical data which is due in part to HIPAA compliance, when the new process is rolled out access to information submitted will still be limited.

- **Mobile Auth Treatment –** E. Alston explained that the VO doesn't deny all requests for Mobile Treatment authorizations. All authorizations are reviwed on case by case basis, especially for consumers in treatment for years, in conjunction with the Medical Necessity Criteria. Discussion led to an agreement that transitioning consumers to traditional services is the expectation of MTS/ACT services but that there are a miniority of cases that will need long term MTS/ACT. Jamie agreed to work with VO Care Mnagament staff regarding what constitutes "working towards transition".

- **Legislative Audit:** Per L. Abrams says DMHM is continuing to work with ValueOptions to identify the supporting documentation for Unisured that auditors should be looking for when they go out and do an audit. That is subject to change.

- **Case Examples:** Per J. Miller, if you are a Provider that believes you've been asked to submit more information then necessary for a case please, send those examples to him to that he can follow –up on them. He can be emailed at jamie.miller2@valueoptions.com.

- **VO Claims/Denials For 65 & Over w/o Medicaid: -** Per L. Abrams VO is the payer of last resort so; DHMH is not directing VO to change its current denial system. Per M. Mastrandrea, the VO system can either remove the edit or take the edit. Although 80% are Medicaid eligible, turning the edit off would mean the 20% that aren't would also go through. The system works better as is; those claims denied can be appealed, and resubmitted with proper documentation.

- **PRPs for Adolescents –**There are group homes through DJS & DHR that receive reimbursements called "Residential Rehab" which is part of the Rehab Options. DHMH is in the process of trying to clarify that with Medicaid, how VO would know perceptively if someone had a Residential Rehab Program Medicaid reimburse claim as the same day as a PRP service.

- **Professional fees for Residential Crisis Bed–** Per L. Abrams it has been corrected and VO is running reports to take a care previously denied claims.

- **Case Management Authorizations** – Providers being told that units have been exhausted, although they shouldn't be.A tech ticket has been submitted to see why that is happening. Please contact M. Mastrandrea with your documentation to have these current denied authorizations, researched and corrected.

The next Provider Committee meeting is scheduled for Friday, March 11, 2011, 10 a.m.
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