MHA/ValueOptions® Maryland
Provider Quality Committee Meeting Minutes

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

In attendance: **In attendance:** Lissa Abrams, Mary Mastrandrea, Karl Steinkraus, Kaleb Berhe, Donna Shipp, Dr. Helen Lann, Jarrell Pipkin, Greg Burkhardt, Michael Schorr, Jamie Miller, Shontae Harrell, Darlene Wehn, Spencer Gear, Jim Chambers, Sharon Ohlhaver, , Herb Cromwell, Mary Whitehouse, Crista Taylor, Terry Brown, and Mike Drummond. **Telephonically:** Shajuan Forsey, Anita Clyburn, Dawn Beckett, Susan Wilkoff, Mark Trader, JR Hughes, Melissa Schober, Mona Figueroa, A. Piers and Mark Mowbray.

Topics & Discussion	Follow-Up Actions
Review and approval of Draft Minutes • February Minutes approved	
MHA/ValueOptions® Maryland Announcements	
MHA UPDATE – Lissa Abrams: • **MHA Staff Update:** DHMH has a new Principle Council, Joshua Auerbach and Deputy of Operations, Thomas Kim. Dan O'Brien resigned and is no longer with the DHMH. • **FY 2012 Budget:** No further decisions have been made on how MHA will manage budget cuts for FY 2012. There are discussions between DHMH and the Department of Budget Management. Budget Management was requiring a cut across the board for all providers. MHA is trying to neutralize process so as to minimize impact. The session will end in April and all final decisions will be made public. • **PRP Rates**: PRP rates are still undergoing revisions, and MHA is in the process of creating a draft of the proposed rates. MHA will then submit a State Plan Amendment to CMS for approval. The proposed rates will change from a monthly rate to a daily rate. The goal is to keep the PRP rates cost neutral. MHA will provide additional information once a consensus is made with CMS on the proposed PRP rates. • **COB with Medicaid and Commercial Vendors:** There have been ongoing discussions with Medicaid and the Office of the Attorney General for DHMH related to how MHA has been implementing COB. Discussions regarding whether MHA is correctly implementing Medicaid as the payer of last resort. At this point, the implementation process currently used appears to be correct, however, there are a few outstanding issues being	

worked out with Medicaid. Once everything has been clarified and completed MHA will send something out stating the federal guidelines regarding Medicaid as the payer of last resort. These federal guidelines allow very little flexibility to make any exceptions. Per Melissa Schober according to the Code of Federal Regulations 42 CFR 433.140, federal financial participation (FFP; the federal share of the state/federal Medicaid or Medicare program) is not available if the agency fails to fulfill the requirements of 42 CFR 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party. Those two sections (42 CFR 433.138 and 433.139) specify in some detail the lengths to which a state Medicaid Program is required to go to resolve any probable third party liability before Medicaid can issue a payment. Per L. Abrams a definitive answer will be made within the next few weeks and providers will be notified in writing.

- **ACA—New Healthcare Reform:** Regulations concerning prevention of fraud and abuse. Effective March 31, 2011, CMS will be enforcing regulations, which includes a significant change related to a State's Authority. The regulations allow the state to withhold payment pending any credible suspicion of fraud. Providers need to be aware that the rules for how to deliver a service, submit claims, and your responsibility as a provider are increasing.. MHA will be sending out 42 CFR 455.23A, and an alert to advise all programs. Medicaid will also send out a notification, and Covington & Burling LLP has a 4 page summary of the new requirements. (http://www.cov.com/health_care/health_care_reform/)

- **COMAR 10.21.25 Proposed Amendment Update:** Parts of the regulations will be withdrawn. Other parts will be maintained. The fee schedule for Tele-Psych will be clarified. Clarification of PHP and IOP billing on the same day also will be investigated.

ValueOptions® Update – Mary Mastrandrea

- **Claims/ Denials for Consumers 65+ w/o Medicare Update**: MHA has continued to direct VO to continue to deny claims until the official clarification is provided.. However, the provider does have the right to appeal the denied claim. Providers can resubmit the denied claim with the proper documentation, and VO can pay the claim. VO will not remove the edit to automatically deny claims until further clarification is available. Whether the edit will be affixed to a consumers file for just a claim or for perpetuity is also a matter of further discussion. Every US citizen may not be eligible for Medicare Part A health coverage but all US citizens are entitled to Part B. At this point, the only identified population that would be exempt from applying for Medicare Part B coverage is illegal immigrants.

- **IT Updates:** Per Greg Burkhardt, there were enhancements to the system with the February 25, 2011 upgrades. This was related to the initial DORS

questions being required in all levels of review. A Provider Alert will go out. Additional enhancements will be made in March. None of the enhancements in March are Maryland specific. G. Burkhardt also discussed 2012 Leap Year and how this is affecting SEP authorizations. Any SEP authorization created on the first day of a month will default to an eleven month authorization. The request is being made that CSA's not change the end date of these authorizations. The plan is for there to be a systemic fix.	

Provider Issues	
• **IRP Requirements and MHA/VO Audit Process**: Lissa will clarify the audit process with Audrey Chase. Jamie Miller said that the dates for everything are based on the initial IRP being completed within 30 days. Even if this document is not on site it must be accessible. MHA will further review to determine some reasonable guidelines for consumers who have been in care for some time. • **QMBs and SLMBs:** Mary M. indicated SLMBs and QMBYs are considered under gray zone or uninsured coverage for PRP coverage • **Mobile Treatment and ACT:** Questions arose regarding the expectation for transitioning. Mobile treatment is expected to be a more long term treatment option however there should still be an expectation that individuals transition to a lower level of care. All authorizations are reviewed on case by case basis in conjunction with the Medical Necessity Criteria. Per Dr. Lann long stays are authorized when the appropriate documentation is provided. Dr. Lann explained recent denials for Mobile Treatment. If documentation is provided that supports continued care in this level of service then VO is approving. If adequate documentation is not provided VO has been reaching out and even giving partial approvals. There has been a request to separate the criteria for Mobile Treatment and ACT. There was a lot of discussion on this issue and it too will be reviewed further. • **OMHC Required Services Update:** OMHCs are required to administer medication. If the standard of care includes managing individuals on IM meds, administer injections, then OMHCs has a responsibility to provider. There should be a RN or a MD who can coordinate and meet this level of need. If the provider is not able to do this then there should be protocol on file as to what should happen with these consumers – Consumers may not just be turned away. The regulations are already established that address this issue. • **Updates on Billing Private Insurance Companies:** COB discussions are ongoing. • **Rules for Billing SE**: Per Jim Chambers the agency may contact him and Steve Reeder, MHA for clarification.	

- **Billing without PMHS Diagnosis**: Per M. Mastrandrea there is no reported indication that claims, that meet this criteria, are being denied. It was suggested that the real issue maybe the provider was not entering any diagnosis which would prevent the claim from even interfacing with the system. The other point of possible rejection is within the provider's own system. If it is required that there be a diagnosis of record in the provider's system–the provider's billing structure may not accept the 799 Code, and deny the claim.

The next Provider Committee meeting is scheduled for Friday, April 8, 2011 10 a.m.
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