BHA/ValueOptions® Maryland
Provider Quality Committee Meeting Minutes

ValueOptions® Maryland
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, January 9, 2015
10:00 am to 11:30 am

In attendance: Daryl Plevy, Guy Reese, Herb Cromwell, Jamie Miller, Jerrell Pipkin, Gregory Burkhardt, Zereana Jess-Huff, Donna Shipp, Karl Steinkraus, Maria Rodowski-Stanco, Jenny Howes, Arnissa Snead, Mike Drummond, Oleg Tarkovsky, John Hcrron, Barrett Cisney and Destiny Lancaster
Telephonically: Tammy Fox , Susan Bradley ,Sharon Jones , Kathy Rebbert-Franklin , Howard Ashkins, Aundrana Jackson, Roe Rodgers, Carol, Mary Baltimore County Health Department, Tim Santoni and Rebecca Frechard

Topics & Discussion	Follow-Up Action
BHA/ValueOptions® Maryland Announcements	
BHA UPDATE – Daryl Plevy • We are 9 days past go-live and BHA is working through a few glitches as would be expected with an implementation of this magnitude. • Questions/concerns that have affected more than one provider are managed by the Department and once reviewed and worked through, will be posted on the FAQ (list website). • Although you can ask general questions to dhmh.bhintegration@maryland.gov, if you have an immediate need or concern, please contact ValueOptions directly. • Provider Alerts are sent out when there is an issue or questions that affect multiple providers. • To receive Provider Alerts please email (insert the email address). **Medicaid- Rebecca Frechard** • Medicaid is actively working on all Go-Live issues and concerns. The Department is working to clarify policy through transmittals and working closely with ValueOptions.	

- The Department will continue to work through and post FAQ documents during this transition phase. FAQ #4 is currently under review by the Department and ValueOptions and will be posted once complete.

ValueOptions® Update- Zereana Jess-Huff

- ValueOptions' Provider service department is available to all providers for questions or concerns and they will be addressed as quickly as possible. VO will make sure that questions are included in the FAQ posting when relevant to more than one provider so that information is distributed amongst providers. Our clinical staff has been trained in assisting OMS and non-OMS providers with understanding the complexities on how the system is set up. VO asks that you call to speak with our clinical staff directly when necessary for immediate concerns. As always you can contact Zereana Jess-Huff via email which is posted on the VO website.
- **Karl Steinkraus** –Providers reported an inability to enter authorizations for IOP and SUD Partial Hospitalization services and made VO aware quickly. Internal testing has been done by VO successfully and a Provider Alert will be sent out this afternoon. There are a few changes to some of the authorization screens for the substance use disorder providers but these changes should be self-explanatory. Screen shots will be included in the Provider Alert that will be sent out later today. For any new consumer needing IOP or PHP substance use disorder services, they will be able to retro enter them back to January 1, 2015 or whatever date in January the consumer has started their care. VO clinical staff will be able to approve valid authorizations. . Secondly, providers have shared some confusion with regard to the OMS process. . VO has provided a series of webinars explaining how OMS works to the substance use disorder community. There are two initial visits and a group of 75 visits after that. Due to the 15 minute increment administration of individual therapy for SUD services, ValueOptions had to change the authorization parameters to allow additional units for the OMS providers. OMS providers will now see 12 units available for the initial two visits and 300 units available for the actual OMS 6 month period. This will allow providers to provide the medically necessary combination of individual and group therapy sessions the consumer may need. A Provider Alert will be coming out about this issue with more information.

Provider Issues

- **What are VO's plans/timelines to issue a revised rate table to reflect the Board of Public Works (BPW) Jan 7 rate increase reduction from 4% to 2%? How will claims paid and submitted based on the 4% be adjusted? There was never a PRP rate cascade issued in connection with the rate table that came out Jan 2; will one come out or will VO wait for the new rate table? The Department** had received instructions to load the full 4% increase in rates for mental health providers that was approved by the general assembly during the legislative session. As part of an overall budget reduction that was brought to the board, those rates were decreased from 4% to 2%. We are working to decrease those rates by 2% effective January 1, 2015. This is a system change, so what that means is providers will be paid at 4% until VO can upload the changes to the system. VO will have to retract 2% of that original 4% increase, effective January 1, 2015. VO is working to adjust the fee schedules and that will probably take 2-3 weeks. A Provider Alert will be sent out once we are ready to do those adjustments.

- **When will providers know what the E/M code rates will be as of April 1 to reflect the BPW cut of all E/M code rates from 100% to 87% of Medicare equivalence** The Medicare rates will be released between the 1st and 2nd weeks of February. A Provider Alert will go out once we know what those rates are going to be.

- **Medicare rates are usually adjusted in January. Does Medicaid and/or VO and/or BHA know what this means for the mental health E/M codes?** See above

- **BHA had said that the new telemental health regs (10.21.30) would be consistent with the new DHMH telemedicine regs, 10.09.49. However, the SPA that was just submitted for 10.21.30 did not include services by psych nurse practitioners as we had understood was agreed to. Why not and can this be changed?** There is a concern about adding in nurse practitioners without a calculation on budget impact.

- **Thanks to all for agreeing to delay the one-day claims payment change until March. Is there anything a provider can do between VO and the agency's bank to make sure the $ get into the agency's account early in the day of transfer? That way if the $ gets in early Friday, the agency could still meet a Friday payroll.**
  A Provider Alert was issued last week to address provider concerns related to the check run schedule. We are currently doing the same check run schedule as we did last year. Check runs are on a Tuesday and providers get paid within a few days. The Department is delaying the change to the Wednesday schedule until March and a provider alert will be issued ahead of the changeover date.
  The Department is in the process of switching from M&T Bank to Bank of America. We have been told that if a provider has Bank of America, they are more than likely to get that payment quicker than if they have a separate bank which requires an additional transfer.
  VO confirmed and further explained that it all depends on the provider's bank and when their bank releases their money.

- **CBH is hearing from providers about a list of new questions added to ProviderConnect as part of the authorization request process. This was done with no apparent notice and no explanation. Why were they added? Will there be information coming out that explains the new questions? I'm hearing confusion on those related to insurance, for example; in that instance, what's checked for dually-eligible individuals?** There are 3 -4 additional questions that have been added to the reporting requirement, to make it parallel to the questions that are mandated on the substance use side of things that have to be reported to the

federal government. If providers have any questions please send those to VO. We can review the questions and answer them.

- **We know cost report data is being used in connection with the CMS-related C&A therapy code issue. But what about salary survey results? Can providers get those soon?** This issue is on hold until the Department completes the calculations for the upper payment limit for OMHCs, which is more urgent because it affects current rates.

- **When will stakeholders see DHMH responses to comments on a) behavioral health regs 10.21.11 and b) 10.01.08 regs on Sexual Abuse Awareness and Prevention Training?** A new version of the BH regs was just posted. We do not expect any changes to the regs on sexual abuse. They are part of a court proceeding and were negotiated among the attorneys and the judge.

- **Any BHA further discussions/decisions on requests to change auth process for under age 6 kids, e.g. adding them to the bundle?** No change**.** We will not be able to tackle this issue until changes related to the new VO contract are implemented.
  Dr. Rodowski offered the following: When looking for exceptions or easy access to somebody Patricia Brannan is the care manager to contact. -Pat Brannan (410) -691-4028

- **We were told several times in the training webinars that all MD outpatient substance use providers should be doing OMS and that we needed to select "OPSU OMS" for the Type of Care when requesting an Authorization. It was our understanding that it would bring up the OMS questionnaire in an additional tab that would be required for the concurrent review and that we should receive 2 visits for an initial authorization and 75 for a concurrent review. However, when we have done this, the OMS tab is not coming up and we are being authorized 12 units. We called VO customer support and got conflicting information about**

our provider setup (meaning if we are setup as an OMS provider or not) and were told that it may have been a problem with the information DHMH provided to VO, but we thought all OPSU providers were automatically setup as OMS providers so we are not sure what to do. Also, one rep told us that even if we were not setup as an OMS provider, if OPSU OMS was selected the OMS stuff should have come up and it should not have approved us for the 12 visits like it did. Is this an overall error within the system that ValueOptions is aware of? If so, should we hold off on entering authorization requests until it is fixed or continue to enter them and get the 12 visits? If we continue to enter them will we need to re-enter them again when the problem is fixed??? See above, the question was answered earlier in the meeting.

- **When requesting authorization for IOP we are getting an error message that states that we are not an eligible provider for IOP. We were told that this was a ValueOptions system error. What is the time frame for this being corrected?** See above, the question was answered earlier in the meeting.

- **When completing a courtesy review for an uninsured grant client, we were given an actual authorization for a 2 or 3 month period for 12 visits. According to the trainings and the demo environment we understood that we were supposed to receive an approval message with a date range of 1 year and needed to go back into the system to re-register them every 3 months. Is this another system error? Please clarify what the specific process is for this as it does not seem to be working as it was outlined in the trainings.** The registration process for consumers covered by base grant dollars is part of the uninsured registration process. This process will yield an authorization time span or registration for 3 months at a time. The requirement is that you reregister those consumers every 3 months and the authorization you are seeking will determine what number of units you will actually get.

- **For our existing clients that currently occupy a grant slot, but do not meet all of the new eligibility requirements for Registration (i.e. their income is higher than 250% poverty level or they have not yet applied for MA, SSI, etc.) what do we do for these people? Can they temporarily be grandfathered in and we work to get them MA? If so, how do we complete the Registration, should we just answer the questions as if they were eligible?** You should not answer the questions as if they are eligible. The registration process is pushing you through to get the consumer in our system with the funds that makes the most sense. If for any reason you get through this process and our system tells you they are not uninsured eligible the next step is to call ValueOptions customer service team and have them create a courtesy review.

- **When the authorization is received for a certain # of "visits" does that mean visits or units? In the past 15 mins of individual = 1 unit, which is still outlined as being true in a recent letter received from DHMH. However, we are not sure if 1 visit = 1 unit or if the visits are actually sessions regardless of the units. If it is actually sessions versus units, do we still have to bill in units? This will make it extremely hard to track our authorizations if we have to bill in units, but track the number of sessions/visits for the authorization.** OMS you are going to be allow two visits. Medicaid counts visits differently between group therapy and individual therapy. We changed the authorized units for the initial visit to 12. 12 is two 6 unit individual therapy sessions which is really 2 visits. (each unit is a 15 minute increment) You can bill up to 6 units per visit for an individual substance use therapy visit.

- **QuIP Updates –No Update**
- **Quality & Compliance Updates –No Update**
- **Other Issues and Announcements:**

The next Provider Quality Committee Meeting is scheduled for:
Friday, February 13, 2015 10 a.m.
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1099 Winterson Road, Ste. 200
Linthicum, MD 21010