BHA/ValueOptions® Maryland
Provider Quality Committee Meeting Minutes

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

In attendance: Stephanie Clark, Herb Cromwell, Mike Drummond, Zereana Jess-Huff, Patricia Langston, Helen Lann, Jamie Miller, Enrique Olivares, Jarrell Pipkin, Daryl Plevy, Donna Shipp, Patricia Langston, Mike Schorr, Guy Resse, Greg Burkhardt, Sharon Jones, Sueqethea Jones, Chris Kujawa, Joana Joasil,Jenny Howe, Robert (Catholic Charities) and Nicole Thompson

Telephonically: Carrie Frost, Mary Brassard, Mary Reeny, Sheba (BHA) and Rebecca Frechard, Sharon Ohlhaver, Milly Richmond

Topics & Discussion	Follow-Up Actions
Minutes from June were reviewed and accepted. **BHA Update – Daryl Plevy** • None **Medicaid Update – Rebecca Frechard** • Regulations for Telehealth were posted to the Maryland Register on 07/10/15. **ValueOptions® Update – Zereana Jess-Huff** • ValueOptions announces that today is the last day for clinical director, Jamie Miller. • Platform for the On-Track program is currently up and running. There will be a call organized in the coming months to discuss providers joining the pilot program. VO is targeting the end of the year to begin this pilot and will send out a provider alert.	

Provider Issues

1) Status of revised BHA Regs

- Daryl reported that regulations are going through the sign-off process. BHA is hopeful that they will be posted soon, but there is no date set at this time. Daryl also stated for providers to be aware that this is a two part process, and that once the BHA regulations are finalized, Medicaid will need to complete their companion regulations.
- These regulations will also address accreditation. A question was raised if providers are already accredited, are they able to follow the regulations immediately. Sharon clarified that Medicaid has to revise their regulations to accept this as the alternative in order to bill. The hope is that this will be a seamless process. Rebecca clarified that while BHA is working towards accreditation, MA will still have regulatory requirements that address payment. This will be developed after they receive the final BHA regulations.

2) Status of revised telemental (telehealth) health Regs

- Herb reported that Telehealth regulations are posted and that they do reflect the changes expected. This includes docs and nurse practitioners.
- Daryl reported that there are some items that are not easily included in the MA regs, such as serving individuals who are deaf or hard of hearing, which BHA will be addressing separately. While MA cannot make changes for one single disability group without making that change to all groups, BHA will track utilization numbers over time, in order to see if areas of concern can be built into Medicaid in the future.
- Further clarification was requested if there was a registration process for the doctors or nurse practitioners to be able to participate. Daryl clarified that this process is in place and that applications go through Molly Marra's unit. This is currently only for Mental Health services and will be triaged by Molly's unit and then passed to Rebecca's unit. BHA and MA will review these applications. Rebecca further clarified that there has been no official decision yet on whether providers who are currently enrolled will need to do a re-application, but this is a possibility

being discussed. Rebecca also clarified that this goes into effect on October 1st, so there is still time to firm up and begin working with providers if MA decides to do a reapplication process.

3) Medicaid is underpaying the Medicaid share of Medicare- Medicaid crossover claims. What process will be put in place to adjust the payments? What will providers need to do, if anything?

   - Rebecca stated they are reviewing claims and the impact on the system as a whole. The process for providers will not be finalized until they are able to fully review the issue. There may be no further action needed from providers or they may have to do a resubmission.
   - Rebecca reported that, while they are not seeing this on the somatic side, they are still reviewing the claims to get a better idea of the scope of the problem. She also stated that they will provide further guidance on how far back payment will go once they better understand the scope.

4) CBH wants to again go on record as urging the rescinding of the July 1 "Change in Audit Procedure" memo. It's another example of a system that distrusts provider integrity and replaces needed provider support with unreasonable, costly and time-wasting oversight burdens that do little to enhance quality. It is perfectly understandable for a provider to be unable to lay hands on a particular piece of documentation at a moment's notice. This is especially so when auditors request material that has little or nothing to do with performance but is more focused on bureaucratic minutia than on consumer well-being and recovery. If there are providers who routinely fail to produce documentation requested by auditors, then go after them. Let the good providers do their jobs.

   - Daryl stated that this new process will be helpful in identifying the fraudulent providers that should not be allowed within our system. While this may appear inconvenient to the vast majority of reputable providers, there is still the ability for them to forward legitimate documentation for consideration after their audit.
   - Zereana reiterated that audit visits are announced to give providers the time they need to ensure documents are present. She also explained that post-audit, Providers have the opportunity to respond to their audit findings and can submit documentation at that time. Guy Reese echoed this process and stated that if there are extraordinary

circumstances related to an audit, that VO is always open to discussing and taking that into consideration.

- Rebecca also confirmed that Medicaid is no longer automatically allowing a 24 hour documentation submission, and this now aligns the process with all other Medicaid audits.
- Mike stated that he has also been working to encourage the provider community to begin using the collaborative documentation process. This allows for client involvement and timely documentation completion.

5) CBH also wants to go on record as urging changes in Medicaid's "revalidation" process that, per federal law, requires states to conduct site visits to verify the existence of Medicaid billers. Two concerns so far are that a) reviewer practices are inconsistent and b) Medicaid uses these visits to review compliance with unrelated and seemingly arbitrary regulatory issues. Two immediate requests are that a) reviewers treat providers with courtesy and respect and b) Medicaid confine the scope of the visits to the provisions of federal law.
   - Rebecca stated that the designated risk rating for behavioral health providers was created by the federal government. There are a series of requirements of the state to ensure that the providers are doing business at the correct location and other compliance checks. All site reviewers come prepared with their check-list and an understanding of their purpose for their visit.
   - Rebecca acknowledged that while there are many different personalities, often providers' interpretation or experience with an auditor can be tied to the audit results. This may cause a provider who struggled in their audit to perceive their auditor as unhelpful or discourteous. Medicaid has received only a small number of complaints and most of those did not reflect on the quality of the site visitors. Overall, there has been very positive feedback on these visits.
   - Daryl emphasized the importance of addressing problems with specific site visitors separately from the overall concern regarding provider unhappiness with another form of auditing. This will allow Rebecca to investigate and address individual problems as they arise, while still allowing group discussion of the overall provider concerns.
   - Rebecca addressed the second point above by acknowledging a recent misunderstanding during a visit. She stated that this was resolved quickly and that she has received no other feedback that site visitors are stepping outside of their scope. She further clarified for providers to be aware that if an item is in regulation, then it is within the scope of the site visit.

- Rebecca asked that if there are any other examples to please forward them and she will review. She also clarified that if you have a board that influences the policy of the program, or has a stake in the program and how it is managed, those individuals do have to be vetted based on the federal rule.

6) Why did VO issue memos on July 8 about PRP staffing? We understand the new regs will keep in the described ratios but there will be other changes. E.g the PRP rehab director and specialist can be one and the same. Plus BHA agreed to expand the credentials for the C&A rehab director to include CPRP + child certification. Please explain.

   - Daryl stated it was a reminder of the rules due to many of the PRP's not doing well on their audits.
   - Sharon added that the new regulations are silent on program director requirements. BHA wanted to ensure it was clear that the rehab specialists would be the ones that are responsible for the actual services delivered.

7) Status of Medicaid training on use of the DLA-20 assessment tool. Is Sept 30 still the date that PRPs and ACT teams will have to begin using it?

   - Daryl stated that issues surrounding the DLA-20 are still being discussed. While September 30th was the official date, with open items still on the table, this date may need to be adjusted.

8) Status of VO Regional Forums that are to include ICD-10 training.

   - Zereana stated ValueOptions will be providing both ICD-10 and ASAM training during our regional forms in August. More information will be provided as the forums approach.

9) Status of BHA feedback, if any, to providers in response to submission of salary data and cost reports for FY14

   - Daryl stated BHA has not identified a resource to analyze the data. They continue to review this and any further cost data needed.

10) A member reported that claims payments this week were in separate batches (MA vs uninsured?) and the uninsured ones were a day late. Is this because of the change in banks?

- Arnissa confirmed that this is due to the two new Bank of America accounts, and this will continue moving forward. She further reminded providers that if they do not currently bank with Bank of America, that they may see a different payment date than usual.

11) From a member: "In 2013, VO clarified that the new Psychotherapy for Crisis codes (90839; 90840) could be billed on the same day as another therapy service since by the nature of a crisis, the client could return on the same day. We are getting denials on these."

- Daryl confirmed that there are providers who are approved for both codes on the same day, and it is allowed. Dr. Lann further clarified that authorization is required and that if providers are receiving denials, they should send examples to VO for review.

12) Diagnostic codes: Is it permissible to bill a 90791 in the initial authorization; then another 90791 and 90792 in the following 6 month OMS auth period? In other words, are there two eval codes available per initial, then per 6 month auth period?

- Dr. Lann stated that while this is allowed, it is not the clinical standard to redo a full assessment every six months on an individual. There are instances of transfer, shifts in staff or a change in condition that requires an entire diagnostic reassessment. VO reviews these services and clinical indication regularly and will identify if any one provider is overusing this assessment function to identify abuse within the network.

Questions:

Mike Drummond, from Arundel Lodge, requested a hard copy of required elements that precede the OMS interview. This will assist in streamlining the assessment process.

- Dr. Lann reported that Donna Shipp would be able to provide those screen shots.