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

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, February 12, 2016
10:00 am to 11:30 am

In attendance: Zereana Jess-Huff, Karl Steinkraus, Donna Shipp, Jarrell Pipkin, Stephanie Clark, Page Morris, Kayla Moulden, Patricia Langston, Sharon Jones, Sueqethea Jones, Greg Burkhardt, Dr. Helen Lann, Dr. Maria Rodowski- Stanco, Joana Joasil, Shanzet Jones, Kathy Rebbert-Franklin, Lauren Herron, Annie Coble, Daryl Plevy, Oleg Tarkovsky, Christina Trenton, Mercy Johnson, Mike Drummond, Andre Delegrini

Telephonically: Abrams, Danita; Appelbaum, Abby; Ashkin, Howard; Baker, Cathy; Bartlett, Robert; Berry-Candelario, Imelda; Bittinger, Kimberly; Branch, Christine; Canipe, Carroll; Collins, Heather; Craig, Veronica; Erskine, Kim; Esters, Veleka; Forster, Cheryl; Garner, Joyce; Gielner, Michelle; Grant-Cunningham, Towanda; Grodnitzky, Jody; Haina, Sara; Hall, Shannon; Hinman, Kennedy; Hughes, J.R.; Hunt, Seante; Hutson, Connie; Jackson, Kirsten; Jeyachandran, Sheba; Jones, James; Karakcheyeva, Victoria; Kevas, Agella; Layman, Donna; Levison-Johnson, Jody; Lewis, Gertha; Mcneil-Johnson, Chandra; Mattison, Kathryn; McCrea, Robin; McGee, Anna; Medlin, Carrie; Ott, Geoffrey; Page, Barry; Perry, Suzanne; Reid, Esther; Rimi, Mary; Schooley, Anne; Smith, Lindsey; Smith, Jennifer; Williams, Keshia; Winebrenner, Mary; Morris, Eugene; Pleasant, Tonya; Porto, Carol; Stanley, Regina; Watkins, Kevin; Wilkoff, Susan; Giles, Lakisha; Green-Briscoe, Sharon; Hinkelman, Lillie; Kammar, Colleen; Njoku, Albert; Okras, Kara, Raynor, Tina; Reines, Helen; Smith, Debbie; Sorrell, Sharon; Sterling, Christie; Urso, Despina; Vaccaro, Christi; Wahl, Barbara; Barnes, Sommer; Towers, Jeff

Topics & Discussion	Follow-Up Actions
Minutes – Reviewed and approved BHA Update – Daryl Plevy Update on CCBHC's: • The Department has received approximately 16 applications from providers showing interest. Of those that were received, some did not answer all of the questions and/or did not meet the requirements. • Next steps will be submitting an application for consideration to be a CCBHC. Once those have been received, two providers will be selected (one rural and one urban) and they will be able to deliver enhanced services. • One grant requirement is that the board should be 51% consumer run or equivalent. BHA is asking stakeholders for input on this issue, including consumer groups, on suggestions and then there will be an advisory group developed. • CMS is allowing a quality bonus payment as part of the rate and BHA is in discussion on one rate or also a bonus payment related to meeting certain outcome measures/targets. BHA, in conjunction with Medicaid and Hilltop, is still reviewing models for rate setting. • Please note that it is a requirement that the CCBHC be a single legal entity. This has been clarified to mean that you cannot have MOUs with other providers and be applying together. Base services must be provided by a legal entity with decision making authority over the entire organization. • For those considering applying, the Department would like to remind all that there is extensive cost reporting data required under the grant. If applying, please check the BHA website because you will need to have the technical capacity to complete the necessary reporting during the demonstration. The RFA will be going out in the next month. • BHA is reviewing the request for providers to know which sites have applied and if they are	

able to disclose this information, it will be posted on their website. • Dr. Lann, Medical Director for Beacon Health Options, informed providers that if there are sites interested in applying, that Beacon has experience with similar sites so we would be happy to consult with those sites and provide technical help/consultation if desired. Medicaid Update – Annie Coble • No updates as content will be covered in the below provider questions. Beacon Health Options Update – Dr. Zereana Jess-Huff • Zereana, CEO for Beacon Health Options Maryland, will be providing ASAM training in Baltimore City next week. Unfortunately, registration for this training is closed but we will be adding additional dates -- look for provider alerts. • Dr. Lann announced that Beacon has put out its white paper on Integration, which explains the company promotion and stance on integrating Behavioral Health Care with PCPs. This paper reviews the collaborative care model and different models for severely chronically mentally ill individuals. There will be a provider webinar on this and if interested in attending, Beacon can push the information out to providers. CEU's are available for attending this training. If there are providers that have done innovative work on integration please contact Dr. Lann at Helen.lann@beaconhealthoptions.com. • The Beacon white paper on the opioid epidemic is currently posted on the Beacon website. • Jarrell Pipkin, Quality Director, reminded providers that recently Beacon, in collaboration with the Department, sent out a provider alert on a capacity survey. So far Beacon has received numerous responses and we will continue to	

collect through end of next week. Daryl adds that this is a critical survey and will give important information for the movement of grant funds. By providing feedback, the Department will be more informed on where there are gaps in capacity and when providers are considering expanding locally or into another jurisdiction. • Providers are updated that the annual consumer survey is being worked through at the IRB and consumers should expect to begin receiving letters in early March. Daryl states we are including substance use clients this year and ensures providers that the surveyor will not know if the consumer is receiving mental health or substance use services.	

Questions

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1. **Can we get a process in place for asking for 1 additional day w/o going thru 12 pages of concurrent review screens? Is there a way to eliminate getting 1 day auth? Not enough time to even process the admission. Can we get coverage thru weekend on Friday admissions?**

- Beacon Health Options makes every effort to ensure a streamlined process that is not administratively burdensome to our provider community. Unfortunately, we would need more information than was addressed above to ensure we are giving the appropriate guidance regarding MNC, level of care, etc. If there is a specific question, providers should contact Page Morris at page.morris@beaconhealthoptions or Dr. Helen Lann at Helen.lann@beaconhealthoptions.com.

2. **We have had several patients insurance change eligibility while they are admitted at our Inpatient Treatment Program. For example, they go from Full Medicaid to Uninsured. This change takes place after we have checked eligibility through EVS and also through Provider Connect (where we find NO expiration date), however; the expiration date is put in retroactively. With the patient then having no benefit that covers our levels of care PHP and up), we are forced to terminate their treatment episode early, usually just after detoxification, and find them a lower**

level of care. We have written off thousands in the past 2 months because of these situations. Are other providers seeing this? We have started EVSing daily and checking status in Provider Connect daily to ensure that we are covered, but the bigger picture is that it is affecting our patients and the amount of intensive treatment they require. Many are homeless with less than adequate support systems. It puts our discharge coordinator in a predicament to find appropriate aftercare in less than 24 hours, and of course the patient feels as though he or she is being rushed out the door. We need better suggestions on how to handle these cases.

- During provider council there were a variety of topics discussed regarding eligibility, with the below being the most current and correct information.
    - There was discussion around a patient being eligible on the first of the month meaning that they are eligible through that month. Unfortunately, in the context of the loss of eligibility retroactively, this does not help with the issue of retroactive loss of eligibility. When recipients neglect to submit proper documentation that supports their financial need for Medicaid then eligibility may be denied and it may be retroactive to the date of application. That is why some recipients could lose eligibility for a date after which a service was rendered and Medicaid, through its ASO, retracts the payment since the recipient was not eligible for that date of service. Medicaid's policy is consistent on this for all providers: If you have proof that you verified eligibility prior to delivering a service on the date of service then we would authorize re-payment (assuming payment was retracted). This verification may be through EVS directly or through Beacon's Provider Connect system where a provider can verify eligibility. During the issue with Medicaid's re-determination system, Beacon developed re-determination reports which should be used by providers to help ensure that they are aware when their patient may be due for re-determination for eligibility for Medicaid. Providers can be an essential resource in helping patients make sure they have the proper documentation during their re-determination period so that an eligible recipient does not incorrectly lose their Medicaid. The Department is working toward improving systems related to eligibility and the work also continues around developing processes to help individuals when they lose their eligibility for a temporary time period.
- Daryl Plevy, BHA, further adds that this is one of the prime reasons the state is looking to move grants from the local level to the Beacon system. This would allow a similar process as is used for mental health -- when an individual loses MA, the provider can go into the uninsured workflow and get uninsured payments with no gap in coverage as long as the person meets uninsured criteria. Now, an individual would have to go to a grant funded provider if they lose eligibility for Medicaid, which often means the participant has to switch providers in the middle of a course of treatment. Ambulatory services will move no later than Jan 1, 2017 and Residential services will move on July 1. 2017. Counties that would like to move their ambulatory services early are able to elect to move them to Beacon Health Options as of July 1, 2016. This will open up providing these services to all providers in those jurisdictions and no longer require providers to have a contract with local authorities. Providers are encouraged to contact

their local health departments if they are in favor of moving these funds from the local jurisdictions over to Beacon Health Options.
- If providers have specific examples that they would like Beacon to review, please email them to providerrelations@beaconhealthoptions.com for full review.

Additional Questions:

1. **Since QMBY and SLMBY can't buy private plans and have non reimbursable private MA, how long will they be covered by BHO once grant funds are moved?**

- If consumers have QMB and/or SLMB, this means that they have an income that makes them eligible from Medicaid for the Co-Pay of their Medicare premium. It does not entitle them to Medicaid covered services, as Medicare is their primary insurer. They do not have secondary Medicaid – it means they needed assistance with their co-pay.
- With regard to grant funds, under the uninsured workflow the participant has to meet the criteria, including 250% of poverty among other things, and providers must attest they have worked with the participant to apply for insurance and keep documentation in the medical record. Providers may obtain two months of auto authorizations to gather necessary documentation to assist consumers in applying for insurance. On the third month, providers are referred to the local governing authority (CSA/LAA). Providers are able to get authorization for a third month of uninsured funding from the local authority, but only if there is a very good reason for not applying for insurance, such as the consumer was unable to complete the application process due to being very ill.

2. **In addition to the above question, what if the exchange is closed and the shift is not a qualifying life event -- what will patients do until next year?**

- The Department will review this scenario and take under advisement.

3. **Since Family Planning Only (FPO) or MA does not pay for OTP services, how long will a participant with FPO only be covered by BHO once grants are moved to BHO?**

- Please see the answer above. FPO has a higher income amount to get that benefit only, so they would most likely be required to go through the exchange. Consumers need to do that as soon as possible so that other insurance is covering the cost of these services. State only funds are there for when there is no other option for the individual. They are very closely audited by the legislative auditors to ensure we are not spending these funds when there is another funding source.

4. **Is the BHA program for housing providers as well?**

- The CCBHC model is a very comprehensive model with outpatient health centers at the core and has to have substance use capacity, have or access crisis services, deliver Evidence-based Practices (EBPs), but housing is not one of the requirements. However,

the CCBHCs can develop relationships with other providers outside of the core services. One of the EBPs is ACT teams. Having a relationship with housing providers would be beneficial, but it is not a core required service.

5. **For the RFA, will providers that did not send a letter of interest still be able to apply?**

- Possibly, please send an email to Jenny Howes at jennifer.howes@maryland.gov if you are interested in applying but did not submit a letter.

6. **Last council there was a request for input on accreditation requirements -- to whom are we to submit this input?**

- There is a website for this input and the comment period has closed. Providers should be aware that the next step is approval.

7. **Will there be any guidelines submitted to the Local Addiction Authority to distribute the monies beyond their health departments prior to 1/1/2017.**

- The budget letter, supplemental award with ambulatory dollars, and grant application instructions have gone out. l The local health department has the right to determine who they contract with and for what types of services. Providers should be aware that this will no longer be an issue as of January 1, 2017, when funds move over to Beacon Health Options. Providers are encouraged to let the local health department know if they are in support of this change due to differences in health department communities.

8. **What ICD 10 code should we be using for clients who do not meet criteria for treatment but have completed an assessment? LAAs reported at one time that R69 was to be used but says is no longer the case?**

- Karl Steinkraus stated that R69 is the proper code. One LAA did send Beacon an advisement of a different code and we are reviewing this code before we send it over to BHA/MA.

9. **Is there an update on increasing qualifying diagnoses for adults for PRP?**

- As of now, the priority population is published on Beacon Health Options' website and if there is feedback/input it can be reviewed. Please send any feedback to Dr. Helen Lann at Helen.lann@beaconhealthoptions.com

10. **The H0001 intake is covered once every 12 months. Is there a way to bill for a second intake?**

- It is available if there is a 30 day break in coverage.

11. Is there a date for accreditation set yet?

- Until regulations are approved, there is no date for the accreditation requirement. Providers should be aware that accreditation will be required 18 months after final approval of the new regulations.

12. When will the provider council minutes go out?

- Provider Council minutes are sent out through the provider alert system and are distributed before the next meeting.

13. Will there be an upcoming provider training on TBS, focusing on changing approval and denial processes?

- At this time, there are no changes to the approval and denial process, and the MNC is the same and the process is the same. There is a workshop that will be looking at child and adolescent service levels. This workshop is collaboration between BHA, MA, Beacon Health Options, and a group of participating providers. This group will focus on developing clarifications on populations, benefits, type of treatment and what those treatments are. While the providers have already been selected, this group welcomes all feedback and encourages non-participating providers to reach out and give their input to those providers that have been included. For a listing of participating providers, please contact Dr. Maria Rodowski-Stanco at maria.rodowski-stanco@beaconhealthoptions.com.

14. As a follow up to the transmittal on re-bundling, it appeared that this document was mainly focused on methadone. Will the same rules be applied for buprenorphine?

- This item, along with all feedback, is still being reviewed by Medicaid (MA) and they are hoping to have comments out next week. Once MA has fully reviewed, they can give input on buprenorphine.

15. Is there an update on Telemedicine? Is Beacon Health Options working on this with the Department? Has anyone been approved?

- Yes, Beacon has been working with the Department and we have received information earlier this week from several providers. Letters should be going out to providers later this week. As far as set-up with Beacon, once approved we have to add the fee schedule to the originating and distance site. Providers will then receive a call from our Provider Relations team and they will walk the organization through the entire process.

Uninsured only covers outpatient? It will in the beginning so the first migration of grants to Beacon will only be ambulatory outpatient services, in full Jan 1, 2017, and partial in July 1, 2016.