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

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, August 11, 2017
10:00 am to 11:30 am

In attendance: Patricia Langston, Steve Reeder, Jody Grodnitzky, Bryce Hudak, Mike Drummond, Jenny Howes, Jody VanOrder, Donna Shipp, Marian Bland, Cynthia Petion, Joana Joasil, Annie Coble, Sueqethea Jones, Michael McCoy, Elaine Hall, Karl Steinkraus, Jessica Allen, Lisa Kugler, Jonquil Ishway, Tyrone Flemin, Adianez Corpes, Lindsey Smith, Shannon Hall, Carol Sanders, Kathleen Franklin, Tracy Bryant

Telephonically: Deondra Smith, Howard Ashkin, Timothy Santoni, Shereen Cabrera-Bentley, Ashley Rock, Renée P. Stokes, Fran Stouffer, Maritrese Nash, Monica Kirkpatrick, James Jones, Anne Schooley, Abby Appelbaum, Tammy Fox, Sheba Jeyachandran, Anna McGee, Nicol Lyon, Mary Beth DeMartino, Michael Ostrowski

Topics & Discussion

Minutes

- Beacon's email address for Provider relations is: MarylandProviderRelations@beaconhealthoptions.com and may be used by providers to submit suggestions or edits for the minutes as well as questions for the next Provider Council. To have your questions considered, please submit no later than the Wednesday prior to the council meeting, to allow time for research and response.

BHA Update

- BHA announced the following staffing changes. Kimberly Cuthrell, Ph.D., formerly Director, Baltimore County Local Behavioral Health Authority (LBHA) will be the new Director, Systems Management Division effective September 27, 2017. Spencer Gear will assume the new position of Director of Accreditation beginning August 16, 2017. Brendan Welsh has been promoted to the position of Director, Office of Consumer Affairs.
- The launch of the Residential SUD treatment benefit in Beacon appears to have been a smooth transition for providers, as there have been minimal reported

issues. We continue to have weekly Joint Operations Team (JOT) calls to address any questions or concerns that providers may have.

- The Transfer Grant process will be building on work with Residential SUD treatment services in phase 1 and starting to focus on details for phase 2. This phase includes Health General §8–507 (civil commitment for SUD treatment) and pregnant women and children in addition to 2 other projects with the Department of Human Services. Phase 2 will roll out January 1, 2018.
- Gambling funds are available for those that are unable to access services through Medicaid. These consumers could be served through the substance use program or mental health program Gambling Fund Services were available in May and will be made accessible for Residential Services. This would mimic the coverage available for SUD services. Level 3.7 will not be covered, but levels 3.3 and 3.5 will be covered. A Provider Alert will come out shortly identifying the additional benefits to our package of covered services.
- An update on Maryland Opioid Rapid Response (MORR) Grant. BHA released a Request for Expression of Interest (REOI) on July 14, 2017 to the Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHAs) in order to seek interest in development of crisis beds within a Level 3.7 facility and/or expansion of Level 3.1 services. The proposals for this action were due yesterday and BHA is currently reviewing the proposals that have been submitted through the REOI process. The goal of the Department is to have services implemented in September. BHA will need to successfully implement MORR grant-funded services and activities by the end of April 2018. Once the funding awards have been finalized, we will disseminate information as to which jurisdictions and providers have been funded.
- BHA is working on awareness activities and will be partnering with Maryland Public Television to create public service announcements on the Opioid Crisis. This will be advertised through Maryland Public Television and will start in January, 2018. The 2 main foci are stigma reduction around Medication Assisted Treatment and raising awareness around being prescribed opioids.

Medicaid Update

- Medicaid updated the council about the incoming provider enrollment vendor, Automated Health Systems (AHS). AHS attended today's meeting to give an overview about future changes to Medicaid's enrollment process.
- **AHS** has been in business for 39 years and began with their first Medicaid contract in 1979. The rollout for the new Medicaid enrollment system will be in the Fall of 2017. There will be an electronic portal for providers to use to enroll with Medicaid. This portal will utilize provider information for enrollment, re-enrollment, re-validation, and information updates. There will be an automated database verification, call center for provider enrollment which includes a Customer Relationship Management tool (CRM) to communicate between the Call Center and Medicaid staff and document repository. More information will be

forthcoming but remind providers this will be phased in with messaging geared to the impacted providers first. . Please see the attached slides from AHS' presentation for more detailed information.

Beacon Health Options Update

- Provider Relations has a new staff member that began on August 7, 2017. Her name is Jonquil Ishway. She will be handling Beacon's substance use calls, concerns, and questions pertaining to claims.
- Beacon is working with the University of Maryland and will be able to provide CEU's for peer support training. The first training will occur in October.
- Beacon also has a new Child and Adolescence Associate Medical Director. Beginning in early September, Dr. Juanita Lynn Taylor will join the Clinical team

Provider Questions

1. For Child and Adolescent PRP Providers there has been discussion around the lag time that is taking place with the approval of authorizations. I know some providers are even reporting more frequent denials. My concern is that with the delayed approval kids are sometimes experiencing a delay in services for 2 weeks or more. These kids have intense needs and we are trying to avoid things like hospitalizations so for them to go 2 weeks without their PRP worker coming out is a problem. As a provider we are uneasy about seeing kids without an approval especially given the increased denials that other providers are reporting. What can be done to address these concerns?

   Beacon recently ran a report to check this concern and the report shows that 96% of reviews were completed within 3 days. Beacon would like to see this number hit 99%. There are a number of factors that took place causing this decrease in the timeframe for reviews to occur. Beacon has hired additional staff that will start work next month and, as part of their orientation, they will review processes for opportunities to streamline these reviews. Beacon reminds providers that you should include clinical information when requesting authorizations, which will help reduce the need for additional follow up. The denial rate for PRP decreased 38% since the adoption of the NCQA authorization standards and best practices. Beacon will continue to work towards improving turnaround time for reviews.

2. If an OTP patient attends 2 groups in a single day, we are submitting the claim using the H0005 and 2 units. We are having these 2 units H0005 claims denied with the BS denial code indicating that the billed amount exceeds fee schedule rate. Are we only able to be reimbursed for 1 group per day per client?

Yes. Please refer to the SUD Service Matrix at: http://maryland.beaconhealthoptions.com/provider/alerts/2017/042817-SUD-Matrix-eff-May-15-2017.pdf . The Department reimburses SUD programs one group per day.

3. My question has to do with State Care Coordination. When moving Residential services to Beacon was in the planning stages there was some talk about how State Care Coordinators would be notified when an individual from their jurisdiction was admitted to Levels 3.7/ 3.7WM. We are now a month into the transition to Beacon and our County has not gotten any notification that we have anyone in those levels of care. Our Care Coordinators have been calling the local facilities weekly to check for admissions, but my fear is we are missing folks. Has there been any determination how the Care Coordinators are being notified and when will it start? Can the Care Coordinators get a list of all the approved Providers who are offering Levels 3.7/ 3.7WM, 3.3 through Beacon Health Options?

   The Release of Information (ROI) specific to State Care Coordination is currently under review by BHA's Assistant Attorney General (AAG) for legal sufficiency. The Department is making minor additions to the ROI in response to the AAG's comments. Once approved, the ROI will be posted on the Beacon website and disseminated to the provider community. Providers are advised that the Medicaid rate for residential SUD treatment includes aftercare coordination. The residential provider, upon soliciting the informed written consent of the individual, would then initiate a referral to State Care Coordinators. Since this is the process that was in place prior to the transfer of grants, there should be no disruption in the flow of referrals for SUD care coordination. BHA has received approval to distribute a list of providers that offer the varied ASAM levels of care.

4. **Aligning Fee Schedule with CPT Codes**. In January 2017, the AMA made changes to the CPT psychiatry code section. Codes 90846 and 90847 (Family Therapy with and without client) had changes to time components. The codes now have a time of 50 minutes. According to time guidelines, the AMA and CMS have instituted mid-point timeframes for billing. The minimum time for 90846 and 90847 is 26 minutes (in other words, the mid-point threshold is passed). For these 50 minute codes, no services can be billed under 26 minutes. A modifier is not appropriate. Per the new Beacon rate sheet, 90847-52 modifier shows an "abbreviated" session for a C&A client, 90847 is listed for 45-60 minutes (adult and C&A). Beacon has not recognized this change. Will it do so? If so, when?

   The Department will take this under review.

5. **Clarifying Provider Alert**. A recent provider alert (dated Aug 4) modifies the authorization span in response to provider concerns, effective for new clients. For existing clients, will a review and modification of authorizations take place? For example, the provider may only bill for services in six of the seven months covered by the authorization span. Can the span be adjusted to end on 11/30/2017, or can a third line be adding approving an additional unit for December 2017?

   The DLA-20 providers who do not have sufficient units to bill for the services will get additional units for their care. Please make a list of the individuals who were impacted and email it to Beacon at Marylandclinicaldept@beaconhealthoptions.com. Beacon is in the process of doing internal reports, in order to generate the information and start on the change and understand it will take time to get addressed.

6. **Clarifying Provider Alert.** A recent provider alert indicated that, effective June 15, 2017, all pre-authorizations are approved for physician's services for 90 days, rather 60 days. Does this include the physician anti-psychotic drug pre-authorization requirement for all youth under 18?

   This information was sent to Medicaid's Pharmacy Program and is currently under review.
   Post meeting update: This alert/transmittal does not include the antipsychotic drug pre-authorization requirement for children under 18. This only applies to prior-authorizations that are done for medical claims.

7. **Clarifying Provider Alert.** From a Provider Alert 7-2010, Family Psychotherapy without client present (90846) for NON-OMS consumers (Children under 5, usually being served in Head Start programs), are limited to 4 per year, and additional may be requested. What is the definition of a year in this context – calendar year, treatment authorization year, or treatment authorization period? Providers have received conflicting guidance and would appreciate clarification.

   This is considered to be on a calendar year.

8. **270/271 Eligibility Verification File Exchange Capacity**. Several CBH members have recently developed the capacity to do 270/271 file exchange, which allows for eligibility verification for multiple consumers. Providers have received conflicting guidance on whether Beacon's system currently has capacity to do 270/271 file exchanges. Does it? If not, is such capacity under development and, if so, by what date do you anticipate having it?

   Beacon's system does have the ability to process 270/271 electronic transactions and is currently testing this process in several of our markets. This has not yet

been offered in Maryland, and Beacon would need to discuss offering this service with the Department. Maryland Medicaid is the system of record for consumer eligibility. The EVS system is the most up to date method to check consumer eligibility and it updates nightly.

Multiple Modifier Capacity. In recent months, we have raised two issues with claims not paying correctly with multiple modifiers (i.e., using -GT and -HE modifiers on RCS services, and using -HE and -22 modifiers on RCS services). It is our understanding that these problems occur because Beacon's system does not support using multiple modifiers on one code. Is that correct? If so, that raises a host of questions about how policies – such as the proposed expansion of Medicaid telehealth services – can be correctly operationalized. If multiple modifiers cannot be used, what steps are planned to correct this, and with what anticipated timeframe?

Beacon is working to resolve this issue. Beacon and Medicaid will meet next week to go over this information. Providers who experience this problem should send an email to marylandproviderrelations@beaconhealthoptions.com and Beacon will make sure the claims are corrected.

9. **Processing Authorizations for Outpatient Services.** In March 2017, Beacon issued a Provider Alert indicating that the deadline for responding to non-urgent authorization requests would be expanded to 15 days. At the time, Beacon indicated that it didn't intend to take longer to process routine authorization requests but, where insufficient information was submitted, Beacon would have time to request more information, rather than deny an authorization request.

   Based on a recent Beacon report, 96% of reviews were completed within 3 days. Providers need to include clinical information when requesting authorizations to reduce the needs for additional follow up.

10. **Inconsistent Slowdown.** Since about mid-July, 11 providers reported a slowdown in processing some authorization requests. Providers report that some authorizations are approved in 2-3 days, while others pend for up to 15 days prior to being approved. Can you clarify what providers should expect for processing a routine, outpatient authorization request that contains sufficient information?

    Questions 10 and 11 have the same answer. Please see above.

11. **Backdating Authorizations for Disappearing DLA-20 Tabs.** Last month, we reported a single-provider issue about not being able to access DLA-20 tabs; that issue has been resolved. However, this month, another provider reports a similar problem; Upper Bay indicates that the DLA-20 tab disappears when they're doing

authorizations. They had previously gotten this problem resolved, and now it's broken again. This has been brought to Beacon, which is working on fixing it again. For providers impacted by DLA-20 functionality problems, can authorizations be back-dated?

The clinical department is not aware of the issues with Upper Bay and if there are specific problems this facility has with the DLA-20 they should send examples to Marylandclinicaldept@beaconhealthoptions.com to further look into this situation. There is a workaround in place that is working successfully for the provider that was discussed, which can be used for Upper Bay. IT is currently trying to fix the system, so there is no issue where we have to use workarounds.

12. **Modifiers for SUD 99211-99215.** (This was asked at July meeting and may be moot if resolved in July minutes.) Three CBH members seek clarification about billing for Type 50 providers. The July question related to a Type 50 SUD trying to provide MAT services by employing a Data Waiver 2000 certified doctor. The provider alert containing the updated fee schedule has HG modifiers required to bill for ongoing services but there are no modifiers for induction (initial intake). How can we see and bill for new clients?

    Please note this information was not shared at this meeting but is being responded to in minutes.

    No induction to buprenorphine code for reimbursement was added to the Provider Type 50 programs. When designing this benefit, Medicaid was assured that access to the Detox code would be adequate to use for induction as long as it was clear that induction was billable in this way. Subsequent information from some providers suggests this is not the case. Programs have the H0001 code for assessment (new patient), H0014 Detox (which was considered to be used for induction when appropriate), and E&M codes specific for medication management for maintenance for patients who are receiving MAT. (Provider Alert 5/3/2017), There is a real concern for duplicative billing using public funds and this issue will be vetted further by MDH.

13. When requesting authorization (Concurrent) for Methadone Maintenance using Methadone OMS it states we should receive 2 weeks to complete the OMS and 30 units, this to cover the first 4 weeks. After the initial Concurrent we are to receive 6 months Methadone Maintenance visits and 160 units. However, that is not how Provider Connect is now authorizing units, which results in a mass amount of claim denials. Why is the service split, (one line for methadone maintenance and a separate line for substance use disorder services? Why does

the date span not match? Per your claims department because of the way it is listed via Provider Connect to split up the dates and list specific services they are now reading as if we have no authorization for these services. I have over 40 claims now that have denied. Is there any update on this issue?

As of May 15, 2017, the OTP bundles have changed to rollout the new rebundling efforts. Prior to the rollout, Beacon completed internal programming to update the service class and units for providers that had existing authorizations. Due to OMS providers being able to enter dates up to 100 days prior, if a provider is entering a concurrent authorization request prior to May 15, then the authorization is picking up your old authorization information and will not pay claims appropriately. To ensure we address these issues until the September cut off, Beacon is running a weekly report of these authorizations and manually adjusting your authorizations. Authorizations created after May 15, 2017 should not see any issues. If providers have claims that are denying because of the way it is set up please send this information to Marylandclinicaldept@beaconhealthoptions.com so it can be addressed appropriately.