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

Beacon Health Options
1099 Winterson Road, Suite 200
Linthicum, MD 21090
Friday, August 9, 2019
10:00 am to 11:30 am

In attendance:

Telephonically:

Topics & Discussion

Minutes

BHA Update

Medicaid Update

Beacon Health Options Update

Provider Questions

1. I heard that Beacon Health Options was not selected to continue as the ASO for MD Medicaid and that, as of January 1, 2020 there will be a new ASO. Is this true? If so, can you tell us who was selected for this role?

2. As more Spanish speaking families are seeking services in our area, does MD Medicaid have any benefits/funds to cover interpretation services?

3. Perhaps I missed it, but I have not received an update on the new requirement for NPI numbers for individual providers in OMHCs. Has a new implementation date been seen?

4. Is Beacon Health Options going to leave all the Grey Zone payments that have been showing up on the MA check each week since 7/9/19 for services after 6/30/19, or will there be a change/reprocessing that Providers should know about, or are we just going to continue to receive our GZ payments on the MA check in the future?

5. FMCS status on active clients. We were told by Customer Service at the beginning of July that this would not affect our client services when we called immediately after the FMCS started to appear on the consumer insurance profiles. The Customer Service Representative said FMCS said that this insurance only applied to 2 providers, Brooklane and Sheppard Pratt, for inpatient stays. When we tried to get Grey Zones for these clients because there is a MA lapse, the Beacon system will first not allow us to input a Grey Zone request online. When calling the 800 number, we were told we had to do over the telephone but, they would deny our request because of the FMCS was active. Can we please understand more about this situation?

6. New Medicaid Eligibility Codes. When verifying Medicaid eligibility for consumers, Provider Connect now lists FM1 and FM2 as funding sources for Medical Assistance. What is the funding source associated with each code, and what is the purpose of the new codes?

7. When a client is receiving services in the 3.7, or 3.7WM LOC, can an external lab bill medical lab charges, such as a CBC and BMP, or are these considered part of the daily rate for SUD?

8. Workflow change for lapsed Medicaid eligibility? Two providers (Behavioral Health Partners of Frederick and Channel Marker) report an operational change for consumers when Medicaid coverage lapsed. Individuals used to be automatically enrolled in the uninsured eligibility category with 30 days of coverage to renew Medicaid. Now, individuals are identified as ineligible unless the provider manually enrolls them in the uninsured workflow, while simultaneously working on the Medicaid renewal. Is this an overall operational change in practice for individuals with lapsing Medicaid? If so, can operational changes like this be communicated to the field in advance of implementation?

9. E&M rate increase – It appears that they were not given the 3.5% increase 7/1/2019. The increase was only pennies? Is there any reason?

10. Accreditation question – Recently we moved. We notified the Joint Commission of our intention to move in April 2019. The Joint commission came to visit within 7 days of our move. They said it was because the State of Maryland required us to have the site visit immediately. I know many other agencies that are accredited by CARF, that when a move occurs CARF issues a preliminary letter stating that the agency is accredited for the new location, and will be reviewed on the next site visit. What is correct, immediately or at next site visit?

11. Beginning in April 2019, our claims for OMHC services have been denied for patients who also receive ABA services from another provider on the same date of service due to the maximum sessions per day rule. These patients receive ABA services every day, therefore, we do not have the option to see them on a day they are not receiving ABA services. It seems the denials began after the new CPT codes for ABA services went into effect earlier this year. Each provider (OMHC and ABA) has received authorization to provide services to the child as they are different services and are both clinically indicated. Please advise if an exception can be made to the maximum services per day rule to ensure both providers can be paid for the services rendered.

ePrep

12. This seems to be a problem for revalidations and other MA related issues. We applied in late April for a move to our new address. This process took 9 weeks to have the MA surveyor out to do a site visit which was fine. Our application appeared fine, all solid green dots. However, after the Surveyor did the site visit, they returned our application for a field that was not checked regarding DBA, which we do not have. Now we are again back to the beginning again. My question really is, once you fix something for something so minor as checking a box that wasn't required, why do we go back to beginning of the Queue again, basically starting all over instead of returning to the same place in the Queue. I could go on and on about the whole EPREP thing for a lot of other reasons, disaffiliations that take months to occur, revalidations gone awry, giving MA numbers to applicants that entered license info wrong, it just goes on and on.

13. In the past, ePrep would send notifications emails to the provider stating that there was a message waiting to be reviewed. Revalidations are taking weeks and weeks and being denied for small errors without any contact with the provider, including the lack of notification emails. This results in suspensions that cannot be reversed quickly. What can be done or is being done to avoid 12 to 15-week

wait times? It is now understood that relying on any communication from ePrep or reviewers is not to be done but the wait times still are long.

14. What is the status of efforts to resolve with CMS the conflict between Medicare "incident to" billing rules and Medicaid rendering NPI rules? Is there an anticipated timeframe for resolution?

ASO Transition

15. **Transfer of unresolved provider billing issues**. How will unresolved billing provider issues be transferred to the new ASO vendor? Will there be a list of "open tickets" transferred from Beacon to Optum? If so, will providers have the opportunity to review it and identify any omissions? For example, Southern Maryland Community Network was awarded EBP status for Supported Employment in May 2019, retroactive to October 2018. It hasn't yet received the seven months of payments. How will the status of pending issues like these be identified and managed during the transition period?

16. **Authorizations**. Will open authorizations be transferred to the new vendor electronically? Will any textual clinical notes transfer with the authorization, such as those noting acuity or factors impacting medical necessity for individual clients?

17. **Transfer of M-number**. Clients who were initially uninsured are assigned an M-number instead of a Medicaid number. Even if the client becomes Medicaid-insured, Beacon continues to track them by the M-number. Will M-number assignments be transferred to the new vendor?

18. **New Vendor's Payment System.** The timing of payments is critical to providers' operational workflows. When will providers be oriented to the new vendor's payment processing system and learn the frequency, day of the week and duration of Optum's claims processing system?

19. **Adequacy of Transition Period.** If the new vendor is unable to start as anticipated on September 1, will the state delay the January 1 implementation date? If delays occur during the transition period, what processes are in place to allow evaluation of extending the implementation date?

20. **Communication**. What provisions does the new vendor anticipate having in place to ensure timely communication with the provider community?

21. **Limitations on Cross-Vendor Take-Backs.** In past ASO vendor transitions, the new vendor has recouped claims from providers without adequate notice or sufficient detail to identify impacted claims. We request that no payment recoupments or take-backs occur across ASO vendors unless the vendor has given 30-day notice of the anticipated take-back to the provider, describing the impacted claims by client number and date of services.