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

Friday, November 8, 2019
10:00 am to 11:30 am

In attendance:

Telephonically:

Topics & Discussion

Minutes

BHA Updates:

- In response to the recent update of American Society of Addiction Medicine (ASAM) copyright permission process for *The ASAM Criteria*, the Behavioral Health Administration (BHA) in partnership with ASAM will be offering FREE ASAM regional training in Maryland, to include 7.5 CEUs. This training will include activities that support the development of the knowledge and skills required to implement *The ASAM Criteria,* and provide updates and information for providers to proactively address the changes. At this time the trainings are all full and BHA. Two additional training dates are being offered on January 6 and January 13, 2020. More information will be forthcoming.

- Announcement impacting Supported Employment Providers (PT SE). Medicaid established a new SE provider type as of June 1, 2017. Although newer SE providers enrolled with the correct new provider type, the system had a workaround to allow for "legacy" SE providers to continue billing under their PR type with a validation on the "back end" of claims to ensure the services were linked correctly. This workaround is not being carried into the new ASO build and providers must obtain the correct provider type prior to 1/1/2020 to continue to receive authorizations and claims payment for SE services. Therefore, Medicaid requires that SE providers use their correct SE provider type and discontinue use of the PR provider type for SE services. What this means:
    - SE must apply for a new Medicaid ID by submitting an application through ePREP.
    - MDH will be doing webinars to walk providers through this process and dates will be shared soon.

- MDH also met with CBH so that they are able to assist their membership in being educated about this change.
- Medicaid acknowledges there have been concerns about expediting applications via ePREP which Medicaid has addressed with the Provider Enrollment Division. The Medicaid Behavioral Health Unit will assist providers in this requirement. Applications must be updated between now and December 31, 2019.
- Please note that the volume of SE providers is relatively small, with approximately less than 60 providers in the network that will need this enrollment support. This requirement does not extend to additional provider types.
- Questions should be emailed to **steven.reeder@maryland.gov**

- The Maryland Department of Housing and Community Development (the Department) seeks qualified and experienced local governments and non-profits to apply for capital funding for the Maternal Opioid Misuse (MOM) Program to develop Supportive Housing for Mothers with Substance Abuse Disorders. The RFA will be posted on the Department's website at the following location: https://dhcd.maryland.gov/HousingDevelopment/Documents/stghp/RFA.pdf Proposals must be received by the Department no later than Wednesday, **January 15, 2020 at 2:00 p.m.** Three (3) copies of the application should be submitted in separate binders along with a zip drive including a file attachment of the application. Written questions should be sent to rfa.dhcd@maryland.gov by no later than December 31, 2019. Answers to questions will be responded to as received.

Medicaid Update

- OMHC Rendering Requirement Update: At this time, Medicaid is not implementing a requirement for OMHCs to include rendering provider. Providers raised concerns over impact around dually eligible individuals and Medicare rules which require only the level of Medical Director. What this means:
    - OMHCs do **not** need to continue to enroll the LC level of licensure with ePREP.
    - MDH is evaluating the impact of the requirement to only the Medical Director to be enrolled but are not ready to implement that change.
    - The Department will more clearly outline the next steps for providers with advanced notice of 60 days before requiring change.

- PRP Provider Billing Transmittal Updates: MDH responded to the concerns expressed by PRP providers around the updated billing practices and an amended alert will be issued soon. This alert will add that once the completed

number of services has been rendered providers may submit your claim for those services. What this means:

- The primary change is that once you have submitted the claim, you can only submit a corrected claim at a future date with all accounted for services (no more back and forth reconciliation). This will be clearer in the updated transmittal.
- Providers should continue the practice of entering the total number of encounters provided, even after they have hit their authorized maximum to support the data of these services. This data is vital to the State to ensure that they have an accurate picture of the true cost of service for setting rates and evaluation of service costs.
- A transmittal will be coming out within the next few weeks but will not go into effect until January 1, 2020.
- ACTION REQUIRED: Any PRP that has outstanding claims today, must reconcile their claims before the end of the contract. Beacon will continue to do outreach to providers to work through the outstanding inventory through the end of the year.

- Redetermination Update: As providers know, Medicaid recipients must go through a redetermination process. Due to the large number of individuals that came in through the expansion, there are approximately 60,000 members that are coming up for redetermination and providers should work with their members to ensure they are completing this redetermination process timely.

- Release of Information (ROI) Update: The release of information process is a critical issue that deals with 42 CFR, Part 2 rules that allow the state and the ASO to share information with the MCOs. For substance use providers, this allows a connection of care to the PCP and MCO and it is extremely important to integrated care planning to have access to this data which supports case management services. An alert was recently sent out to remind providers that it is very important to obtain the ROI's for their consumers. Providers should begin to have their participants' sign new ROI's for the Optum transition and submit them as soon as possible. All consumers with a primary diagnosis of substance use do need to complete the ROI to ensure the authorization, claims and care coordination activities can be shared. If the primary diagnosis is mental health, you are able to bypass and indicate that the member does not need the ROI.

- CMS Policy Coverage Update OTP Coverage: Medicaid is following closely the recent changes to coverage by Medicare of Opioid treatment Programs. Special thanks to MATOD (Maryland Association Treatment of Opioid Dependency) for

keeping BHA and Medicaid "in the loop" and for their work with OTPs to support them during this change. What this means:

- Impact to the state is that when Medicare begins to cover SLMB/QMB beneficiaries, the state will realize a savings. For those that are dually eligible (Medicare and Medicaid) Medicare will reimburse 80% of the service and Medicaid will realize a savings of the difference.
- There is still a lot that needs to be put in place by CMS. There will be a call on November 12th for OTP's led by Frank Dyson and BHA to further discuss these upcoming changes.
- Medicaid will continue coverage for the duals while providers get paneled with Medicare to ensure that providers are able to continue providing quality services to Maryland members.
- Providers should note that getting **enrolled with Medicare** is very different and handled by a different entity to enroll than the team they have traditionally worked with at Medicaid. You will not be able to reach out to the enrollment team at Medicaid to assist with Medicare paneling. Providers will need to ensure that they are actively paneling and working to navigate the change.

- ASO Transition Update: A provider alert will be issued later today addressing many of the key transition questions that were submitted by providers. And while the meeting will address questions as able, providers should refer to the provider alert to continue to stay up to date on transition information and timelines.
  - HEALTH HOMES WILL NOT TRANSITION 1/1/2020 – BUT WILL BE PHASED IN AT A LATER DATE (More information below in the Q&A)

Beacon Health Options Update

- Beacon's office has been closed as of October 31, 2019. Our staff will be available by all usual means to assist in resolving issues and providers should not see an interruption in our service. However, Beacon acknowledges that many of our staff are in the process of migrating over to the new vendor. While this is an excellent and knowledgeable resource that will allow the new vendor to absorb the historic knowledge and skill sets of individuals that have been dedicated to Maryland for many years, it does mean that turnaround times may begin to see some slowness. This includes both authorizations and provider inquires. We are continuing to attend to issues as quickly as possible but if you have an authorization or provider issue that needs to be escalated, please always reach out to our clinical and provider relations teams. For clinical matters you can reach Joana Joasil at **joana.joasil@beaconhealthoptions.com** and for provider relations matters please email **marylandproviderrelations@beaconhealthoptions.com.** These issues do not have an impact on our claims departments currently so providers should not see any change in the claims payment process.

Provider Questions

1. **We request that no payment recoupments or take-backs occur across ASO vendors unless the existing 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, and completed the retraction no later than mid-November. This allows the provider to research, resubmit claims and receive payment when a client's eligibility has changed.**

The Department is aware of the concerns around large retraction projects during ASO transitions. At this stage, there are no plans for any large retraction projects. However, normal day to day business functions such as claims reprocessing, audit retractions, and PRP reconciliation will continue until the end of the contract on December 31, 2019. For PRP providers, Beacon will not be retracting any claims related to claims that are less than 30 days old. Outreach to assist providers in reconciling their outstanding claims will continue until the end of the contract.

2. **What is Beacon's planned last date to accept claims? In past, departing ASO vendors have asked providers to submit all claims by about December 15th. What is last date that Beacon will accept authorizations?**

As indicated in the provider alert, the last day for Beacon claims payment submission will be December 29, 2019.

3. **On what date in December will Beacon stop accepting uninsured spans? Depending on when the data migration happens between Beacon and Optum some of these could slip through the cracks.**

For exceptions, providers should continue to use the existing process of reaching out to the local jurisdiction for approval and submit those via paper-based documents to Optum. Individuals that do meet the uninsured criteria should be continued to be submitted to Beacon through the Provider Connect portal through December 31, 2019.

4. **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?**

Beacon's goal is to resolve all open issues prior to the end of the contract but there will be a process of transitioning known provider issues over to the new vendor. If you have a specific issue that you are concerned about, please email the provider relations team at marylandproviderrelations@beaconhealthoptions.com so that we can ensure we are closing out as many issues as possible prior to the transition of vendors.

5. **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?**

Authorization and all clinically entered data will be transitioned to Optum electronically.

6. **Is the plan still for us to be able to bill health home services to Optum as of January 1st If so, when can we get the guidelines for the billing like how do we report the visits that the client has had to support the monthly billing?**

There are functionalities in E-Medicaid that MDH needs more time to resolve but provider recruitment, training, building out health homes and complete outreach will still go live in January. Optum is actively recruiting for the staff to support the Health Home projects. The Department will continue to keep providers updated on the Health Home full transition in the coming months. The authorizations and claims operational system will continue as it occurs today and as this changes, they will prepare training for providers.

7. **Will providers have to assign departmental or individual licenses to access the new vendor's authorization system? Providers need to schedule and train the appropriate number of staff, including potentially all clinicians, on the new authorization system. This is a process that could take weeks and should take place before Thanksgiving to avoid staff vacations associated with the holidays.**

The Optum trainings will begin on December 2, 2019 and will include provider portal access, claims administration, the provider connect system, and electronic clearing house submissions. The webinars do have a limit of 999 participants per training session. Please only sign up for the initial training sessions if you are a provider that will need to utilize the system starting in January. These December trainings are only the beginning and more dates will be provided into the New Year. Optum has several training rooms at their location and will host onsite in-person training for providers to attend. Please note that the Department acknowledges that the initial errors in the training links were due to the Department reconfiguring the links and this should be

resolved. More announcements around trainings will be coming out and are being tailored to provider type to ensure unique aspects of each type of provider is attended to in the trainings. Trainings will be recorded and posted online for providers, who will be able to access these once the Optum website has gone live on January 1, 2020. Providers should note that Optum does allow the capability of direct claims submission and batch submissions and this will be reviewed during training.

8. **What will the new vendor's billing system require? EHR configuration changes can take several weeks to complete, and should ideally be complete by late October in order to be complete in time to allow sufficient staff training before Thanksgiving, meaning that the EHR modifications should begin by early October.**

Billing codes will remain the same with the potential of one different modifier and this will be coming out in the next week. All codes, fee schedules, etc. are owned by the Department and will remain the same for providers and their EHR's. There are no anticipated major changes and the Optum billing and companion guides should be released shortly.

9. **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?**

In spirit, the M number is a unique identifier within the Beacon system. Providers should be shoring up their EHR's to ensure that they have the appropriate Medicaid ID in their member's file. At this time, there is no plan to migrate the Beacon M number as the unique identifier in the Optum system. However, the Department has heard the concerns and will review this item internally for further determination.

10. **At the October Provider Council, MDH indicated that Beacon's archive of provider alerts would not be migrated into Optum's provider website, although a copy would be stored for audit purposes. There is no up-to-date alternative library or manual of policies, billing rules and transmittals for providers to reference. In order to promote compliance with MDH's existing rules and policies, providers must be able to access and reference the rules and policies. Access to the alert archive is essential for providers and the stakeholder community. We urge this to be incorporated into the ASO transition planning.**

This appears to be a miscommunication. The Department indicated that it was the responsibility of Optum to ensure that all transmittals, provider alerts and Department communications are transitioned to Optum's new website for provider use and reference.

11. **The FAQs state, "Once overall testing of the system is complete, providers will be able to test their clearinghouse and claims submission. More information from Optum will be forthcoming in November." What date in November will this info be available? Providers have to train all billing staff on the new billing system and all clinicians on the new authorization system, which can take weeks.**

Optum training will begin on December 2, 2019 and providers should register using the link in the provider alert.

12. **This was brought up in the August 2019 meeting. 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? Provider Council's Response: This concern has been brought to the attention of the ABA team at Medicaid and will be further reviewed. Please share examples/scenarios of when this occurred for review by emailing Marylandproviderrelations@beaconhealthoptions.com. I've emailed three times to follow-up and have not received a response. I'd like if the council could provide an update on how the ABA team at Medicaid is responding to this issue as we are still getting claims denied for clients that receive outpatient mental health services and ABA services on the same day.**

Medicaid is still reviewing the current guidelines to identify if there will be any change to the billing and service delivery guidelines. Providers should note that there is no plan to

make any changes to the current combination of service rules for the remainder of 2019. This will be revisited in the future but the current combination of service rules are in effect.

13.. Will the emails to providers with lists of members in need of ABA services continue after the transition? Will there be dedicated staff ABA providers can reach out to when we open our waitlist and can take on new members and will they have a list of members in need of services based on location?

Yes. The operations of the ABA program in Maryland will remain unchanged and the new ASO will take over these responsibilities starting January 1, 2020.

14. What authorization format will we be using? Do we need to request new log in? Will current authorizations remain in place? When will authorizations be transferred to the new system?

Current and open authorizations will be transferred to Optum. Monthly and weekly authorization files have already begun being shared to ensure a smooth transition in January.

15. When will information be sent out about contracting with Optum for current providers? Will new applications have to be completed for each NPI associated with a program? Will the contracts include the EFT/837 transfers as well?

Providers do not contract with the ASO. Providers should handle all credentialing through the ePREP vendor with Maryland Medicaid. Providers that are already enrolled with Medicaid will not have to re-enroll due to the transition of ASOs. Providers should go into their ePREP file and ensure that all data is accurate with special attention to their “pay to” information. Information in the ASO system mirrors the Medicaid file and can only be corrected through MMIS/Medicaid (via ePREP). Providers will need to register with Optum for submission of authorizations and claims payments.

16. Will providers continue to access pay span for EOB information, Claim denial and reports of payments?

For Beacon related claims, Payspan will be available for 18 months after the contract to review your information.

17. Will there be an end date to submit claims to Beacon on a certain date? How will outstanding claims submitted to Beacon be managed after 12/31/19? What is the first expected pay date by Optum for submitted clean claims?

The last date to submit claims to Beacon will be on December 29, 2019. Beacon's final check run will be the week of January 2, 2019 and include claims submitted through 12/29 that successfully adjudicated. Non-adjudicated claims will transfer to Optum for processing. The new vendor Optum will be taking over the check run process the following week of January 7, 2020.

18. As an end user of Beacon health system for many years we had several Recommendations regarding the new system that I hope an ASO would consider incorporating.

- **A Report that would allow you to see all the authorizations expiration dates for the patients that have open authorization in your clinic in one page accordingly to date of expiration of the authorization. Beacon had a report that produced this only for authorization that are expiring within one week. It would be very beneficial to see all the authorization expirations in one page for the whole clinic or at least for the ones that expirations are within one month.**

- **Report that we can generate on monthly bases for any patient that has an open authorization in clinic that their insurance has lapsed in that month, and don't have insurance any longer. In Beacon system it automatically changes to uninsured status without alerting the provider.**

- **Report that would allow us to see patients that have 3rd party insurance (for example Care first) as a primary and Medicaid as secondary.**

- **Report that would generate list of patients with open authorization in our OTP that are receiving IOP in another facility and therefore our OTP cannot bill for counseling services for them.**

- **I make these recommendations after consultations with several other OTPs. I hope the transition team would consider implementing these**

changes and incorporating these reports as they would make the OTP operation much more effective and avoid billing than can get rejected and waste ASO customer service time during the operation.

MDH would like to thank providers for their continued engagement and suggestions to improve the Public Behavioral Health System for the state of Maryland during this transition. Additional suggestions and concerns should be sent to the transition mailbox for review.