07/13/2020

LAKESHORE REGIONAL ENTITY

Information Officer Report – July 2020

Summary:

1. **MCIS Software**: No new updates at this time.

2. **Planned Data Exchanges with Beacon Health Options**: These efforts continue moving forward:
   - Authorizations and Paid claims details (*CMHSP to Beacon, to inform UM analyses*): Implementation of these data feeds is still moving through the final testing stages and is nearing completion. *Note: Additional delays have been experienced on this task due to the intensity of demand on CMH IT departments as a result of the COVID-19 pandemic.*
   - Encounters and BH-TEDS: The initial encounters data extract is still in Beacon's hands undergoing the first testing and feedback cycle on their side.
   - Provider Data: LRE received improved provider file submissions from 4 out of 5 CMHSPs – no file has been received from HealthWest. Test data has been sent to populate the test directory. Testing will occur later this month or in early August. A delay has been introduced because some of the CMH provider files which were due in by the end of June were received during the first week of July, and because the HealthWest file has still not been received. At this late stage in the project, this will directly impact the timeline to the live publication of our regional provider directory (which we had hoped to finalize and publish by July 31st).
   - Additional data extract files have been requested by Beacon and are on the project design board including: SIS data, LOCUS data, decision support tables, Eligibility 834/271 data, and PMPM payment details. There has been no movement on these additional items over the last period.

3. **FY20 data reporting to MDHHS:**

Encounter reporting for FY20 is still showing a significant drop in services in February through May, due to both the **COVID-19** Pandemic, its effect on service delivery and the additional workload it brings to CMH IT systems and Billing functions. A **complicating factor** continues to be the $2/Hour Direct Care Wage "**Hazard Pay**" pass through, the resulting cost of which MDHHS is mandating be reported as individual impacts on each reported claim/encounter line (even though most of the payments will go out "lump sum" to the providers). This additional MDHHS requirement [vs just adding the additional cost to the associated totals in the year-end financial reporting] is causing a significant additional administrative burden in claims and encounter processing within each CMHSP. Those whose systems have no systemic or programmatic ability to enact (temporary) mass rate changes to submitted encounters are forced to process these rate changes manually at the encounter line level, creating a very large manual workload.

Part of the reporting delay is also due to the EMR implementation at HealthWest. The new HealthWest **Cx360** EMR system began processing SUD services in December 2019 and Mental Health services in February 2020. Testing and troubleshooting continue while encounter reporting is still experiencing a pronounced lag. The first successful SUD encounters (457 lines) from the new **Cx360** installation were

submitted to the LRE system last week. Due to the pronounced and continuing lag in data submissions from HealthWest, LRE has initiated a formal Plan of Correction (POC) process to promote and track progress in all the areas where the Cx360 submissions are behind schedule and/or where there are concerns over potential data integrity issues. Affected areas include: Encounters, BHTEDS, MMBPIS Quality Indicator Data, and the weekly Consumer List data.

HealthWest POC: A formal Plan of Correction (POC) request was sent to HealthWest on 7/2/2020, and LRE received a detailed POC workplan and timeline from HealthWest on 7/10/2020. Some of the corrective actions that HealthWest will be taking to remediate the data submission issues include:

- Escalation of software issues with Core Solutions where those impact required data reporting to LRE
- Updating Cx360 system edits and configurations to promote more complete data when the service reaches the claims/encounters processing.
- An enhanced focus on CMH staff training and re-training to strengthen end users' skills in the new system to prevent additional unnecessary errors that subsequently require corrective attention by the Finance team.
- Increasing the number of Finance team staff who are trained to resolve encounter reporting issues and submit encounters.
- Increased and focused efforts to resolve outstanding data completeness issues that are holding up encounter and BHTEDS submissions so that overdue data submission can be caught up.

4. OIG Enhanced oversight:

The MDHHS Office of the Inspector General (OIG) has increased the level detail reporting required in some of their oversight procedures, including in some cases detailed explanations at the claim line level for items flagged for follow-up as potential fraud, waste, or abuse (UM perspective). The vast majority of these items are turning out to be either misunderstandings of the data, timing issues with claim submissions, or simple errors in billings that need to be corrected and resubmitted. The Beacon Health Options Data Analytics and Reporting Team has done a great deal of work in preparing these reports for CMHSP's to review, mark up and return, so that they can then be returned timely to OIG.

5. MDHHS Data Reporting changes for FY21:

CLS per-diem in an unlicensed setting (H0043) will no longer be an acceptable code for CLS services beginning 10/01/2020. MDHHS advises the use of H2015 (per 15 minutes) instead. After a long period of fact finding to understanding the issue and options, MDHHS has decided that the per-diem code is too difficult to cost out actuarially and that it provides insufficient transparency with regard to how much actual "face-to-face CLS time" with the client is actually occurring (which had been a concern raised not only by MDHHS but also by some consumer advocates). Concerns about the removal of the H0043 code include the potential loss of service contracts with some providers because some of the services, although very important, are very short in duration and will not make the threshold for minimum minutes to bill a single unit of H2015. The added provider burden in time tracking and documentation that will be required using the "per 15 minute" H2015 code was also a key element of the system wide discussions leading up to this change.

As part of the MDHHS Behavioral Health Fee Screen Development project, it has been recommended that new modifiers and modifier changes occur in the encounter reporting, some with proposed effective dates of 10/01/2020 and some effective 10/01/2021. These items are still in draft/proposed status and will be discussed further at the MDHHS Encounters Data Integrity Team (EDIT) meeting on Thursday July 16. For additional information on these proposed changes, please see "Additional Details" on page 3-5 below.

Additional Details:

Behavioral Health Fee Schedule Project

Key Proposed Code Set Changes

- ❑ Introduce additional granularity in unit cost reporting and rates to account for differences in provider types, potential staffing ratios (e.g., services provided in group settings), and potential differences service-related transportation requirements
  - Addition of provider grouping granularity within service codes where provider qualifications allow for multiple different provider types to render the service
  - Change from TT modifier to UN-US modifiers to provide additional granularity of group size
- ❑ Addition of modifier to identify self-directed services
- ❑ Removal of HK modifier
- ❑ Updates to be more consistent with national standards for procedure codes and modifiers
  - National modifiers currently used to monitor programs will be transitioned to state-specific modifiers if possible to avoid inconsistency with national definitions
- ❑ Milliman is working with MDHHS to consider additional modifications to codes and modifiers with the goal of making service unit reporting more consistent, and to add precision to the independent rate model process

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New proposed modifiers - 10/1/2020 Target

Program Description	Current Modifier	New Modifier
Self directed	None	U7
Independent facilitator	None	WQ
Participant hired	None	WX
Supported Employment*		
Career planning/discovery	None	1Y
Job development/ placement	None	2Y
Self employed	None	3Y
Financial planning	None	4Y
Supported employment transportation	None	5Y

Program Description	Current Modifier	New Modifier
2 patients served	TT	UN
3 patients served	TT	UP
4 patients served	TT	UQ
5 patients served	TT	UR
6 or more patients served	TT	US

Supported employment code changes are pending policy promulgation.

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Expanded use of existing modifiers – 10/1/2021 Target

Program Description	New modifier
Specialty physician	AF
Clinical psychologist	AH
The rendering provider has a highest educational attainment of less than a bachelor's degree	HM
The rendering provider has a highest educational attainment of a bachelor's degree	HN
The rendering provider has a highest educational attainment of a master's degree	HO
The rendering provider has a highest educational attainment of a doctoral degree	HP

Modifiers to be used when multiple levels of credentialed staff provide services
All modifiers are included in the current Mental Health Code Chart except AF.

New proposed modifiers - 10/1/2021 Target

Program Description	Current modifier	New modifier
ASAM 3.1	none	W1
ASAM 3.3	UB	W3
ASAM 3.5	TF	W5
ASAM 3.7	TG	W7
Beneficiary is HSW enrolled and received HSW services	HK	***None***
Certified Peer Specialist provided or assisted with covered service	HE	WS
Youth peer specialist	TJ	WT
Peer Mentor provided or assisted with a covered service	HI	WU
Family psycho-education provided as part of ACT activities	AM	WV
Assisted Outpatient Treatment	H9	WW
With H0031 for SIS face to face assessment	HW	WY
Monitoring treatment plans with codes H2000, H0032	TS	WZ

New proposed modifiers with change implementation over 12 months to 10/1/2021 target. As patients have services, update over the course of the year.

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New proposed modifiers - 10/1/2021 Target
Evidence Based Practices

Program Description	Current modifier	New modifier
Individuals receiving one of the MYTIE EBP (16-17 years old)	HA HV	Y1
Individuals receiving one of the MYTIE EBP (18-21)	HB HV	Y2
Parent Management Training Oregon Model (EBP only)	HA	Y3
SAMHSA approved EBP for co-occurring disorders	HH TG	Y4
Individual placement support/EBP	TG	Y9

New proposed modifiers with change implementation over 12 months to 10/1/2021 target. As patients have services, update over the course of the year.

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