

**STATE OF MA DOCUMENTATION PROJECT
COMPLIANCE REVIEW TEAM
07-10-07**

Consultant: Mary Thornton, MTA, Inc.

Facilitator: Kathy Janssen, Riverside

Present: Jim Haughey, BHN, Michele Savage, Bay Cove Human Service, , Craig Gaudette, Advocates, Inc., Michael Wagner, North Suffolk, , Doug Thompson, Beacon Health, Jane Eckert, MSPCC, Fran Markle, High Point, Judith Boardman, HES, Madeline Becker, Vinfen, Carol Kress, MBHP, Christine Paschal, Wayside, Marcy Morgenbesser, Network Health

Absent: Grace Beason, DMH,

AGENDA

MINUTES

1. David Lloyd reviewed:
 - the timeline approved by the QMC for the pilot project
 - implementation of the pilot project in February
 - a copy of the new timeline will be sent all three committees involved in the project
 - plan is that by June QMC will get final draft of documents and manuals for approval
 - electronic format of manuals and forms will be made available for the team to edit the various revisions of the documents will also be available and dated to indicate when the documents were developed, and what is most recent.
 - the SDT will review the feedback from the pilot project.
 - reviewed an outline of the evaluation tool – each type of program will have a program specific tool
2. Reviewed the memo from the CRT to the SDT. Everyone agreed the draft was ready to go the SDT as written
3. Reviewed the grid for the 24 hour care programs included in the project (EATS, DDART, CBAT, and ICBAT). Need to review the regs from DEEC for child services. Christine will do this review. Doug and Marcy will do the review for the MA MCOs.
4. Reviewed the treatment plan grid for EATS, DDART, CBAT, and ICBAT. Needs to include discharge planning. Plans need to be able to be updated on a regular basis.
5. Reviewed the progress note grid for EATS, DDART, CBAT, and ICBAT. This was the based on the outpatient note. The notes for these programs do not require all the elements that are required for the outpatient note. After Care (transition planning) will need to be included. The grid needs to be completed for this form. Everyone needs to review the regs they have taken responsibility for.

6. Reviewed samples of documents for methadone programs. An issue of treatment protocols came up. Kathy will seek guidance from the QMC. Everyone will need to complete their column on this type of note.
7. In the manual we need to distinguish between the requirements for the MCO carve outs vs. the Medicaid fee for service clients (Medicare/Medicaid).
8. Identified the following elements as part of current physician notes
 - Name
 - Risk assessment
 - Signature line with licensure
 - Target symptoms
 - Mental Status Exam
 - Change from last visit
 - Diagnosis or symptoms
 - Treatment recommendations
 - Informed Consent for new meds
 - Date of Service
 - Response to previous meds
 - Review of any labs
 - Order for new labs
 - Order for new meds
 - Reasons for med changes
 - Plan
 - Refills
 - Training and education
 - Brief psychotherapy

M0064 5-10 minute visit (Paid by Medicare)

 - Change in meds
 - Symptoms
 - Changes in MS

E&M Code (start with 99)
9. Next time will do grids for MD notes and identify tasks for developing manuals

JOINT MEETING WITH SDT

1. Reviewed the Scope of Work developed by the SDT
2. The draft of forms will be on MTM web site
3. Dave will send Kathy a sample communication tool for CRT and SDT to share information/comments

HOMEWORK

1. Christine will review regs from DEEC for the child inpatient services included in this project.
2. Doug and Marcy will review the requirements of the state MCOs
3. Everyone needs to complete their column on the inpatient progress note grid and get them to Mary within 2 weeks.

4. Everyone will also need to complete their column on methadone progress notes and get them to Mary within 2 weeks.

ATTACHMENT A

Meeting with Jeff Lubitz September 12, 2007

Identified issues

For dually eligible clients: who must sign treatment plans?

What does the waiver wave?

What is the relationship of the Medicaid contracted HMOs to DMA?

What is the relationship of the Medicaid HMOs to federal regulations as it pertains to:

- Case management
- Rehabilitation
- Can the federal auditors go through the HMO's and into the providers?
- Do the Medicaid integrity auditors just audit state or providers and/or HMO's as well
- Do HMO regs supercede the DMA and Federal regs both?

What is the audit risk for providers, where are providers most vulnerable?

What is going on in MA? OIG?

Is case management a fee-for- service in MA?

Community Support Program – who is this available to?

When is a physician's signature required (which documents)?

Is MDT sign-off, as required under DMA, required for MBHP and the Medicaid contracted HMOs?

When is a physician face-to-face required?

Jeff Lubitz Responses

130 CMR in the 400 + area – spell out differences between managed care product and behavioral health managed care product and dual eligibles. Rules dictated by those managed care companies. Limited by the BBA and other requirements. These are in the provider contracts.

Rules depend on the type of benefit the client has – managed care, traditional – reference 450.508 and BBA 42 CFR 438.

- Federal rules are most, if not all, fee-for-service – sections which also governed managed care – but generally at a clinical level that is FFS – no independent obligation to follow these unless the state has imported that into the model contract for the HMO's – this model contract is holistic.
- Part of original goal was to have public clients treated in the same way as commercial clients.
- Relationship between MCO's and state Medicaid agency - State contract should now be with EOHHS. Relationship is contractual as a result of an RFP process.

Federal auditors must audit the MCO's – EQRO must come in and look every two years –look at activities and regulations. Providers do not get audited through this process.

Fiscal audits – don't remember seeing anything about that in the contract. The contracts have been somewhat behind the times of the audit capability of the MCO.

Definition changes: done through a contract amendment.

Three month reviews:

- DPH changed their reviews to 1 year
- Licensure requirements apply to everything
- The DMA reqs are they moot with MCO's ? yes provisionally.
 - Could PA's stand for the 3 month

Provider manuals and provider contracts – combination – alerts and other transmittals. Minimized contract so that the provider manual serves as a more regulation type document.

MCO's cannot supercede the professional licensure requirement. NO

Is a treatment plan an order? For FFS yes

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