



Maryland
DEPARTMENT OF HEALTH

AAHAM Meeting

Medicaid Team

April 28, 2023



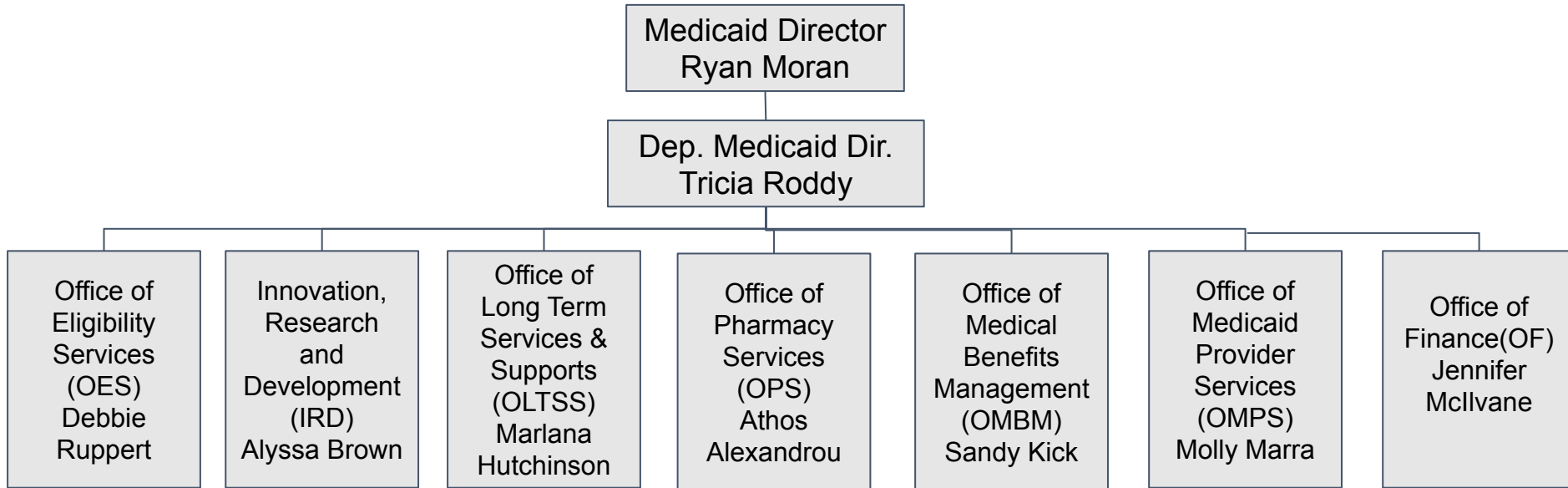
Agenda

1. Introductions & Medicaid Organization/Roles & Responsibilities
2. Office of Eligibility Services (OES)
 - Unwinding - Updates, Forthcoming release of unwinding SOP 23-01
 - Unborn Coverage
 - X02/X03 Approvals
3. Utilization Control Agent
4. Office of Medicaid Provider Services (OMPS)
5. Office of Medical Benefits Management (OMBM)
6. Questions

Introductions

- **Debbie Ruppert**, Director - Office of Eligibility Services (OES)
- **Linda Rittelmann**, Acting Deputy Director - Acute Care Administration (OMBM)
- **Jason Higgins**, Utilization Control Manager - Office of Long Term Services and Supports (OLTSS)
- **Molly Marra**, Director - Office of Medicaid Provider Services (OMPS)

Medicaid Organization



Unwinding the PHE - Redeterminations

- The Consolidated Appropriations Act 2023 (CAA) became law on December 29, 2022. The legislation amended specific provisions of the FFCRA including:
 - The gradual phasing out of the enhanced FMAP by December 31, 2023
 - CE sunset on April 1, 2023.
 - April 2023 will resume system auto-renewals and mail standard redetermination packages as needed.
 - First cohort disenrolled at the end of May 2023 if they **no longer meet** the eligibility criteria for coverage.

Healthy Babies/Unborn Coverage

- The Healthy Babies Equity Act (HB 1080 enacted in 2022) requires the state of Maryland to provide substantive care to Non-citizen Pregnant Women who would be eligible for the program but for their immigration status.
 - Implementation - July 1, 2023
 - Up to 264% FPL
- Categories - **X11 (prenatal)** and **X12 (postnatal)**
 - X11 - Duration of their pregnancy (to include dental)
 - X12 - The 12-month postpartum period
 - [Maryland Department of Health announces expanded Medicaid coverage for new mothers](#)

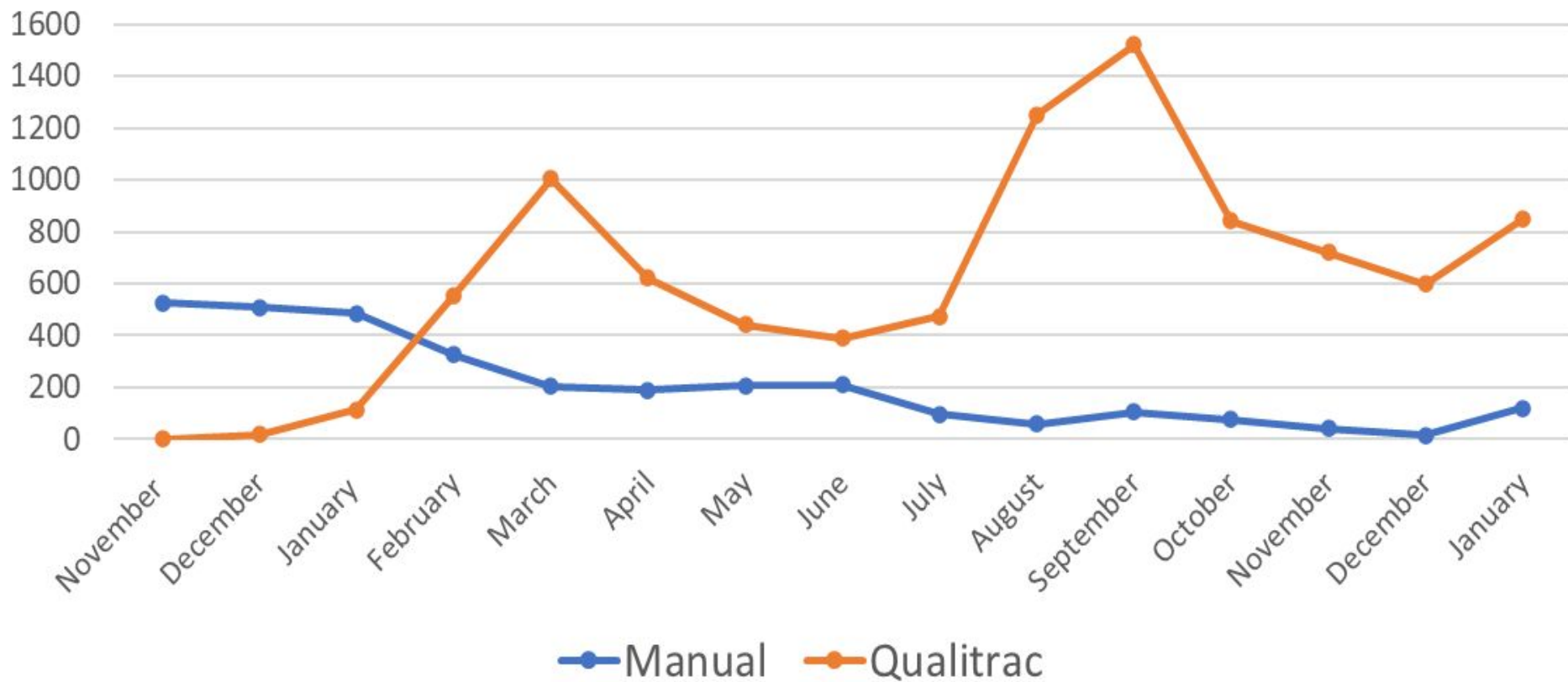
X02/X03 Approvals

- System Updates
 - Automatic uploads -instead of entering manually into the Alien database(see chart)
 - Sending direct lists to the third-party vendors
- Working with third party vendors
 - Complete the eligibility process for aged emergency medical cases (X02/X03)
 - Reached out to hospitals
 - Completed clean-up for cases that did not have 401 forms returned in the system.

Utilization Control Agent, Telligen

- Originally received X02/X03 requests through fax, email, and mail.
- Now uses Qualitrac, a provider-based web portal.
 - Providers create profiles for their companies so their staff can submit utilization review requests directly to Telligen.
 - Each request gets an ID and the submission process is standardized where both parties receive notifications of progress or any needs.
 - The requests can be looked up and viewed at any time there for status.
- Reviews contractually completed in 5 business days
- If additional information is requested, 20 business days
- Average review has a decision in < 4 business days

X02/X03 Reviews by Submission Source (November 2020 to January 2022)



X02/X03 Reviews by Submission Source (February 2022 to February 2023)



Billing Requires Two Reviews from the UCA

- **Step 1: X02/X03 Review** - To establish medical eligibility for the MA span. The UCA reviews if nature of the visit meets COMAR criteria of an emergency.
- **Step 2: Retrospective 3808 Authorization** - To determine the medical necessity of each day for billing. The UCA provides an authorization to bill against an *active* X02/X03 span.

OES 401 Review & Approval (Qualitrac)

- Providers must submit a completed OES 401 form along with any relevant medical documentation for review electronically through Qualitrac.
- The OES 401 requests are entered in the Qualitrac system under the review type “Undocumented Alien - X03 (or X02) Eligibility Review”
- With the exception of dialysis services, each X02/X03 applicant’s visit to the hospital requires a new and complete OES 401 form reflecting the specific dates of service.

OES 401 Review & Approval (Qualitrac)

- For dialysis patients, providers may request up to one year of coverage in advance. The individual visits for dialysis during this span do not require new OES 401 forms or reviews by the UCA.
- To avoid errors, one-year dialysis requests should reflect one day less than the anniversary for the end date (Example: 6/1/2023 - 5/31/2024). Open-ended requests or those beyond a year are not accepted and will be closed as incomplete requests.
- Once approved, the provider may submit 3808 retrospective review requests for the dates of service.

Retrospective Review & 3808 Authorization

- The 3808 retrospective review requests are also submitted to Telligen through Qualitrac.
- These are entered under the review type “Acute Medical Surgical.”
- Beginning June 1, 2023, retrospective 3808 requests for X02/X03 applicants that do not have a matching OES 401 approval by the UCA will be denied.
- Until that time, Telligen will mark non-matching requests as “Outcome Not Rendered,” return them to the provider without denial, and allow an opportunity to submit the necessary OES 401 request before resubmitting for authorization.

Office of Medicaid Provider Services

- Five areas within OMPS:
 - Three areas prior to 2018:
 - Provider Policy & Compliance
 - LTSSMaryland Program Office
 - Provider Enrollment
 - **NEW!** October 2022 - Centralized nearly all provider enrollment under my team (away from OMBM & OLTSS)
 - Two areas added as Medicaid reorganized:
 - January 2019 - Provider Relations and Long Term Care Provider Resolution Unit (LTCPRU)
 - **NEW!** October 2022 - Claims Processing & Adjustments

Institutional Provider Relations

- Front-end customer service/liaison services between the Maryland Department of Health (MDH) and the participating providers, institutions/facilities, stakeholders and internal MDH administrations.
- Staff work with stakeholders to assist with investigation, resolution and response regarding payment related issues as a result of eligibility (recipient/provider) and billing errors:
 - Status of submitted claims
 - Assistance with resolution of problem claims
 - Education on billing procedures
 - Coding (limited)
 - Problem claims review for consideration of payment

Institutional Provider Relations

- This team within the Office of Medicaid Provider Services manages the following tasks:
 - Call Center - Receive and return calls ~3.5 days/week
 - Review and process claims beyond statute (>365 days) - “problem claims”*
 - Hospital claims, including X02/X03 claims
 - Long term care
 - Dialysis
 - Hospice
 - Home Health, and other institutional providers

Institutional Provider Relations

- How to reach us?
 - Leave a message for a call back that day or following business day at: 410-767-5503 option 3 or 410-767-5457
 - Normal business hours:
 - Monday 8:30 AM - 12 PM
 - Tuesday, Wednesday, and Friday 8:30 AM - 4 PM
- Where to send claims for Institutional Provider Relations?
 - Institutional - Provider Relations (UB04)
PO Box 22751
Baltimore, MD 21203

Special Projects & Upcoming Initiatives

- eMedicaid/eClaims portal for UB04 (FFS & secondary claims) - Target Fall 2023
- Returning paper secondary claims prior to keying that facilities submit >120 days from Medicare paid date as the Claims unit denies these without supporting documentation - Target May 2023
- Recent update to eMedicaid requiring all users to reset their passwords - please contact your own local administrator first if you have issues prior to contacting Medicaid - mdh.emedicaidmd@maryland.gov
- New website: <https://health.maryland.gov/mmcp/provider/Pages/default.aspx>
 - Entire website will go through a change soon

Medical Benefits Management

Responsibilities include:

- Design, development, oversight and management of managed care and acute fee-for-service policy, as well as managing the implementation of professional quality and medical necessity reviews of health services.
- Directing the monitoring and oversight of nine MCO contracts and regulations, the REM contract, Dental Administrative Services Organization (ASO), Behavioral Health ASO, and contract and grants to all Local Health Departments for coordination of care services

20

Medical Benefits Management

Responsibilities include:

- Procurement functions related to the enrollment of MCOs, implementation of dental services, external quality review organization and quality vendors, behavioral health administrative services organization (BHASO), support and policy impacting the Public Behavioral Health System (PBHS), and the Recovery Audit Contract (RAC)
- Management of preauthorization of services, the EPSDT program, quality assurance for HealthChoice, ongoing program evaluation, program specific complaint resolution for providers and recipients, appeals for specific programs and resolution of legislative audit/ internal provider audit issues.

21

Medical Benefits Management

- **Adult Dental Expansion effective January 1, 2023**
 - Dental services now available for all adults > 21.
 - > 900K new enrollees. Total enrollees = 1.7 million
 - More than 66K adult patients have been treated since 1/01/23.
 - March 1, 2023: Silver Diamine Fluoride code was added for children. It is intended to inhibit caries from progressing further. Preauthorization and SDF-specific parental consent required.
 - HB1146: requiring a survey of hospitals to identify and ensure the availability of hospital dental OR access for Medicaid patients.

Medical Benefits Management

Forthcoming Medicaid Guidance:

- Coverage of routine costs associated with Qualifying Clinical Trials
- Doula program expansion / approval process
- UB04 Billing Manual Updates in partnership with OMPS - Provider Relations
- Newborn enrollment process and training for enrolling newborns in Medicaid (1184 process).

Questions?

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