


**NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH PLAN CONTRACTING AND OVERSIGHT
ARTICLES 44 AND 49 STATEMENT OF DEFICIENCIES**

NAME OF MANAGED CARE ORGANIZATION Independent Health Association, Inc.	TYPE OF SURVEY: Behavioral Health Claims Denial Root Cause Analysis Target Survey
STREET ADDRESS, CITY, STATE, ZIP CODE 511 Farber Lakes Drive Buffalo, NY 14221	SURVEY DATES: July 7, 2020 – January 7, 2021

NOTE: The following list of deficiencies was identified by Health Department representatives during an Article 44 and/or Article 49 operational or focused survey of your Managed Care Organization (MCO). Correction of these deficiencies is required in order to bring your MCO into compliance with Article 44 and/or 49 of the New York State Public Health Law and the New York State Official Compilation of Codes, Rules, and Regulations (10NYCRR). In the column headed Provider Plan of Correction, describe the Plan of Corrective Action and anticipated date of corrections. The Plan of Correction should be returned within 15 business days.

Deficiencies	Plan of Correction with Timetable
<p>98-1.11 Operational and financial requirements for MCOs.</p> <p>(h) The governing authority of the MCO shall be responsible for establishment and oversight of the MCO's policies, management and overall operation, regardless of the existence of any management contract.</p> <p>Deficiency: Based on interviews, review of the 6-week documentation and plan reported claims data workbook submitted by IHA, IHA failed to provide adequate oversight of claims adjudication by their behavioral health vendor, by allowing their behavioral health vendor to inappropriately deny claims for no prior authorization. Specifically, Adult BH HCBS claims were inappropriately denied as the dates of service fell within the first three visits which does not require prior authorization. This requirement had been reiterated to the plan in a Memo entitled <i>Revised Adult BH HCBS Workflow Guidance for HARP and HIV SNP Members Enrolled in Health Home—Effective 10/1/2017</i>.</p> <p>IHA's BH Vendor reported during the interview on 9/3/2020 that an error was discovered with the Adult BH HCBS claims processing logic developed to allow claims to pass through within the first three visits causing inappropriate denials.</p> <p>IHA reported in the QA interview held on 1/7/2021 that they had not identified this issue before the survey.</p> <p>Chapter 57 of the Laws of 2017, Part P, 48-a.1</p> <p>§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health is authorized, subject to the approval of the director of the budget, to transfer to the</p>	<p><u>Corrective Action:</u></p> <p><u>Review:</u> Beacon identified the root cause for claims denied in error was related to members having closed episodes of care in Beacon's HCBS case management system. Beacon's IT team updated the logic to allow initial HCBS visits to pay without authorization when the Community Based Service Episodes are closed.</p> <p>Following the audit, Beacon pulled a report of claims back to 10/1/16 where HCBS claims denied in error related to first 3 visit rule. Beacon found a total of 59 claims that denied in error. These claims were corrected, and payment was issued to the impacted providers. Beacon finalized an enhanced monitoring report focused on identifying any new inappropriate denials moving forward. Any claims identified were corrected.</p> <p>On December 10, 2020, the claims system logic was finalized and put into production. The remediation corrected the authorization exceptions logic allowing claims to pay correctly during the open community-based service episode. Since this implementation, neither Beacon nor Independent Health have found any inappropriately denied HCBS claims.</p> <p><u>Responsible Party:</u> Eric Blackman – Independent Health - Director – HCS/PHM Vendor Management Victoria Craig – Beacon – Regional Operations Director</p>

MCO Representative's Signature 	Date 6/30/2021
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Title: Chief Compliance Officer

commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the Medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health provided to Medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for Medicare and Medicaid services (CMS).

Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of alcoholism and substance abuse services, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver;... The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section 29 of part B of chapter 59 of the laws of 2016 through March 31, 2020 for patients in the city of New York, for all rate periods on and after the effective date of section 29 of part B of chapter 59 of the laws of 2016 through March 31, 2020 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through March 31, 2020 for all services provided to persons under the age of twenty-one;...

Deficiency:

Based on interview and review of Behavioral Health claims data documentation, IHA and their BH Vendor failed to review and pay BH claims correctly and timely in accordance with regulatory guidance. Specifically, the following issues were identified:

IHA and their BH Vendor failed to pay the government rate by inappropriately denying Adult BH HCBS claims for no prior authorization for dates of service which fell within the first three visits.

During the July 7, 2020 target survey interview, the Plan self-disclosed inappropriate denials for these services were a result

Date Certain: 8/1/21

Monitoring and/or Auditing:

Beacon has a bi-weekly report that captures all Adult and Children HCBS claims that denied for no authorization in the previous two (2) week time period.

Beacon reviews all denied claims & validates if the claim was an appropriate denial. Beacon's clinical team works to reprocess any impacted claims.

To validate that both the monitoring and system fixes have remediated the issue, Independent Health is receiving screenshots of claims and authorizations for HCBS denials and confirming that the claims denied appropriately.

Independent Health will continue to monitor HCBS authorizations and denials by screenshot validation for a 6-month period. If no inappropriate denials are identified after that monitoring period, monitoring will revert to standard auditing process and reporting.

Education:

Beacon created a standard operating procedure (SOP) for HCBS claims monitoring and reviewing to ensure that HCBS claims do not deny for no authorization incorrectly; this SOP includes a process to reprocess any impacted claims if necessary.

MCO Representative's Signature



Date

6/30/2021

Title: Chief Compliance Officer

of systems configuration issues within the BH Vendor's FlexCare platform. Specifically, of the 68 Adult BH HCBS denied claims sampled for no prior authorization, 35 claims required reprocessing. This resulted in a 51% inappropriate Adult BH HCBS denial rate for No Prior Authorization.

Subsequent BH claims documentation was submitted on 11/24/20 and reviewed. The review revealed an additional 59 adult BH HCBS claims that needed reprocessing due to inappropriate claims denials for no prior authorization.

MCO Representative's Signature



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Statement of Findings
Independent Health Association, Inc.
Behavioral Health Claims Denial Root Cause Analysis Target Survey
July 7, 2020 – January 7, 2021
Survey ID# 456604462

10.21 Mental Health Services

d) The Contractor shall reimburse any OMH licensed provider, including out of network providers, at Medicaid Fee for Service rates for 24 months from the effective date of the Behavioral Health Benefit Inclusion in each geographic service area for ambulatory mental health services provided to Enrollees.

Finding:

Based on interview and review of Behavioral Health claims data documentation, IHA and their BH Vendor failed to review and pay BH claims correctly and timely in accordance with regulatory guidance. Specifically, the following issues were identified: IHA and their BH Vendor failed to pay the government rate by inappropriately denying Adult BH HCBS claims for no prior authorization for dates of service which fell within the first three visits.

During the July 7, 2020 target survey interview, the Plan self-disclosed inappropriate denials for these services were a result of systems configuration issues within the BH Vendor's FlexCare platform. Specifically, of the 68 Adult BH HCBS denied claims sampled for no prior authorization, 35 claims required reprocessing. This resulted in a 51% inappropriate Adult BH HCBS denial rate for No Prior Authorization.

Subsequent BH claims documentation was submitted on 11/24/20 and reviewed. The review revealed an additional 59 adult BH HCBS claims that needed reprocessing due to inappropriate claims denials for no prior authorization.

Corrective Action:

Review:

Beacon identified the root cause for claims denied in error was related to members having closed episodes of care in Beacon's HCBS case management system. Beacon's IT team updated the logic to allow initial HCBS visits to pay without authorization when the Community Based Service Episodes are closed.

Following the audit, Beacon pulled a report of claims back to 10/1/16 where HCBS claims denied in error related to first 3 visit rule. Beacon found a total of 59 claims that denied in error. These claims were corrected, and payment was issued to the impacted providers. Beacon finalized an enhanced monitoring report focused on identifying any new inappropriate denials moving forward. Any claims identified were corrected.

On December 10, 2020, the claims system logic was finalized and put into production. The remediation corrected the authorization exceptions logic allowing claims to pay correctly during the open community-based service episode. Since this implementation, neither Beacon nor Independent Health have found any inappropriately denied HCBS claims.

Responsible Party: Eric Blackman – Independent Health - Director – HCS/PHM Vendor Management

Victoria Craig – Beacon - Regional Operations Director

Date Certain: 8/1/21

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