Statement of Findings
Independent Health Association, Inc.
Behavioral Health Root Cause Analysis
December 1, 2017 – May 31, 2018
Survey ID# -401226979

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 the review of Plan-submitted monthly claims reports which demonstrated persistently high claim denials for behavioral health services (ACT, PROS, HCBS, Partial Hospitalization, and CPEP) over a period of six months from 12/1/17-5/31/18, as well as information contained in the subsequent August and December 2018 Root-Cause analysis submissions which were requested by New York State to explain the reasons for such high denial rates, the Plan failed to reimburse providers at Medicaid Fee for Service and/or APG rates for ambulatory behavioral health services due to a configuration error in their Behavioral Health vendor Beacon's FlexCare claims platform which led to the inappropriate set-up of provider profiles.

Corrective Action:

Beacon identified the universe of possible claims impacted related to ACT, PROS, CPEP, Partial Hospitalization, and HCBS services for dates of service from December 1, 2017 – May 31, 2018. Beacon then identified any issues with provider demographic data, benefit setup, and fee schedule accuracy and updated provider fee schedules to reflect the appropriate reimbursement methodology. Beacon also outreached to providers to obtain current demographic information and updated the provider records appropriately. Beacon reprocessed the claims related to ACT, PROS, CPEP, Partial Hospitalization, and HCBS services for 12/1/17 – 5/31/18. Additionally, Beacon reviewed claims for these services going back to when they started processing claims on IHA's behalf and reprocessed impacted claims accordingly. Beacon and IHA monitor denial rates for ACT, CPEP, PROS, Partial Hospitalization and HCBS services and these continue to trend downward. IHA and Beacon continue to work together to ensure appropriate claims processing.

Responsible Party:

Kim Barker, Manager Delegated Entities

Date Certain:

ACT, CPEP, Partial Hospitalization, PROS, and HCBS services have been processing correctly since January 11, 2019.

All historical claims related to ACT, CPEP, Partial Hospitalization, PROS, and HCBS were reprocessed appropriately as of May 22, 2019.

Monitoring and/or Auditing:

Each week, Beacon provides a report to IHA of all open claims, days since the claim was received, the associated total dollars for the claims and the reason(s) the claim has not been adjudicated. Each week, Beacon provides a report of claims issues affecting providers and meets with IHA to discuss progress and steps to resolve the issues. Every two weeks, Beacon meets with IHA representatives from Vendor Management, Claims Management and Network Management to review a report of not only the Diversionary claim types but also all claim types paid and denied. The report also includes a summary of facilities that have multiple denials. At the conclusion of these meetings, IHA identifies any action items for Beacon and tracks action items through to their resolution.

Education:

IHA has been actively and regularly engaged with Beacon, discussing regulatory and contractual requirements as part of each of the meetings discussed above and on an ad hoc basis as needed.

Revised POC in response to Letter dated July 26, 2019

a) The POC fails to explain and/or provide criteria for how the Plan/Vendor determined whether a claim denial was inappropriate versus appropriate.

IHA Response:

Based on FAQs issued by New York State that provided clarification on the definition of inappropriately denied claims, Beacon developed a list of the denial reasons which are identified as inappropriate denials.

The denial reasons were categorized and defined as follows:

- Beacon Set up Error Denials: The following denials were identified as indicative of a possible Beacon system/setup issue.
  - DNoRate: Provider contracted/negotiated rate expired or not on file
  - DNoPlaceBenefit: Provider not in network for Behavioral Health, pre-authorization required.
- Timely Denials (DTimely, DTimelyReSub and DTimelyPrev): Were identified as inappropriate denials if they occurred in conjunction with one of the Beacon Setup Denials.

    - Due to circumstances surrounding historical denials for HARP/QMP, Beacon did a onetime reprocess of claims on December 13th, 2018 that were originally denied only for timely submission. Beacon waived timely filing requirements for these claims.
    - Beacon also waived timely when reprocessing inappropriately denied claims
- Authorization Denials (DServNotCertUn, DOverCertUn): These authorization denials were deemed as inappropriate denials if in combination with one of the above Beacon Setup Denials.
    - Beacon waived authorization requirements when reprocessing inappropriately denied claims

All other denial reasons are considered to be appropriate denials. To ensure accuracy, Beacon evaluated each denial reason to confirm their handling was correct based upon contractual and regulatory information.

Once appropriate denial rules were validated, Beacon analyzed each claim and reprocessed any denials that were made in error as described above. As part of this process, Beacon also analyzed provider set up and contractual arrangements to ensure incorrect provider set up issues were corrected and to ensure claims would be processed appropriately moving forward.

Beacon created a new report in December 2018, called the Liability report. This report contains inappropriate denials for all services with a date of service of January 1st, 2016 to current. Additionally, Beacon launched a formal cross-functional workgroup to ensure that issues uncovered by the August denial root-cause analysis were solved for all providers. By using the new Liability report and reviewing each claim with a problematic denial reason, all of the Diversionary Claims that were denied inappropriately as described above were corrected as of January 23rd, 2019.

To ensure Beacon's work was complete and accurate going forward, Beacon pended all claims with a problematic denial reason and reviewed for appropriateness prior to issuing a denial. This process was performed from December 31st, 2018 through June 30, 2019. As of June 30th, 2019, claims are no longer being pended and processing through the system without manual intervention.

b) The POC fails to provide details on specific actions taken to ensure that Vendor's FlexCare claims system can appropriately pay New York State mandated government rates for applicable behavioral health services without requiring ongoing manual intervention.

IHA Response:

Policies and procedures were updated, and system configuration changes were made in order to resolve the outstanding claims payment issues. These changes are addressed below.

- Beacon identified the source and time frame for each government rate and will finalize a policy for continually updating and keeping rates current in their system. (See Policy #1 – attached -

Beacon Provider Remediation_NY Fee Schedule Maintenance Guidelines) and Exhibit 1 - attached (Beacon Provider Remediation_NY Fee Schedule Maintenance_Grid)

- Beacon developed a systematic methodology to upload rate changes for state fee schedule changes rather than manual input to reduce errors. See Grouper Functionality Description below.
- Beacon developed a standard approach and used new system functionality to manage rates that pay at a percentage of a base rate.
- Beacon increased the volume of comprehensive end-to-end claim reviews to better ensure payment accuracy (See Policy #2 Quality Control Claims Testing Audit Steps (random sample)). In addition, Beacon is verifying against the New York State source document (New York State fee schedules) when completing the rate review.
- Beacon adjusted the post-adjudication claim sampling approach from a straight percentage to an industry-standard confidence level to ensure a more representative sampling. Beacon also began reviewing the entire claim rather than only selected claim lines. (See Policy #3 Quality Control Claim Testing Audit Steps Post Adjudication)
- Beacon will finalize a new Government Rates report for CFTSS built out for Children's HCBS that will allow us to see if there is a mismatch between the rate code and the amount paid for the service. IHA has required this report be inclusive of the Adult population as well.

The following system configuration changes were made in the Beacon system to process claims in accordance with State government rates.

The following outlines the dates and processes for the rate corrections for the Diversionary Services:

- Grouper Functionality: Live May 2018
    - The Grouper functionality in Beacon's claim's system allows for rates to be loaded to a default fee schedule and providers to be linked to the default. Anytime that there is a change to a rate the rate is changed once on the default and will automatically propagate to the providers providing that service.
- Creation of Diversionary Groupers:
    - ACT was created on 12/10/18
    - All Other Diversionary on 12/12/18
- Linkage of Providers to Groupers (Update Provider Rates):
    - ACT 12/17/18
    - All Other Diversionary Groupers 1/11/19
- Claims Reprocess for Beacon Denials
    - ACT 12/1/17 to 12/17/18 Claims completed on 12/21/18
    - ACT 10/1/15 to 11/30/17 Claims completed on 1/16/19
    - All Other Diversionary completed on 1/23/19

Beacon has developed a crosswalk between the codes used and where the rates are obtained from the state web site. This document is an extensive excel file but can be produced to the state if needed.

Beacon's cross-functional workgroup developed Grouper Templates with current, updated rates for the non-3M rates. The Grouper Template was validated back to source data (NY State fee schedules). Prior to implementation, the Grouper Templates were reviewed, attested to, and signed off by the Contracting and Provider teams. To ensure ongoing accuracy, Beacon developed a test table in SQL to

produce expected rate output in the claims data. This test table is used in conjunction with actual production data and matches on all applicable values (procedures, modifiers, amounts, dates, etc.). If all items match, the data passed. If the data is not a 100% match, it is returned to development for a new round. Through this process, all input data will be checked, and accuracy of the rates validated prior to being loaded to the system.

Please note that screenshots showing how this is processing through Beacon's system can be produced if needed.

As part of the remediation process, all fee schedules were reviewed for accuracy and any necessary updates performed. Beacon reviewed all fee schedules that were either at or based upon New York State Medicaid rates. Though Beacon's ongoing process is still in draft form, Beacon has a work group assembled to finalize the processes to ensure new rates are identified and implemented timely. We have attached a draft for your reference to illustrate as noted above (See Policy #1 attached).

Independent Health is requiring a "New Rate Report" that is currently in draft form at Beacon that will be inclusive of Adult/Children. This report will be reviewed at the biweekly Claims Work Group meetings already in progress.

Include Policy #1: NY Fee Schedule Maintenance Guidelines (attached)

Include Policy #2: Quality Controls Claims Testing Audit (attached)

c) The POC fails to provide evidence of any material changes to the Plan/Vendor's claims processing policies and procedures to ensure payment of government rates for applicable behavioral health services.

IHA Response:

Please see the attached historical denial rates as compared to our current reporting from June 2019. As you can see, the denial rates for virtually all services have been substantially reduced. Those that are higher than the threshold has valid variance reasons such as low claims volume. Please also see the attached policies from Beacon.

Service	State Threshold	Dec 17 - May 18 Denial Rate	June 2019 Data Denial Rate
PROS	25%	21%	11%
ACT	40%	16%	18%
Part Hosp	40%	76%	29%
CPEP	15%	5%	4%
HCBS Psychosocial Rehab 7784-7789	15%	63%	15%
HCBS CPST 7790-7793	15%	75%	43%
HCBS Peer Support Services 7794	15%	68%	19%
HCBS Habilitation 7795	15%	0%	47%
HCBS Short-term Crisis Respite 7796-7797	15%	0%	0%
HCBS Intensive Crisis Respite 7798	15%	0%	0%
HCBS Family Support and Training 7799-7800	15%	0%	100%
HCBS Pre-vocational 7801	15%	54%	13%
HCBS Transitional Employment 7802	15%	0%	0%
HCBS Intensive Supported Employment 7803	15%	13%	0%
HCBS On-going Supported Employment 7804	15%	44%	0%
HCBS Education Support Services 7805	15%	9%	23%
HCBS Provider Travel Supplement 7806-7807	15%	29%	12%
Totals and overall Denial Rate		52%	16%

Denial Reason Groupings

Appropriate/ Inappropriate	Denial Reason	Denials 2017 Dec - 2018 May	Denials 2019 Jun
Appropriate	DCOBPrimePmtMissing	2	
	DCovExpire	21	5
	DDOSInvalid	1	
	DDuplClaim	93	20
	DDxMedical	31	
	DDxRequires5thD	18	
	DDxRequiresAdditionalDigits	33	
	DDxVCode	4	1
	DInfoCPT	575	3
	DManagedCare	2	
	DNPI_ValueCodecomboInvalid	69	8
	DNPIBillingInfo	13	1
	DNPIRenderingInfo	3	1
	DNPIRenderingInvalid	492	16
	DOther	1	
	DOverCertUn	12	13
	DResubInfo	7	1
	DRevCodeInvalid	2	
	DServNotCert	259	32
	DServNotCov	204	8
	DServSep	2	
	DSingleClaim		3
	DTimely	40	4
	DTimelyPrev	28	5
	DTimelyResub	212	7
	Appropriate Total	2,124	128
Inappropriate	DNoPlaceBenefit	7	
	DNoRate	85	
	Inappropriate Total	92	
Grand Total		2,216	128