


**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
STREET ADDRESS, CITY, STATE, ZIP CODE 511 Farber Lakes Drive Buffalo, NY 14221	SURVEY DATES: December 1, 2017-May 31, 2018 Survey ID# -401226979

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. (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><u>Deficiency:</u></p> <p>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 provide adequate oversight of delegated management function, claims adjudication, by allowing their Behavioral Health vendor, Beacon, to deny a proportion of claims without being able to determine cause for those denials.</p>	<p><u>Corrective Action:</u></p> <p>In response to the Root-Cause analysis submissions that were conducted in 2018, Independent Health (“IHA”) has worked to strengthen its oversight of Beacon Health Options (“Beacon”) through enhanced reporting and closer collaboration.</p> <p>In addition to the existing Joint Oversight Team (“JOT”) Meetings, IHA established a Claims Work Group meeting and set a standing Provider/Facility Claims Resolution Meeting to address provider complaints.</p> <p>The Claims Work Group began meeting on January 11, 2019 and meets every 2 weeks. IHA Claims subject matter experts review several weekly reports with Beacon, including an Aging Report, Claim Denial/Paid Report, and Rejection Report. These reports help identify trending of claims payment issues by service type, denial reasons and by specific provider to determine impact for</p>

	<p>claims not yet processed/paid. Timeliness, accuracy, and other claims issues are identified and discussed, with corrective action plans assigned according to IHA's Corrective Action Policy. Updates are brought to JOT meetings to discuss remediation steps and timelines for resolution with a broader audience.</p> <p>Since January 4, 2019, Beacon and IHA have been discussing provider complaints related to claims denials and timeliness as part of the Provider/Facility Claims Resolution Meeting. At these meetings, representatives from IHA and Beacon review and discuss complaints received from providers along with steps needed and timelines associated with resolution of the issues. Updates are brought to JOT meetings to discuss remediation steps and timelines for resolution with a broader audience.</p> <p><u>Responsible Party:</u></p> <p>Kim Barker, Manager Delegated Entities</p> <p><u>Date Certain:</u></p> <p>January 2019</p> <p><u>Monitoring and/or Auditing:</u></p> <p>Continued monthly reporting by Beacon and reviewed by IHA to identify and resolve issues.</p> <p><u>Education:</u></p> <p>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.</p>
<p>MCO Representative's Signature</p> 	<p>Date</p> <p>August 9, 2019</p>
<p>Title</p> <p>Chief Compliance Officer</p>	

NEW YORK STATE DEPARTMENT OF HEALTH

ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONTINUATION SHEET

Name of Managed Care Organization

Independent Health Association, Inc.

Survey Dates December 1, 2017-May 31, 2018

Survey ID # -401226979

Deficiencies

Provider Plan of Correction with Timetable

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 July 26, 2019 letter

- a) The POC fails to provide a status of claims identified in the root cause analysis as not being traceable to the vendor or the Provider.

Below please find updated grids relating to the status of the claims identified in the root cause analysis response dated December 21, 2018. Please note that based on the Office of Mental Health claim

reporting requirements, the denial rates can be above 100% due timing of adjudication.

IHA Partial Hospitalization Denial Reason Analysis (Sept 2018 - Nov 2018) (updated 08/05/2019)								
Denial Reason	Denials	Denial Rate	Provider issue		Beacon		Other	
			Denial Count	Denial Rate	Denial Count	Denial Rate	Denial Count	Denial Rate
DDuplClaim	16	13%	16	13%				
DInfoCPT	11	9%	11	9%				
DNoRate	1	1%			1	1%		
DNPI_ValueCodecombInvalid	10	8%			10	8%		
DOverCertUn	1	1%	1	1%				
DServNotCert	12	10%	12	10%				
DServNotCov	77	64%	77	64%				
DTimely	24	20%			24	20%		
DTimelyResub	1	1%			1	1%		
Grand Total	153	128%	117		36			
Total Claims	120							
Denial Rate	128%			98%		30%		0%

IHA Partial Hospitalization Denial Reason Analysis (Sept 2018 - Nov 2018) Erie County Medical Center (updated 08/05/2019)								
Denial Reason	Denials	Denial Rate	Provider issue		Beacon		Other	
			Denial Count	Denial Rate	Denial Count	Denial Rate	Denial Count	Denial Rate
DInfoCPT	11	9%	11	9%				
DNoRate	1	1%			1	1%		
DNPI_ValueCodecombInvalid	10	8%			10	8%		
DOverCertUn	1	1%	1	1%				
DServNotCert	12	10%	12	10%				
DServNotCov	20	17%	20	17%				
DTimelyResub	1	1%			1	1%		
Grand Total	56	47%	44		12			
Total Claims	120							
Denial Rate	47%			37%		10%		0%

IHA HCBS Denial Reason Analysis (Sept 2018 - Nov 2018) (updated 08/05/2019)								
Denial Reason	Denials	Denial Rate	Provider issue		Beacon		Other	
			Denial Count	Denial Rate	Denial Count	Denial Rate	Denial Count	Denial Rate
DDuplClaim	50	6%	50	6%				
DNoRate	4	0%			4	0%		
DNPIRenderingInvalid	2	0%	2	0.2%				
DOverCertUn	2	0%	2	0.2%				
DServNotCert	39	5%	39	5%				
DServNotCov	3	0%	3	0.4%				
DTimely	11	1%			11	1%		
DTimelyResub	20	2%			20	2%		
Grand Total	131	16%	96		35			
Total Claims	836							
Denial Rate	16%			11.5%		4.2%		0%

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.


In order to validate Beacon's work on diversionary claims and review of all denials, 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 address how the issue will be prevented in the future.

IHA Response:

To confirm that the corrective actions have addressed the underlying root causes, Beacon continues to analyze all claim denials to ensure the claims are processing in a consistent and appropriate manner. Any errors identified are reprocessed timely and reviewed to assess the cause of the error and if additional remediation is needed. If the underlying cause of the denial relates to a system configuration issue, the system updates will be made as quickly as possible.

MCO Representative's Signature 	Date August 9, 2019
Title Chief Compliance Officer	

NEW YORK STATE DEPARTMENT OF HEALTH

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Independent Health Association, Inc.

Survey Dates December 1, 2017-May 31, 2018

Survey ID # -401226979

Deficiencies

Provider Plan of Correction with Timetable

Chapter 57 of the Laws of 2017, Part P, 48-a.1

§ 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 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 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:

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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

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.

In order to validate Beacon's work on diversionary claims and review of all denials, 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.

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 (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 – attached - 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 policies and procedures included within this Plan of Correction illustrating how payment of government rates for applicable behavioral health services will be done consistently and accurately. Also, please reference the grids at the end of this POC. 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

MCO Representative's Signature 	Date August 9, 2019
Title Chief Compliance Officer	