

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

<b>NAME OF MANAGED CARE ORGANIZATION</b>  Health Insurance Plan of Greater New York	<b>TYPE OF SURVEY:</b>  Behavioral Health Claims Denial Root Cause Analysis
<b>STREET ADDRESS, CITY, STATE, ZIP CODE</b> 55 Water Street New York, NY 10041	<b>SURVEY DATES:</b> December 1, 2017-May 31, 2018 <b>Survey ID#-1432126196</b>

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.

<b>Deficiencies</b>	<b>Plan of Correction with Timetable</b>
<p><b>98-1.11 Operational and financial requirements for MCOs.</b></p> <p><b>{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.</b></p> <p><b><u>Deficiency:</u></b></p> <p>Based on the review of Plan-submitted monthly claims reports which demonstrated persistently high claim denials for behavioral health services (HCBS, Partial Hospitalization) 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 due to human processor error.</p>	<p>EmblemHealth has enhanced the oversight of our vendor, Beacon Health Options, with a more targeted focus on administration of Medicaid services, specifically including review of services and payment. The procedures below will continue to help ensure improved overall service to our members while continuing to guarantee that all requirements and service level measures are met to our satisfaction. The summary below outlines some of the more significant steps that have been implemented.</p> <p>1) EmblemHealth hired an additional claim auditor dedicated to Behavioral Health to increase the frequency of our claim audits and to perform focused audits on Medicaid services:</p> <ul style="list-style-type: none"> <li>The resource was hired in December 2018 and is working with her peers to review Beacon claims. <b><u>Responsible Party: Rhonda Robinson, VP Vendor Management</u></b></li> <li>In addition, EmblemHealth increased the administrative capitation payment to Beacon for the sole purpose of enabling Beacon to add resources dedicated to ensuring payment accuracy for EmblemHealth. Beacon is recruiting those resources with a target hire date of September 30, 2019. <b><u>Responsible Party: Rhonda Robinson, VP Vendor Management</u></b></li> </ul> <p>2) EmblemHealth conducts monthly WebEx meetings with Beacon to review a random sample of adult Behavioral Health service claims to ensure proper processing:</p> <ul style="list-style-type: none"> <li>Samples are pulled based on claims processed in the immediately preceding month. The first WebEx was held in March of 2019 with accuracy at 68%. The accuracy in April and May improved to 95% and 93% respectively. EmblemHealth receives confirmation of reprocessing of incorrectly adjudicated claims within 3 business days post the WebEx. These WebEx meetings will continue until we have accuracy for three consecutive months at 98% or greater. The WebEx also includes senior leadership at both EmblemHealth and Beacon as the part of the review process. <b><u>Responsible Party: Rhonda Robinson, VP Vendor Management</u></b></li> </ul>

3) EmblemHealth placed Beacon on a formal corrective action plan that required refresher training of their staff:

- As a result of our reviews in August and December 2018, Beacon was put on a formal corrective action plan ("CAP"). Through this CAP, EmblemHealth requested that Beacon delineate the specific steps taken to decrease inappropriate claim denials and improve accuracy. A key element of the plan is additional training for Beacon staff. EmblemHealth has required Beacon to provide claim examiners dedicated to our account with additional training with a focus on authorization to claim matches, which will ensure claims are no longer denied incorrectly for no authorization when an authorization was received. We have also required Beacon to enhance their quality assurance program based on findings in our WebEx. Refresher training for claims examiners identified during claim denial root cause analysis occurred on January 22<sup>nd</sup>, 2019, and EmblemHealth continues to audit claims as noted above. **Responsible Party: Rhonda Robinson, VP, Vendor Management**

4) EmblemHealth conducts outbound calls to a sample of Beacon providers that have a greater than 10% denial rate for adult services monthly:

- In January 2019, the EmblemHealth team began to perform outbound calls to Beacon contracted providers that submitted claims for our members. The calls include a discussion around claims processing and any service issues or concerns related to their relationship with Beacon specific to our members; to ensure they have the necessary information required to bill appropriately and that they are being supported. These calls also allow us to identify issues and concerns real time with the Beacon contracted providers so that issues are remediated immediately. The EmblemHealth vendor management and network teams have worked with Beacon providers and offered prospective payments to four providers based on their higher than average denial rate. Each provider contacted declined our offer for a prospective payment. Beacon also performs its own outreach to providers with a denial rate of greater than 10%. EmblemHealth receives that report monthly and contacts a sample of the providers who received Beacon's outreach. **Responsible Party: Rhonda Robinson, VP, Vendor Management**

5) EmblemHealth increased the frequency of Beacon's submission of the denial reporting tool and clarified the specificity of the required root cause information related to the denials, segregated by provider:

- As of April 2019, Beacon begin supplying EmblemHealth with the denial reporting tool on a weekly basis so that we can proactively manage the denial rates and monitor any aberrant trends on a more timely basis. The revised format of the denial report also provides greater specificity into the root cause of the denial as well as clearer information as to the rate by provider. This information helps us to ensure that our claim audits are risk based and assists with targeting our provider outreach. **Responsible Party: Rhonda Robinson, VP, Vendor Management**

6) EmblemHealth added a performance penalty to its contract with Beacon related to claim denial rates:

- In the most recent amendment to EmblemHealth's contract with Beacon, effective 1/1/2019, a service level measure with a performance penalty specifically related to Medicaid claim denials was added. **Responsible Party: Rhonda Robinson, VP, Vendor Management**

7) Status of claims denied due to human error:

- In November/December 2018 EmblemHealth performed a targeted audit of a sample of Beacon claims for adult services. As reported to the State in December of 2018, in our sample of 73 claims, we identified 13 partial hospitalization and 10 HCBS claims that were inappropriately denied for no authorization due to human error. As a result, the steps outlined in 1-6 above were implemented. We received confirmation that the 23 claims were adjusted appropriately on 12/19/2018. We continue to perform our monthly WebEx audits with Beacon to review claims to ensure that all of the actions noted above result in improved claims accuracy and payment. When inaccurate payments are identified through our audit, Beacon is required to adjust the claims and provide evidence of adjustment within 3 business days of identification (by EmblemHealth to Beacon). **Responsible Party: Rhonda Robinson, VP, Vendor Management**

MCO Representative's Signature



Date

8/8/19

Title:

VP, Vendor Management

NEW YORK STATE DEPARTMENT OF HEALTH

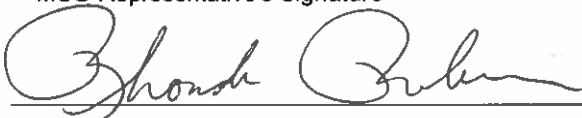
ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONTINUATION SHEET

Name of Managed Care Organization Health Insurance Plan of Greater New York	Survey Dates December 1, 2017-May 31, 2018 Survey ID# -1432126196
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).	<ul style="list-style-type: none"><li>• Please see our response next to the Chapter 57 deficiency below.</li></ul>

MCO Representative's Signature

Date



8/8/19

Title

VP, Vendor Management

NEW YORK STATE DEPARTMENT OF HEALTH	
ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
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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;...	<ul style="list-style-type: none"> <li>Please see our response next to the Chapter 57 Deficiency statement below.</li> </ul>

MCO Representative's Signature

Date

*Shoush Gulim*

8/8/19

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VP, Vendor Management

**NEW YORK STATE DEPARTMENT OF HEALTH**

**ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<p><b>Deficiencies</b></p>	<p><b>Provider Plan of Correction with Timetable</b></p>
<p><b><u>Deficiency:</u></b></p> <p>Based on the review of Plan-submitted monthly claims reports which demonstrated persistently high claim denials for behavioral health services (HCBS, Partial Hospitalization) 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 in a timely manner due to human processor error.</p>	<p>EmblemHealth has enhanced the oversight of our vendor, Beacon Health Options, with a more targeted focus on administration of Medicaid services, specifically including review of services and payment. The procedures below will continue to help ensure improved overall service to our members while continuing to guarantee that all requirements and service level measures are met to our satisfaction. The summary below outlines some of the more significant steps that have been implemented.</p> <ol style="list-style-type: none"> <li>1) EmblemHealth hired an additional claim auditor dedicated to Behavioral Health to increase the frequency of our claim audits and to perform focused audits on Medicaid services:             <ul style="list-style-type: none"> <li>• The resource was hired in December 2018 and is working with her peers to review Beacon claims. <b><u>Responsible Party: Rhonda Robinson, VP Vendor Management</u></b></li> <li>• In addition, EmblemHealth increased the administrative capitation payment to Beacon for the sole purpose of enabling Beacon to add resources dedicated to ensuring payment accuracy for EmblemHealth. Beacon is recruiting those resources with a target hire date of September 30, 2019. <b><u>Responsible Party: Rhonda Robinson, VP Vendor Management</u></b></li> </ul> </li> <li>2) EmblemHealth conducts monthly WebEx meetings with Beacon to review a random sample of adult Behavioral Health service claims to ensure proper processing:             <ul style="list-style-type: none"> <li>• Samples are pulled based on claims processed in the immediately preceding month. The first WebEx was held in March of 2019 with accuracy at 68%. The accuracy in April and May improved to 95% and 93% respectively. EmblemHealth receives confirmation of reprocessing of incorrectly adjudicated claims within 3 business days post the WebEx. These WebEx meetings will continue until we have accuracy for three consecutive months at 98% or greater. The WebEx also includes senior leadership at both EmblemHealth and Beacon as the part of the review process. <b><u>Responsible Party: Rhonda Robinson, VP Vendor Management</u></b></li> </ul> </li> <li>3) EmblemHealth placed Beacon on a formal corrective action plan that required refresher training of their staff:             <ul style="list-style-type: none"> <li>• As a result of our reviews in August and December 2018, Beacon was put on a formal corrective action plan</li> </ul> </li> </ol>

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**Statement of  
Findings  
Health Insurance Plan of Greater New York, Inc.  
Behavioral Health  
Root Cause Analysis  
December 1, 2017 -  
May 31, 2018  
Survey ID# -1432126196**

**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 (HCBS, Partial Hospitalization) 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 in a timely manner due to human processor error.

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