NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Transition Reports

Behavioral Health Transformation

May 9, 2016

OMH - OASAS - MCOs Webinar

NEW YORK STATE OF OPPORTUNITY.
Office of Mental Health

Agenda

1. Introductions
2. Behavioral Health Monitoring
3. Requirements for Plan Data Submission
4. Monthly Submission of Inpatient Denials– Process and Content
5. Quarterly Submission of Ambulatory Care Service Denials– Process and Content
6. Submission Process and Time Line
7. Next Steps
8. Questions & Answers

Introductions

OMH: Managed Care – Tom Smith, Maria Pangilinan, Xian Li, Trish Perazelli, Melissa Janidlo, Jonathan Sauerschell

OMH IT – Dave Gestwick, Christopher Rambo, Jonathan Cole, Manasa Tamatan

OASAS: Ilyana Meltzer, Dawn Lambert-Wacey, Shazia Hussain

MCOs – Affinity, Amida Care, CDPHP, Crystal Run, Emblem, Excellus, Fidelis, Healthfirst, Healthnow, Healthplus, Independent Health Association, Metroplus, MVP, Total Care/Today's Options, United, VNS, Wellcare, YourCare, Beacon

Behavioral Health Monitoring During The Transition

- Monitor plan specific data in three areas of concern during the transition to managed care: Service use, denials and timely payment to providers.
- Detect system inadequacies as they occur.
- State to initiate steps in addressing the issues as soon as possible.
- Data on service use and timeliness of payment will come from Medicaid encounters, and information on denials will be collected through new monthly (inpatient) and quarterly (outpatient) plan submissions.

Data Monitoring Sources

1. Encounter Data

- Track behavioral health service utilization. OMH will produce monthly utilization reports for all behavioral health services at the plan level and provider levels.

- Medicaid Encounter data availability is currently experiencing lag issues in uploading to the OMH data mart.

- Track timeliness of payment. Due to encounter data issues, OMH had started looking at claims processing denials, pends and approved/paid from health plan biweekly-submissions to monitor issues with claims submission and processing.

Data Monitoring Sources

2. Plan Data Submission

- On a monthly basis, Mainstream, HIV Special Needs Plans (SNP), and Health and Recovery Plans (HARP) will be required to electronically submit a report to the State on all pre-authorization, concurrent and retrospective denials for inpatient behavioral health services based on medical necessity.

- On a quarterly basis, Mainstream, HIV SNP, and HARP Plans will be required to electronically submit a report to the State with a 3-month capture of ambulatory service denials aggregated at the plan level by service.

Data Monitoring Sources

2. Plan Data Submission

- On a bi-weekly basis, plans are asked to submit information about claims processing: Number of claims processed, number of claims pended, number of claims paid.

Systems Requirements for Plan Denial Reporting

- MCO contract with the State provides for the State to request reports from the MCO for data not available through existing contractor reports.

- System of File Transfer between the Offices and MCOs:

  OMH-BH-Transition-monitoring@omh.ny.gov

- Data Format and Specification for submission.

Data Specification Documents

- The Offices provide specifications and documentation of the technical aspects of the data submissions: Specification Document and a companion Visual Guide.
- The Specification and Visual Guide are live --- modifications and changes are made for better reporting purposes.
- A document containing the current changes and historical changes to the specification is sent to plans, when changes are made.

Specification/Visual Guide Documents

- For ROS MCOs who are reporting for the first time, we are using the Specification and Visual Guide documents as they have evolved.

- Att A-Data specs for inpatient denial monthly reporting-05092016.docx
- Att A1-Visual Guide for Inpatient Denial Monthly Reporting-05092016.docx

- Att B -Data Specs for Outpatient Denial Quarterly Reporting 05092016.docx
- Att B1-Visual Guide for Outpatient Denial Quarterly Reporting -05092016.docx

Log Changes and Provider Reference Documents

- Changes are logged in a document:
  Log for Modifications to Inpatient and Outpatient Denial Specifications.docx, which is sent to plans.

- Two additional documents are sent to plans in order to assist in identifying inpatient provider identification and location.

- INP MH Locator codes.xlxs
- INP SUD Locator codes.xlxs

Modifications To The Specification and Visual Guide, 5/9/2016

- Specific Changes:
  - Ambulatory Care services provided in Federally Qualified Health Center (FQHC) facilities are now listed as a category in the outpatient denial service report.
  - A new CPEP rate code, effective October 2015, is now listed in the rate code guide column in Attachment B1.
  - Clarification is made on counting both clinical and non-clinical (administrative) denials when reporting denials.
  - Administrative denials should be a subset of total denials.

Monthly Submission of Inpatient Denials

- The report will include aggregated provider level data of inpatient denial information for the reporting month, and whether the denial was Pre-Service, Concurrent, Retrospective, and the reason for the denial.

- In identifying the providers where denials occur, plans should use the reference list of providers distributed with these specifications.

- The report for a calendar month will be due on the fifteenth day of the next calendar month.

Monthly Submission of Inpatient Denials

- File naming convention:

PlanName_IP_Line of Business_Month_Year_v#.txt

examples: ABCHealthPlan_IP_M_OCT_2015_v1.txt

XYZPlan_IP_H_DEC_2015_v2.txt

CityPlus_IP_S_JAN_2016_v1.txt

RehabHouse_IP_H_NOV_2015_v2.txt

Note:

PlanName_ = up to 16 characters, including underscore

IP_Line of Business= 4 digit character, could take the values:

IP_M = Inpatient Mainstream plan

IP_H= Inpatient HARP

IP_S= Inpatient HIV SNP

Month = use first three letters of the month, CAPITALIZED; Year= 2015, 2016, 2017; v# = version number seeded at 1.

Monthly Submission of Inpatient Denials

File Content

1. Reporting Period
2. Plan Identifiers
3. Provider Identifiers
4. Pre-Service Denial Information
5. Concurrent Review Denial Information
6. Retrospective Denial Information
7. Denominators for Denials: Monthly authorization requests

Monthly Submission of Inpatient Denials

Things To Remember

1. One file is to be submitted for each line of business using the appropriate file-naming convention. Each report has only one plan type.
2. Version number in file name should correspond to version number in the data element. Each report has only one version number.
3. Report and plan identifiers are all the same in all the rows of one report.
4. The authorization and denial reason counts being reported are those that occurred during the reporting month.

Monthly Submission of Inpatient Denials

Reporting of Denials and Authorization Requests

- Health plans should include authorization requests from all contracted inpatient providers even if there were no denials in order to get the whole universe of authorizations, and the relative size of denials by every provider.
- Plans should report provider identifiers from the reference list produced by OMH and OASAS.
- If in a particular month, an authorization request from a non-contracted provider occurs, the health plan should also report all associated information about this authorization in the report.

Quarterly Submission of Ambulatory Care Denials

- Each quarterly report contains three separate months of data on ambulatory service denials aggregated at the Plan level by service.
- HARP and HIV SNP Plans will be required to report denials on Home and Community Based Services (HCBS).
- The quarterly submission will be due to the State fifteen days on the following month after the end of the quarter being reported.

Quarterly Submission of Ambulatory Care Denials

- File naming convention: PlanName_OP_Line of Business_Qtr_Year_version#.txt

  examples: ABCHealthPlan_OP_M_4_2015_v1.txt

  XYZPlan_OP_H_4_2015_v2.txt

  CityPlus_OP_S_1_2016_v1.txt

  RehabHouse_OP_H_4_2015_v2.txt

Note:

PlanName_ = up to 16 characters, including underscore.

OP_Line of Business= 4 digit character, could take the values:

OP_M = Outpatient Mainstream plan

OP_H= Outpatient HARP

OP_S= Outpatient HIVSNP

Qtr = either 1,2,3 or 4; Year= 2015, 2016, 2017; v# = version number seeded as 1.

Quarterly Submission of Ambulatory Care Denials

File Content

1. Report Identifiers (Plan and reporting period information)
2. Behavioral Health Ambulatory Services
   - Enrollees receiving the service
   - New Episode of Care (Denials and Authorizations)
   - Continuing Care (Denials and Authorizations)
   - Retrospective Reviews (Denials and Authorizations)
   - Administrative Denials
   - Internal Appeals Requested
   - Appeals where denial was upheld

Quarterly Submission of Ambulatory Care Denials

File Content

2. Behavioral Health Ambulatory Services (con't)

- Denials w/ request for External Review/ State Fair Hearing Process
- Denials overturned following External Review/Fair Hearing Process
- Denials still in External Review/Fair Hearing Process

Quarterly Submission of Ambulatory Care Denials

File Content

3. HCBS Services

- Enrollees receiving the service
- New Episode of Care (Denials and Authorizations)
- Continuing Care (Denials and Authorizations)
- Retrospective Reviews (Denials and Authorizations)
- Administrative Denials
- Internal Appeals Requested
- Appeals where denial was upheld

Quarterly Submission of Ambulatory Care Denials

File Content

3. HCBS Services(con't)
   - Denials w/ request for External Review/ State Fair Hearing Process
   - Denials overturned following External Review/Fair Hearing Process
   - Denials still in External Review/Fair Hearing Process

Quarterly Submission of Ambulatory Care Denials

Things To Remember

1. Each file contains three months of data.
2. One file is to be submitted for each line of business using the appropriate file-naming convention. Each report has only one plan type.
3. Plan and report identifiers are the same in all the rows for one report; each of the three months in the quarter are in the same report.
4. Version number corresponds to version number in the file name.
5. Data counts (number of enrollees, authorizations, denials, appeals) are for those that occurred during the reporting month.

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Quarterly Submission of Ambulatory Care Denials

Things To Remember

6. Mainstream plans should report all 20 ambulatory service categories in their own rows even if associated data variables are all zero for some service categories.

7. The data for the 20 service categories will be reported for each of the three months in the quarter, resulting to 3x20=60 rows of information.

Quarterly Submission of Ambulatory Care Denials

Things To Remember

7. HARPS and HIV SNPs should additionally report all 13 HCBS services in their own row even if associated data variables are all zero for some service categories.

8. HARPS and HIV SNPs will report a total of 33 rows of denial information for ambulatory and HCBS services for each month.

9. HARPS and SNPS will report 3 months of data for all service outpatient categories (33x3=99 rows of service denial information).

Other Reminders for Both Inpatient and Outpatient Submissions

- File is ASCII fixed length format, no delimiter.
- Follow file-naming convention. Files that do not follow the naming convention will be rejected.
- OMH IT will have an edit list for the submissions. If data elements fail the edits, the submission will be reviewed and the plan will be advised about correcting the submission.
- Plans will be given a list of edits to be corrected prior to re-submission.
- A resubmission should contain the whole file, and not just the corrected rows.

Other Reminders for Both Inpatient and Outpatient Submissions

- Do not include header rows in the reports.
- Do not compress or zip the file.
- There is no PHI so do not encrypt the file.

Submission Process and Timeline

8/21/2015 – Guidance letter sent to NYC plans. Guidance letter to ROS will be forthcoming.

5/9/2016 – Webinar on the Specifications and Submission Process.

5/9/2016 – 5/25/2016 – Feedback from health plans on monthly and quarterly reports; OMH-OASAS responds/makes adjustments.

Submission Process and Timeline (con't)

5/30/2016 – Plans submit contact information of at least two individuals responsible for submitting the reports. Please also let us know definition of 'New Enrollees'.

6/6/2016 – Plans submit inpatient Monthly test files to OMH.

6/20/2016 – OMH informs plans of test file results.

8/15/2016 – Actual first monthly inpatient denial submission.

Submission Process and Timeline (con't)

9/1/2016 – Quarterly Test file submission

9/12/2016 – OMH informs plans of quarterly test file results

10/15/2016 - Third ROS Inpatient Monthly Denial report submission and First ROS Quarterly Outpatient Denial submission.

11/15/2016 – Fourth Inpatient ROS Monthly Denial report submission

12/15/2016 –Fifth Inpatient ROS Monthly Denial report submission.

1/15/2017 – Sixth Inpatient ROS Monthly Denial report and Second ROS Quarterly Outpatient Denial report submission.

Next Steps

- Health plans submit contact and back-up information of individuals submitting the reports: Name, title, telephone number, email, and fax number. Email information to

  OMH-BH-Transition-monitoring@omh.ny.gov by 5/30/2016.

- Health plans to send OMH feedback on specs and format 5/9 – 5/25: OMH-BH-Transition-monitoring@omh.ny.gov

- OMH-OASAS respond to feedback as soon as possible.

Contact Information

If you have questions on

- the report specification, please contact Maria Pangilinan or Xian Li:
  - OMH-BH-Transition-monitoring@omh.ny.gov
  - Tel # 518-474-6911
- data-upload and electronic submission issues, please contact Jonathan Cole
  - Jonathan.Cole@its.ny.gov
  - Tel # 518-486-5877

Questions?