



**Office of
Mental Health**

Transition Reports

Behavioral Health Transformation

OMH - OASAS - MCOs Webinar



**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, Mouad Seridi

IT – Dave Gestwick, Christopher Rambo, Jonathan Cole, John Biernik, Dorie Valente, Steve Schoenhaus

OASAS: Ilyana Meltzer, Dawn Lambert-Wacey



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.
- Track timeliness of payment. OMH will be looking at the time from date of submission to date of payment on encounter claims (available in the Encounter Intake System beginning September 2015) and compare it to the State's prompt pay standard.



Data Monitoring Sources

2. Plan Data Submission

- On a monthly basis, Mainstream, HIV SNP, and HARP Plans 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.



Systems Requirements for Plan Data Submission

- 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.



Modifications To The Specification and Visual Guide

- Specification and Visual Guide document sent to medical directors on 8/21/2015. The modified specs are now included in version 2.
- Based on input and experience of OMH IT from BHO I, the Specifications and Visual Guide documents are modified to better conform to a database structure and improve data submission and tracking purposes.
- Changes will improve data reporting efficiency, integrity, and upload.

Modifications To The Specification and Visual Guide

- Specific Changes:
 - Header lines in the excel table visual guide were moved to a database column.
 - When applicable, data reporting minimizes the length of the flat file, with information stacked for categories requiring the same information.

- Documentation of Changes to the Report Specifications:

[Log for Modifications to Inpatient and Outpatient Denial Specifications.docx](#)



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.
- 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; 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

Suggested Change By Plans During The Webinar 09/18/2015

- The denial report should include authorization request for all contracted 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 list in their report all their contracted providers and the associated authorization and denial information required.



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 HCBS services.
- 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 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.



Quarterly Submission of Ambulatory Care Denials

Things To Remember

6. Mainstream plans should report all 17 ambulatory service categories in their own rows even if associated data variables are all zero for some service categories.
7. The data for the 17 service categories will be reported for each of the three months in the quarter, resulting to $3 \times 17 = 51$ 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 30 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 (30x3=90 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 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 health plans.

9/18/2015 – Webinar on the Specifications and Submission Process.

9/19/2015 – 9/30/2015 – Feedback from health plans on monthly and quarterly reports; OMH-OASAS responds/makes adjustments.

9/30/2015 – Plans submit contact information of at least two individuals responsible for submitting the reports.



Submission Process and Timeline (con't)

10/15/2015 – Inpatient Monthly test files to be submitted to OMH.

10/22/2015 – OMH informs plans of test file results.

11/15/2015 – Actual first monthly inpatient denial submission.

12/1/2015 – Quarterly Test file submission

12/10/2015 – OMH informs plans of quarterly test file results



Submission Process and Timeline (con't)

12/15/2015 - Second Inpatient Monthly Denial report submission.

1/15/2016 - Third Inpatient Monthly Denial report submission and First Quarterly Outpatient Denial submission.

2/15/2016 – Fourth Inpatient Monthly Denial report submission

3/15/2016 –Fifth Inpatient Monthly Denial report submission.

4/15/2016 – Sixth Inpatient Monthly Denial report and Second 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
- Health plans to send OMH feedback on specs and format 9/22 – 9/30: 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?

