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	TYPE OF SURVEY:
.Amida Care, Inc.	Behavioral Health Claims Denial Root Cause Analysis
STREET ADDRESS, CITY, STATE, ZIP CODE 14 Penn Plaza 2nd Floor New York, NY 10122	**SURVEY DATES:** December 1, 2017-May 31,2018 **Survey ID#** -532518121

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
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.** **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 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. Part 98-1.11(h) the POC is unacceptable. 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 and did not address how this issue will be resolved and prevented in the future. The POC is unclear regarding how long the enhanced Vendor monitoring program will continue.	The reporting of "untraceable" claims denials was the result of Beacon and Amida Care's inability at that time to definitively explain the denial reason and root cause of all denials. Claims denials that could not be explained at the time were reported as "untraceable" – the associated "untraceable" denial percentages varied by program but were significantly smaller than the main drivers of denials (e.g., 10% of CPEP denials). On January 25, 2019 Amida Care's consulting partner Consentia Health received from Beacon the first comprehensive file that included claim-line level detail for both paid and denied claims. This was a critical step in the implementation of Amida Care's enhanced, data-driven denial oversight program. It should be noted that previously Amida Care received claims files consisting only of paid claims lines. Since January, Amida Care and Consentia have received these files on a monthly basis – and, at times, more frequently. As a result of Amida Care and Consentia's analysis of the denied claims and our plan-led collaborative efforts with Beacon – primarily in twice-weekly operational meetings and in ad-hoc meetings and discussions as needed – all denials that were previously reported for the period 12/1/17 – 5/31/18 as "untraceable" were determined to have specific root causes. These claims were then "bucketed" with related claims and resolved and tracked according to the respective reprocessing efforts that were underway for each denial category. We should also note that Amida Care has a working knowledge of all of the root causes for every denial category. Since the initial work with the claims file received in January 2019, Amida Care and Consentia have completed a monthly analysis of all denied claims and root causes (subsequent to the 12/1/17 – 5/31/18 period) and have been able to associate denials with defined denial reasons and root causes. This work is performed by Consentia Health under the direction of Nick Liguori, Amida Care Executive Vice President, who is the accountable person. A report consisting of denial trend summaries (denials by category and root cause) and details of significant issues are presented to Mr. Liguori and Annmarie Murphy, Director of Claims and Payment Oversight, and brought by them to the twice-weekly management meetings between the two organizations. 100% of claims have been traceable to root causes for a seven (7) month period. As such, the data-driven oversight of claims denial reasons has resolved and prevented the issue of "untraceable" denials. Any further instances of "untraceable" claims will immediately

	be brought to the twice-weekly operational meetings with Beacon and into the internal Amida Care claims oversight protocol. Amida Care's enhanced claims oversight process, which began in January 2019, will continue indefinitely and until such time that Amida Care has seen three (3) quarters of consistent denial levels and patterns within industry standard levels. Major enhancements to our oversight program have been implemented. These include the following: • Starting July 1, 2019, Consentia Health began receiving weekly claims line files – including paid and denied claims and analysis of denied claims patterns, categories and root causes on a weekly basis. This has allowed more timey insights for the twice-weekly operational meetings. This work is performed by Consentia Health under the direction of Nick Liguori, Executive Vice President, who is the accountable person. A report consisting of denial trend summaries (denials by category and root cause) and details of significant issues are presented to Mr. Liguori and Annmarie Murphy, Director of Claims and Payment Oversight, and brought by them to the twice-weekly management meetings between the two organizations. • Starting August 2019, Amida Care with its Consentia Health partner will begin two new oversight routines. 1. A quality assurance audit of selected post-payment claims for adjudication and payment accuracy. This audit will be performed by Amida Care or Consentia on a monthly basis and will include checks against government fee schedules and expected rates as well as adjudication accuracy across benefits administration, eligibility, and coding dimensions. 2. A review of 100% of claims post-adjudication and pre-payment for inappropriate denials and accurate payment against NYS mandated rates. Under this program, Beacon would not be authorized to effectuate provider payment for claims inaccurately adjudicated or priced. This process will help to prevent inaccurate adjudications and payments. This work will be performed by Consentia Health for and under the direction of Nick Liguori, Executive Vice President, who is the accountable person. A report consisting of every identified denial and payment accuracy issue will be presented to Mr. Liguori and Annmarie Murphy, Director of Claims and Payment Oversight, and brought by them to the twice-weekly management meetings between the two organizations. Amida Care is negotiating with Beacon to account for the cost associated with this greater oversight capability and to include service level agreements (with financial penalties) in the go-forward Master Services Agreement (MSA) being co-developed at this time. This MSA will replace the existing MSA that is under extension through 12/31/2019.
MCO Representative's Signature	Date
Title	

NEW YORK STATE DEPARTMENT OF HEALTH

ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONTINUATION SHEET

Name of Managed Care Organization	Survey Dates December 1, 2017-May 31, 2018
Amida Care, Inc.	Survey ID # -532518121
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.	

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NEW YORK STATE DEPARTMENT OF HEALTH

ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION CONTINUATION SHEET

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<tr><td>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).
The POC is unacceptable. The Plan fails to give specific status of affected claims from the root-cause analysis period. 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. 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.</td><td>In reporting on the reprocessing status of all denied "affected claims" for the period 12/1/2017 – 5/31/2018, Beacon has informed Amida Care that all related reprocessing has been completed and associated payments transacted. Amida Care will confirm this in the following ways:

1. As part of Amida Care's further enhancement to Beacon claims denial and accuracy oversight detailed below, Amida Care and Consentia Health will perform quality assurance audits of selected paid and denied claims (post-adjudication, post-payment) for payment and adjudication accuracy. This work will be performed by Consentia Health for and under the direction of Nick Liguori, Executive Vice President (EVP), who is the accountable person. A report consisting of every identified denial and payment accuracy issue will be presented to Mr. Liguori and Annmarie Murphy, Director of Claims and Payment Oversight, and brought by them to the twice-weekly management meetings between the two organizations.

2. As part of Amida Care's ongoing weekly review of claims line denials, the Plan does not see residual evidence of denials for the affected claims from the period 12/1/17 – 05/31/18. That said, Beacon claims denial and accuracy performance requires continuous improvement and major enhancements to Amida Care's oversight of this performance, which are detailed in this plan of correction, are warranted at this time.

Amida Care has taken specific actions to ensure that Flex Care claims system can appropriately pay New York State mandated government rates for applicable behavioral health services. Listed below are action items implemented:

• Starting in Q1 2019, Amida Care began receiving updated file reports of grouper systems/methodologies and fee schedules currently in use by Beacon's Flex Care system.

Amida Care's Claims and Payment Oversight staff, led by Annmarie Murphy, Director of Claims and Overpayment Oversight, monitors the procedure code files and rates (i.e., documented groupers and fee schedules) used by Beacon as part of ongoing oversight efforts detailed in this POC. Codes and actual rates are compared by Amida Care's Claims and Payment Oversight staff with expected sets of codes and rates. Questions and concerns are brought to Nick Liguori, EVP, and Beacon management in performance oversight meetings detailed in this POC.</td></tr>
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- Beacon's Provider Remediation NY Fee Schedule Maintenance Guidelines were updated on 1/1/19 and have been reviewed by Amida Care's Claims and Payment Oversight staff, led by Annmarie Murphy. Amida Care is introducing an SLA to the go-forward MSA with Beacon to include the delivery of all testing and audit findings related to the ongoing implementation of this policy and any necessary corrective action plans. Amida Care expects this SLA will be part of a new MSA effective 1/1/2020.

- Beacon's Quality Control Claims Testing Audit Steps policy was updated on 1/1/19 and has been reviewed by Amida Care. Amida Care is introducing an SLA to the go-forward MSA with Beacon to include the delivery of all testing and audit findings related to the ongoing implementation of this policy and any necessary corrective action plans. Amida Care expects this SLA will be part of a new MSA effective 1/1/2020.

- Beacon's Quality Control Post Adjudication Claims Audit SOP policy was updated on 1/25/19 and has been reviewed by Amida Care. Amida Care is introducing an SLA to the go-forward MSA with Beacon to include the delivery of all testing and audit findings related to the ongoing implementation of this policy and any necessary corrective action plans. Amida Care expects this SLA will be part of a new MSA effective 1/1/2020.

- In response to Amida Care's requirement of documented completion of training of new policies, procedures, and systems, Beacon has reported that all Claims and System staff satisfactorily completed training in June 2019.

- Starting August 2019, Amida Care with its Consentia Health partner will begin two new oversight routines.

  1. A quality assurance audit of selected post-payment claims for adjudication and payment accuracy. This audit will be performed by Amida Care or Consentia on a monthly basis and will include checks against government fee schedules and expected rates as well as adjudication accuracy across benefits administration, eligibility, and coding dimensions.

  2. A review of 100% of claims post-adjudication and pre-payment for inappropriate denials and accurate payment against NYS mandated rates. Under this program, Beacon would not be authorized to effectuate provider payment for claims inaccurately adjudicated or priced. This process will help to prevent inaccurate adjudications and payments. This work will be performed by Consentia Health for and under the direction of Nick Liguori, EVP, who is the accountable person. A report consisting of every identified denial and payment accuracy issue will be presented to Mr. Liguori and Annmarie Murphy, Director of Claims and Payment Oversight, and brought by them to the twice-weekly management meetings between the two organizations.

	Amida Care is negotiating with Beacon to account for the cost associated with this greater oversight capability and to include service level agreements (with financial penalties) in the go-forward Master Services Agreement (MSA) being co-developed at this time. This MSA will replace the existing MSA that is under extension through 12/31/2019. Amida Care has taken specific actions to ensure that Flex Care claims system can appropriately pay New York State mandated government rates for applicable behavioral health services. Listed below are action items implemented: • Starting in Q1 2019, Amida Care began receiving updated file reports of grouper systems/methodologies and fee schedules currently in use by Beacon's Flex Care system. Amida Care's Claims and Payment Oversight staff, led by Annmarie Murphy, Director of Claims and Overpayment Oversight, monitors the procedure code files and rates (i.e., documented groupers and fee schedules) used by Beacon as part of ongoing oversight efforts detailed in this POC. Codes and actual rates are compared by Amida Care's Claims and Payment Oversight staff with expected sets of codes and rates. Questions and concerns are brought to Nick Liguori, EVP, and Beacon management in performance oversight meetings detailed in this POC. • Beacon's Provider Remediation NY Fee Schedule Maintenance Guidelines were updated on 1/1/19 and have been reviewed by Amida Care's Claims and Payment Oversight staff, led by Annmarie Murphy. Amida Care is introducing an SLA to the go-forward MSA with Beacon to include the delivery of all testing and audit findings related to the ongoing implementation of this policy and any necessary corrective action plans. Amida Care expects this SLA will be part of a new MSA effective 1/1/2020. • Beacon's Quality Control Claims Testing Audit Steps policy was updated on 1/1/19 and has been reviewed by Amida Care. Amida Care is introducing an SLA to the go-forward MSA with Beacon to include the delivery of all testing and audit findings related to the ongoing implementation of this policy and any necessary corrective action plans. Amida Care expects this SLA will be part of a new MSA effective 1/1/2020. • Beacon's Quality Control Post Adjudication Claims Audit SOP policy was updated on 1/25/19 and has been reviewed by Amida Care. Amida Care is introducing an SLA to the go-forward MSA with Beacon to include the delivery of all testing and audit findings related to the ongoing implementation of this policy and any necessary corrective action plans. Amida Care expects this SLA will be part of a new MSA effective 1/1/2020. • In response to Amida Care's requirement of documented completion of training of new policies, procedures, and systems, Beacon has reported that all Claims, Provider, and Systems staff satisfactorily completed training in June 2019.

MCO Representative's Signature	Date
Title	

NEW YORK STATE DEPARTMENT OF HEALTH

ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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Name of Managed Care Organization Amida Care, Inc.	Survey Dates December 1, 2017-May 31, 2018 Survey ID# -532518121
Deficiencies	**Provider Plan of Correction with Timetable**
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;...	

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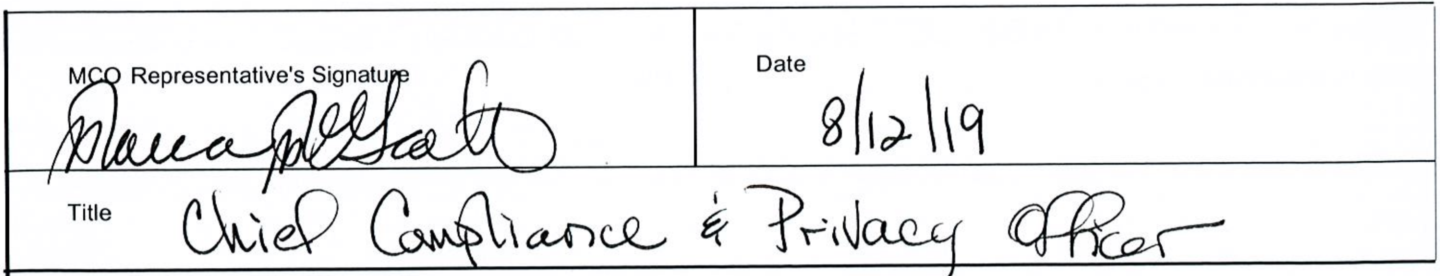

MCO Representative's Signature	Date 8/12/19
Title Chief Compliance & Privacy Officer	

Statement of Findings
Amida Care, Inc.
Behavioral Health Root Cause Analysis
December 1, 2017- May 31,2018
Survey ID# -532518121

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.

Medicaid Managed Care Model Contract 10.21.d The POC is unacceptable. The Plan fails to give specific status of affected claims referred to as reprocessed. 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. 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.

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