NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Mental Health Advanced Cash Payment Requirements:

What Providers Need to Know

December 27, 2018

Agenda

1. Root Cause Analysis
2. Cash Advance Requirements
3. What providers can do to prepare
4. Billing best practices

Investigating root cause of persistent claims denials

- In August 2018, MCOs with high claims denial rates for the period of 12/1/17-5/31/18 were required to conduct a root cause analysis to identify and resolve the issues contributing to the denials for:
  - CPEP
  - Partial Hospital
  - ACT
  - PROS
  - HCBS
- MCOs identified a range of causes that vary by MCO and service including:
  - MCO systems configuration issues
  - Provider claiming errors (incorrect rate/procedure code combination)
  - Provider submitted claims passed timely filing requirements
  - Lack of prior authorization requested
  - Services billed not included in provider agreement

Advanced Cash Payment Directive

New York State directed several MCOs to resolve outstanding claiming issues with providers within 60 days (by 2/24/19).

1. Within 60 days, MCOs and providers must reach agreement on the total amount of inappropriately denied claims to date and pay that amount to the affected provider.

Cash Advance Requirements if agreement is not achieved within this timeframe

2. Retroactive Cash Advance - MCOs must offer each affected provider a one-time retroactive cash advance payment for the total amount of denied claims in dispute during the root cause timeframe (excluding duplicate claims submitted).

3. Prospective Cash Advance – MCOs must fix systemic claims payment issues or offer each affected provider a Monthly Prospective Cash Advance equal to the average monthly denied amount (minus duplicate claims) until all payment issues are fixed by the Plan.

4. Additionally, the MCO must resolve any inappropriately denied claims going back to the start of the behavioral health transition and pay any interest owed for failure to comply with prompt pay laws.

5. All cash advanced payments must be reconciled through future claims submissions.

What Providers Can Do to Prepare

1. Identify affected claims:
   - Examine accounts receivables to determine claims that were inappropriately denied or paid at incorrect rates
2. You may already have been contacted but if not, reach out to the MCO.
   - (Go to https://matrix.ctacny.org for MCO contact information)
3. Manage cash advance carefully
   - Cash advanced payments will be reconciled against claims.
   - It may be determined you were not entitled for some of the reimbursement received and may get recouped in future payments.
   - Retain a portion of the cash advance in the event you were overpaid.
4. If a provider believes Behavioral Health claims (MH/SUD) not covered by the root cause analysis were inappropriately denied reach out to the MCO first.
   - If there is no resolution with the MCO, contact:
     - The NYS Department of Health (Behavioral.Health.Complaints@health.ny.gov)
     - The NYS Office of Mental Health (OMH-Managed-Care@omh.ny.gov)

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Cash Advance Calculation has 2 Components

1. One Time Retroactive Cash Advance
   - This is money owed to the provider for historical inappropriately denied claims.
2. Monthly Prospective Cash Advance
   - Calculated using the average monthly amount billed by the provider to the MCO for all services affected by high denials identified in the root cause analysis.
   - This amount will be paid to the provider for the period of time it will take to fix all systemic issues related to inappropriately denied claims.
   - Payment will continue until claiming issues are completely resolved.

Dealing with Cash Advances on Provider Claiming Errors

In some cases Provider claiming errors are the root of denied claims. When negotiating cash advances in these circumstances the following applies:

1. If the MCO and Provider agree on the number of denied claims due to Provider claiming errors, a process to resubmit the claims for payment needs to be established.
   - **No cash advance is needed for these claims.**
2. If the MCO and Provider disagree that claims were denied due to provider claiming errors and/or the total number of claims impacted:
   - **A cash advance needs to be negotiated within 60 days.**
     - A process to work though dispute needs to be put in place.
     - Cash advance will need to be reconciled against findings.
   - **The MCO must pay the full One Time Retroactive Cash Advance payment for the total amount of claims in dispute to date (minus duplicate claims).**

Examples of Cash Advances

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Cash Advance Case Scenario #1 - Single Service Provider Example

- Single Service Provider
  - This is a large provider whose only Medicaid Managed Care reimbursable mental health service is ACT
- MCO
  - This a Medicaid Managed Care Plan who has contracted with a vendor to administer the Behavioral Health benefit.
  - This MCO has inappropriately denied medically necessary ACT claims due to several issues, including system configuration.
  - It will take MCO/vendor a year to fix identified issues related to inappropriately denied claims.

Cash Advance Case Scenario #1 - Single Service Provider Example

One Time Retrospective Cash Advance

- Example: ACT service is the only behavioral health Medicaid service under contract with the MCO/vendor
  - ACT provider bills MCO $50,000 for ACT services per month.
  - Over the last 3 years, 50% of all ACT claims were inappropriately denied resulting in a loss of $25,000/month.
- If MCO and provider fail to agree on the **total amount** of inappropriately denied claims, MCO will make a One Time Retrospective Cash Advance for all denied claims from 12/1/2017 to present.
  - **In this scenario, the One Time Retrospective Cash Advance from the MCO to the ACT provider is $*325,000*, equal to 13 months worth of denials valued at $25,000 per month (the monthly amount of denied claims).**

Monthly Prospective Cash Advance

- The MCO anticipates it will take 12 months to fix the systemic issues causing inappropriate denials.
  - The MCO must make a **Monthly Prospective Cash Advance *of $25,000*** for the next 12 months or until the system issues are solved.

Reminder: The MCO and provider must still resolve any inappropriately denied claims going back the full three years plus any interest owed to the provider for failure to comply with prompt pay laws. MCO and provider must reconcile all claims.

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Cash Advance Scenario #2 - Multiple Service Provider

- Example: Large hospital system with multiple behavioral health services including CPEP, BH HCBS, Clinic and PROS. High percentage of MCO denials for all services except clinic.
- Every month Many Services Provider bills the following:
  - $20,000 for PROS since October 2015
  - $5000 for BH HCBS since January 2016
  - $100,000 for CPEP since October 2015
  - Total = $125,000
- Over the last 3 years, 50% of all PROS, 50% of all BH HCBS and 90% of all CPEP claims were inappropriately denied every month resulting in a $102,500/month deficit to the provider.
  - PROS = $20,000/.5 =$10,000/month
  - CPEP = $100,000/.9 = $90,000/month
  - BH HCBS = $5,000/.5 = $2,500/month
  - Total Deficit per month = $102,500/month

Cash Advance Scenario #2 - Multiple Service Provider

One Time Retrospective Cash Advance

- If MCO and provider fail to agree on the **total amount** of inappropriately denied claims, MCO will make a One Time Retrospective Cash Advance for all denied claims (minus duplicates) for all services affected by high denials identified in the root cause analysis from 12/1/2017 to present.
  - **In this scenario, the One Time Retrospective Cash Advance from the MCO to the multi-service provider is $*1,332,500* equal to 13 months worth of denials valued at $102,500 per month (the monthly amount of denied claims).**

Monthly Prospective Cash Advance

- The MCO anticipates it will take 12 months to fix the systemic issues causing inappropriate denials.
  - **The MCO must make a Monthly Prospective Cash Advance of $102,500 for the next 12 months or until the system issues are solved.**

Reminder: The MCO and provider must still resolve any inappropriately denied claims going back the full three years plus any interest owed to the provider for failure to comply with prompt pay laws. MCO and provider must reconcile all claims.

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Best Practices for Successful Billing and Payment

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Top Reasons for Claim Denials Within Provider Control

1. Timely filing
   - Providers need to be aware of their timely filing timeframes in their provider/plan contract
   - Providers should not hold onto claims for long periods of time before submitting to ensure they do not go over timely filing timeframes, and account for any needed corrected claim activities, including resubmission
2. Prior Authorization required
   - To avoid denials due to no prior authorization, providers should follow NYS prior authorization guidelines and MCO provider billing manual (NYS OMH Ambulatory Services Prior Authorization Guidelines)
   - Contact provider services when unsure if a service requires prior authorization (MCTAC Plan Matrix)
   - Ensure claim submissions include appropriate prior authorization numbers as needed
3. Incorrect Rate/ Procedure code combinations
   - MMCOs should pay based on OMH/OASAS posted rate codes and procedures – (NYS HARP and Mainstream Billing and Coding Manual)

Top Reasons for Claim Denials Within Provider Control (Continued)

4. Duplicate Claims
   - Reconcile your records using EHR to ensure that claims already submitted are not resubmitted unless a correction is required
   - Ensure Bill Type Field is accurate if a claim needs to be resubmitted
5. Bill Field Incomplete or Invalid
   - Be sure to fill in accurate code in Bill Type Field per CMS guidelines https://ctacny.org/sites/default/files/Codes.pdf
6. Disallow-not allowed under contract
   - Make sure that all locations/services/programs are reflected in your contract
   - When not under contract, sign single case agreement in order to get paid
7. No provider notification to MCO so no authorization entered into MCO billing system for first 3 HCBS Visits

Prompt Pay Law

- Per Prompt Pay Law (DFS Prompt Pay Guidelines), MCOs must adjudicate clean claims within 30 days for electronic submission and 45 days for paper submission.

- Complaint filing procedures can be located at the following link: https://www.dfs.ny.gov/consumer/fileacomplaint.htm

Reconciliation Reminder

- One Time Retrospective Cash Advances will be reconciled as inappropriate claims denial reasons are discovered and rectified.
  - This may include issues related to system configuration, duplicate claims, provider claiming errors, or other issues.
- Monthly Prospective Cash Advances must also be reconciled as denial reasons are discovered and reconciled.
- Providers must understand impact of future reconciliation process.
  - Providers should be certain that it only expends funds that were paid for services rendered and that were authorized (if required) on the date of service.
- **Providers should retain a portion of the cash advance in the event it is determined during the reconciliation process that you were overpaid.**

Additional Information on Managed Care Billing is available Online

- On the OMH website: http://www.omh.ny.gov/omhweb/bho/billing-services.html
- On the CTACNY/MCTAC website: http://www.ctacny.org/
- The MCTAC Billing tool - an interactive UB-04 form that walks through the components required to submit a clean claim. http://billing.ctacny.org/
- The managed care revenue code list and guidance: http://ctacny.org/sites/default/files/trainings-pdf/revenu-codes-updated-12-21-15_0.pdf
- The managed care plan matrix includes plan billing information – contacts, billing manuals, etc. http://matrix.ctacny.org/

Table 1: MCOs in Receipt of Root Cause Analysis Letter for State Plan Services				
MCO	ACT	CPEP	Partial Hospitalization	PROS
Affinity	NYC/ROS	NYC/ROS	NYC/ROS	NYC
AmidaCare		NYC	NYC	NYC
Emblem	NYC		NYC/ROS	NYC/ROS
Fidelis		NYC/ROS	NYC	
Health Plus	ROS	NYC	NYC	
IHA			ROS	
MetroPlus		NYC	NYC	
Molina		ROS		ROS
MVP		ROS	ROS	ROS
United		NYC/ROS		
VNS	NYC		NYC	
WellCare	NYC	NYC/ROS	NYC/ROS	NYC/ROS
YourCare			ROS	ROS

Table 2: MCOs in Receipt of Root Cause Analysis Letter for Adult BH HCBS, by Service Type

MCOs	CPST	FST	Education Support Services	Habilitation (RSS)	ISE	Intensive Crisis Respite	OSE	Peer Support Services	Pre – Vocational Services	Provider Travel Sup.	PSR	Short-term Crisis Respite	Trans. Employ-ment
Affinity	NYC/ROS		NYC/ROS					NYC/ROS		NYC/ROS	NYC/ROS	NYC/ROS	
AmidaCare	NYC		NYC	NYC				NYC		NYC	NYC	NYC	
Emblem	NYC/ROS		NYC/ROS	ROS	ROS			NYC/ROS	NYC/ROS		NYC/ROS	NYC	
Excellus					ROS				ROS				
Fidelis	NYC/ROS	ROS		NYC/ROS	NYC	ROS		ROS	NYC	NYC/ROS	NYC/ROS	NYC/ROS	
HealthFirst				NYC/ROS	NYC				ROS	NYC/ROS	NYC		
HealthPlus	NYC	NYC			NYC		NYC	NYC	NYC	NYC	NYC	NYC	
IHA	ROS						ROS	ROS	ROS	ROS	ROS		
MetroPlus	NYC		NYC	NYC	NYC			NYC	NYC	NYC	NYC	NYC	NYC
Molina			ROS	ROS	ROS			ROS	ROS		ROS		
MVP	ROS	ROS	ROS	ROS	ROS		ROS	ROS	ROS	ROS	ROS	ROS	
United				ROS					NYC	ROS		ROS	
VNS	NYC		NYC		NYC			NYC	NYC				
YourCare	ROS	ROS	ROS	ROS	ROS		ROS	ROS	ROS		ROS		ROS