STATE OF NEW YORK : DEPARTMENT OF HEALTH

IN THE MATTER

OF

MARY T. BASSETT, M.D., M.P.H., as Commissioner of Health of the State of New York, to determine the action to be taken with respect to:

MVP HEALTH PLAN, INC.
625 State Street
Schenectady, New York 12305

Respondent,

arising out of alleged violations of Article 44 of the Public Health Law of the State of New York, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, and Chapter 57 of the Laws of 2017, Part P, 48-a

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STIPULATION

AND

ORDER

MC-22-001

WHEREAS, the New York State Department of Health (the "Department") has conducted surveys of MVP Health Plan, Inc. (the "Respondent") and has found alleged violations of Article 44 of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR), and Chapter 57 of the Laws of 2017, Part P, 48-a; and

WHEREAS, Statements of Deficiencies based on surveys of the operations of the Respondent have been issued to the Respondent as follows: on May 23, 2019, for the survey conducted December 1, 2017, through May 31, 2018; and on August 30, 2021, for the survey conducted August 12, 2020, through January 15, 2021; and

WHEREAS, each of the aforesaid Statements of Deficiencies sets forth alleged violations by the Respondent of Article 44 of the Public Health Law, Title 10 (Health) of

the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR), and Chapter 57 of the Laws of 2017, Part P, 48-a; and

WHEREAS, prior to commencement of administrative enforcement action based upon the alleged violations by service of a Notice of Hearing and Statement of Charges, the Department and the Respondent engaged in settlement discussions; and

WHEREAS, the parties wish to resolve this matter by means of a settlement instead of an adversarial administrative hearing.

NOW, THEREFORE, IT IS STIPULATED AND AGREED AS FOLLOWS:

1. The violations of Article 44 of the Public Health Law, 10 NYCRR Part 98-1.11, and Chapter 57 of the Laws of 2017, Part P, 48-a.1 alleged in the Statements of Deficiencies issued on May 23, 2019, and August 30, 2021, are settled and discontinued with prejudice upon the terms and conditions set forth in this Stipulation and Order.

2. The Respondent, for the purpose of resolving this administrative matter only, admits to having its claims payment system configured to use provider contracted rates as opposed to rates established by the government that required retrospective updates in violation of 10 NYCRR Part 98-1.11, Public Health Law Article 44, and Chapter 57 of the Laws of 2017, Part P, 48-a.1 in connection with the Statements of Deficiencies specified in paragraph 1 herein, attached hereto and made a part hereof as attachments "A" and "B", respectively.

3. Pursuant to Public Health Law §§ 12(1)(a) and 206, the Respondent is assessed a civil penalty of $1,080,000.00 Dollars and shall pay the entire amount of that

sum within thirty (30) days of the effective date of this Stipulation and Order.

4. Payment shall be sent by certified mail and shall be made payable to the New York State Department of Health, Bureau of Accounts Management, Corning Tower, Room 2748, Empire State Plaza, Albany, New York 12237-0016.

5. Any civil penalty not paid in accordance with this Stipulation and Order shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection and non-renewal of permits or licenses [Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32].

6. It is further stipulated and agreed by the Respondent and the Department that there exist valid and sufficient grounds as a matter of fact and law for the issuance of this Stipulation and Order under the Public Health Law and the Respondent consents to its issuance, accepts its terms and conditions and waives any right to challenge or review this Stipulation and Order through administrative or judicial proceedings, including a proceeding pursuant to Article 78 of the Civil Practice Law and Rules.

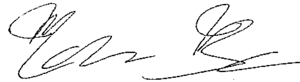
7. The foregoing admissions made by the Respondent in this Stipulation and Order are solely for the purpose of resolving the instant administrative matter and are not intended for use in any other forum, tribunal or court outside the Department, including any civil or criminal proceedings in which the issues or the burden of proof may differ. In addition, any such admissions are without prejudice to the Respondent's rights, defenses and claims in any other matter, proceeding, action, hearing or litigation

not involving the Department.

8. This Stipulation and Order shall be effective upon service on Respondent or Respondent's attorney or representative of a copy by personal service or by certified or registered mail.

DATED: Schenectady, New York
June 10, 2022

MVP Health Plan, Inc.

BY: 

Print Name: Monice Barbero

AGREED AND SO ORDERED:

DATED: Albany, New York
September 15, 2022

New York State Department of Health

BY: MARY T. BASSETT, M.D., M.P.H.
Commissioner of Health

Mail Stipulation and Order To:

Eric J. Mantey, Senior Attorney
Bureau of Administrative Hearings
Corning Tower, Room 2412
Empire State Plaza
Albany, New York, 12237-0016

Mail Payment To:

New York State Department of Health
Bureau of Accounts Management
Corning Tower, Room 2784
Empire State Plaza
Albany, New York 12237-0016

ATTACHMENT A

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:
MVP Health Plan, Inc.	Behavioral Health Claims Denial Root Cause Analysis
STREET ADDRESS, CITY, STATE, ZIP CODE 625 State Street Schenectady, NY 12305	**SURVEY DATES:** December 1, 2017-May 31, 2018 **Survey ID#** 590754451

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.	On December 19, 2018, MVP Health Plan, Inc. issued a Corrective Action Plan ("CAP") to Beacon Health Options, Inc. ("Beacon") to address the persistently high claim denials. MVP monitored Beacon's status of the required actions addressed in the CAP. As of April 12, 2019, all claims were reprocessed and the CAP is now closed. In addition to the CAP referenced above, MVP has taken the following steps to resolve the persistently high claim denials for behavioral health services identified in the DOH survey for December 1, 2017 – May 31, 2018: Commencing in September, 2018, MVP began requiring Beacon to develop and provide MVP with weekly reports detailing denial rates, denial volume and denial reasons for ACT, PROS, HCBS, Partial Hospitalization, and CPEP services. These reports also show results of quality reviews performed for each denial and any required actions for incorrect denials. In September, 2018 MVP also implemented a requirement for Beacon's leadership to meet with MVP staff on a weekly basis to discuss the reports, any findings and any action that is required.

	In January, 2019, MVP's implemented an additional requirement adding MVP's operations specialists to the weekly meetings with Beacon's leadership, to increase the rigor of the reviews. Beacon continues to provide the reports to MVP on a weekly basis. The meetings continued on a weekly basis until mid-July, 2019, when the parties determined that a bi-weekly call was sufficient. The cadence of the meetings will be monitored and increased if necessary. MVP also requires Beacon to provide MVP with monthly reports of claims quality results and claims turnaround time. MVP reviews this reporting to monitor performance and follows up with Beacon by in the weekly meetings. In January, 2019, MVP implemented a quarterly audit of claims processed by Beacon as well as Beacon's claim policies and procedures to ensure compliance with regulatory requirements and plan rules. This quarterly audit is conducted in addition to the annual audit that was already required by MVP. As part of this quarterly audit, a random sample of claims is selected for review of timeliness, accuracy and appropriate adherence to member notification requirements. The first quarter of 2019 audit files were received from Beacon on June 6, 2019. MVP's audit resulted in several findings. MVP forwarded these findings to Beacon on August 2, 2019 and is awaiting Beacon's response. Audit results and any requested corrective action are reported to MVP's Delegation Oversight Committee ("DOC") and Operations senior leadership. MVP also reviews Beacon's audited control report (SOC reporting) each year. Results of MVP's annual audit of Beacon are reported to MVP's DOC. MVP requires Beacon to develop a CAP (as referenced above) for any deficiency identified through these audits as well as for any significant issue highlighted during a monthly report. When

	MVP requires a CAP, MVP first reviews the CAP for adequacy and once the CAP is deemed adequate, the CAP is issued. MVP then monitors Beacon's progress under the CAP until the deficiency is fully remediated. **Responsible Party**: Rosemarie Hogan, Senior Leader, Claims, Configuration and Support Services. **Timeframe for Implementation:** Referenced above. **Date Certain**: MVP is conducting quarterly audits of claims processed by Beacon. MVP's first quarter of 2019 audit files were received from Beacon on June 6, 2019. MVP's audit resulted in several findings. MVP forwarded these findings to Beacon on August 2, 2019 and is awaiting Beacon's response. MVP's second quarter of 2019 claims data files were received from Beacon on July 19, 2019 and the audit is underway.

NEW YORK STATE DEPARTMENT OF HEALTH

ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONTINUATION SHEET

Name of Managed Care Organization MVP Health Plan, Inc.	**Survey Dates** December 1, 2017-May 31, 2018 **Survey ID #** 590754451
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.	MVP's management services agreement with Beacon will terminate on December 31, 2019. **Timeframe for Implementation**: MVP is terminating the Management Services Agreement with Beacon and bringing all management functions for behavioral health, including claims processing for dates of service January 1, 2020 and beyond and utilization management in house effective January 1, 2020. MVP and Beacon are negotiating an agreement for transition services. MVP has been working closely with Beacon and all affected claims for ACT, PROS, HCBS, Partial Hospitalization, and CPEP from 12/1/17-5/31/18 have been reprocessed. **Responsible Party**: Rosemarie Hogan, Senior Leader, Claims, Configuration and Support Services. **Date Certain**: April 12, 2019

Name of Managed Care Organization	Survey Dates December 1, 2017-May 31, 2018
MVP Health Plan, Inc.	Survey ID # 590754451

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).**	

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
MVP Health Plan, Inc.	Survey ID # 590754451

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;...	

NEW YORK STATE DEPARTMENT OF HEALTH

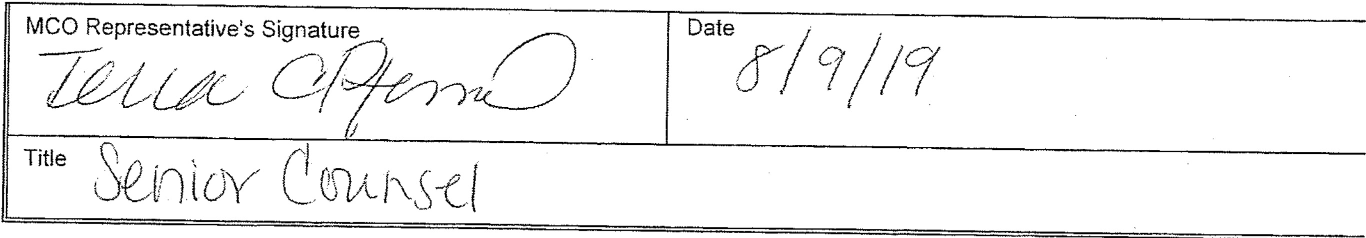
ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONTINUATION SHEET

Name of Managed Care Organization	Survey Dates December 1, 2017-May 31, 2018
MVP Health Plan, Inc.	Survey ID # 590754451

Deficiencies	Provider Plan of Correction with Timetable
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 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.	All MVP claims processed by Beacon and identified in the survey (December 1, 2017 – May 31, 2018) were processed on Beacon's FlexCare system, which was incorrectly configured for individual providers providing ACT, PROS, HCBS, Partial Hospitalization, and CPEP services. As of February 7, 2019, of the claims identified in the survey, there were 4,219 claims reprocessed and paid totaling $1,299,783. By April 12, 2019, all claims were appropriately reprocessed, as evidenced in the May 2019 cash advance report submitted to NYS on May 11, 2019. There were four providers eligible for a cash advance for claims which were not appropriately reprocessed by the deadline imposed by DOH. The four providers' claims totaled $1,754. In lieu of accepting the cash advance, each of the four providers met with Beacon individually to review the list of denials, submission requirements, and reasons for the denials. Each of the claims eligible for a cash advance were reprocessed and paid or appropriately denied. As of October 1, 2018, MVP claims processed by Beacon for dates of service on or after October 1, 2018 are processed on Beacon's Connects platform. To date, there have not been any consistent configuration issues causing claims denials as was the experience with FlexCare.

	Certain MVP claims for dates of service prior to October 1, 2018 continue to be processed on Beacon's FlexCare platform. As described in more detail above, as of September, 2018, MVP monitors claims reports submitted by Beacon on a weekly basis and conducts claim audits on a quarterly basis to ensure that any issues related to the FlexCare platform are promptly identified and addressed. **Timeframe for Implementation:** As referenced above. **Responsible Party**: Rosemarie Hogan, Senior Leader, Claims, Configuration and Support Services. **Date Certain**: April 12, 2019



MCO Representative's Signature	Date 8/9/19
Title Senior Counsel	

Statement of Findings
MVP Health Plan, Inc.
Behavioral Health Root Cause Analysis
December 1, 2017 – May 31, 2018

10.21 Mental Health Services.
d) The Contractor shall reimburse any OMH licensed provider, including out of network providers, at Medicaid Fee for Services rates for 24 months form 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 the 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 12/1/27-5/31/18, 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 for provider profiles.

MVP Response

All MVP claims processed by Beacon and identified in the survey (December 1, 2017 – May 31, 2018) were processed on Beacon's FlexCare system, which was incorrectly configured for individual providers providing ACT, PROS, HCBS, Partial Hospitalization, and CPEP services.

As of February 7, 2019, of the claims identified in the survey, there were 4,219 claims reprocessed and paid totaling $1,299,783.

By April 12, 2019, all claims were appropriately reprocessed, as evidenced in the May 2019 cash advance report submitted to NYS on May 11, 2019.

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As of October 1, 2018, MVP claims processed by Beacon for dates of service on or after October 1, 2018 are processed on Beacon's Connects platform. To date, there have not been any consistent configuration issues causing claims denials as was the experience with FlexCare.

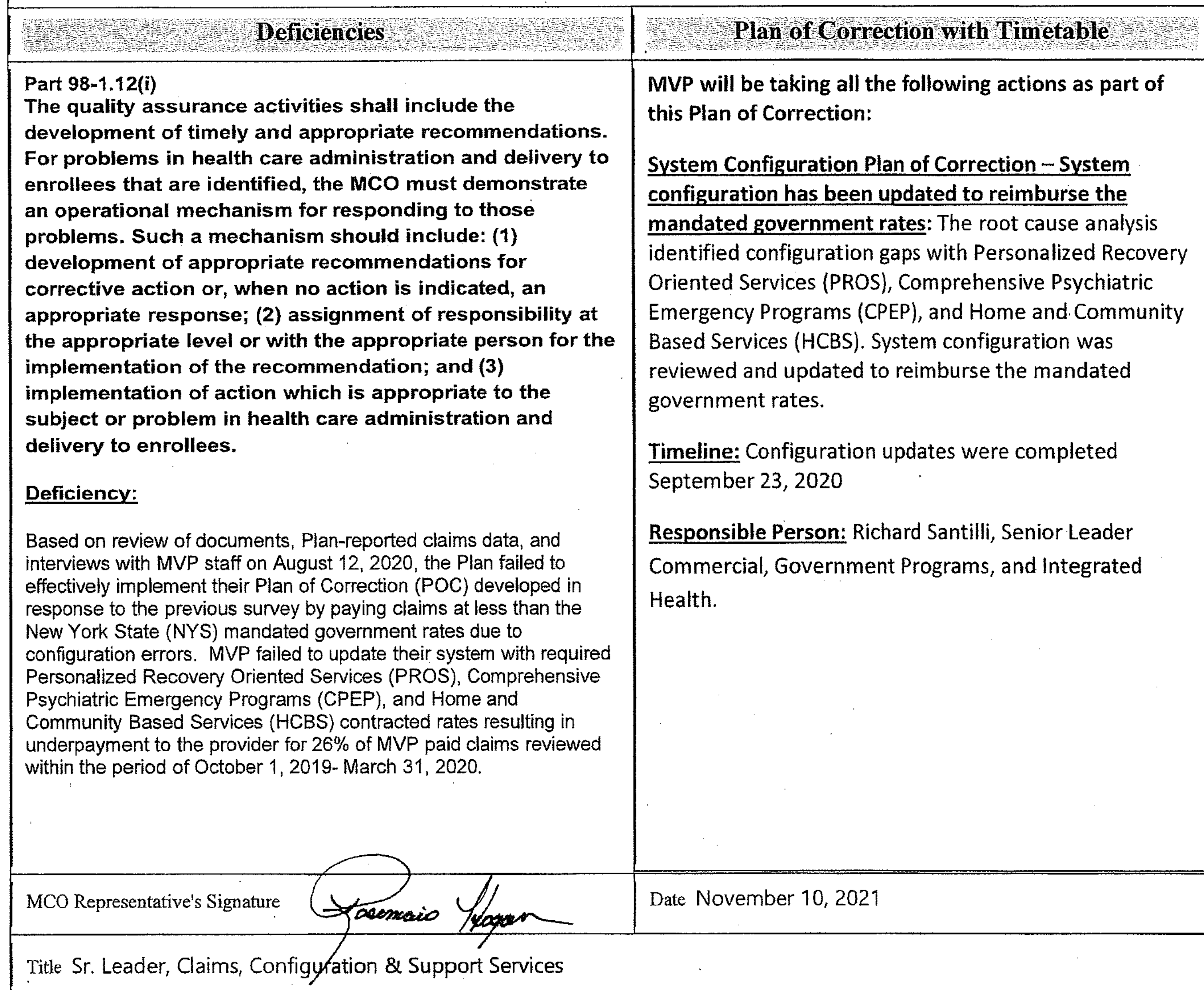
Certain MVP claims for dates of service prior to October 1, 2018 continue to be processed on Beacon's FlexCare platform. As described in more detail above, as of September, 2018, MVP monitors claims reports submitted by Beacon on a weekly basis and conducts claim audits on a quarterly basis to ensure that any issues related to the FlexCare platform are promptly identified and addressed.

ATTACHMENT B

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:
MVP Health Plan, Inc.	Behavioral Health Claims Denial Root Cause Analysis Target Survey
STREET ADDRESS, CITY, STATE, ZIP CODE 625 State Street Schenectady, NY 12305	**SURVEY DATES:** August 12, 2020 – January 15, 2021 Survey ID #: 1594144341

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
Part 98-1.12(i) **The quality assurance activities shall include the development of timely and appropriate recommendations. For problems in health care administration and delivery to enrollees that are identified, the MCO must demonstrate an operational mechanism for responding to those problems. Such a mechanism should include: (1) development of appropriate recommendations for corrective action or, when no action is indicated, an appropriate response; (2) assignment of responsibility at the appropriate level or with the appropriate person for the implementation of the recommendation; and (3) implementation of action which is appropriate to the subject or problem in health care administration and delivery to enrollees.** **Deficiency:** Based on review of documents, Plan-reported claims data, and interviews with MVP staff on August 12, 2020, the Plan failed to effectively implement their Plan of Correction (POC) developed in response to the previous survey by paying claims at less than the New York State (NYS) mandated government rates due to configuration errors. MVP failed to update their system with required Personalized Recovery Oriented Services (PROS), Comprehensive Psychiatric Emergency Programs (CPEP), and Home and Community Based Services (HCBS) contracted rates resulting in underpayment to the provider for 26% of MVP paid claims reviewed within the period of October 1, 2019- March 31, 2020.	**MVP will be taking all the following actions as part of this Plan of Correction:** **System Configuration Plan of Correction – System configuration has been updated to reimburse the mandated government rates:** The root cause analysis identified configuration gaps with Personalized Recovery Oriented Services (PROS), Comprehensive Psychiatric Emergency Programs (CPEP), and Home and Community Based Services (HCBS). System configuration was reviewed and updated to reimburse the mandated government rates. **Timeline:** Configuration updates were completed September 23, 2020 **Responsible Person:** Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health.
MCO Representative's Signature [signature]	Date November 10, 2021
Title Sr. Leader, Claims, Configuration & Support Services	

Classified as Confidential

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

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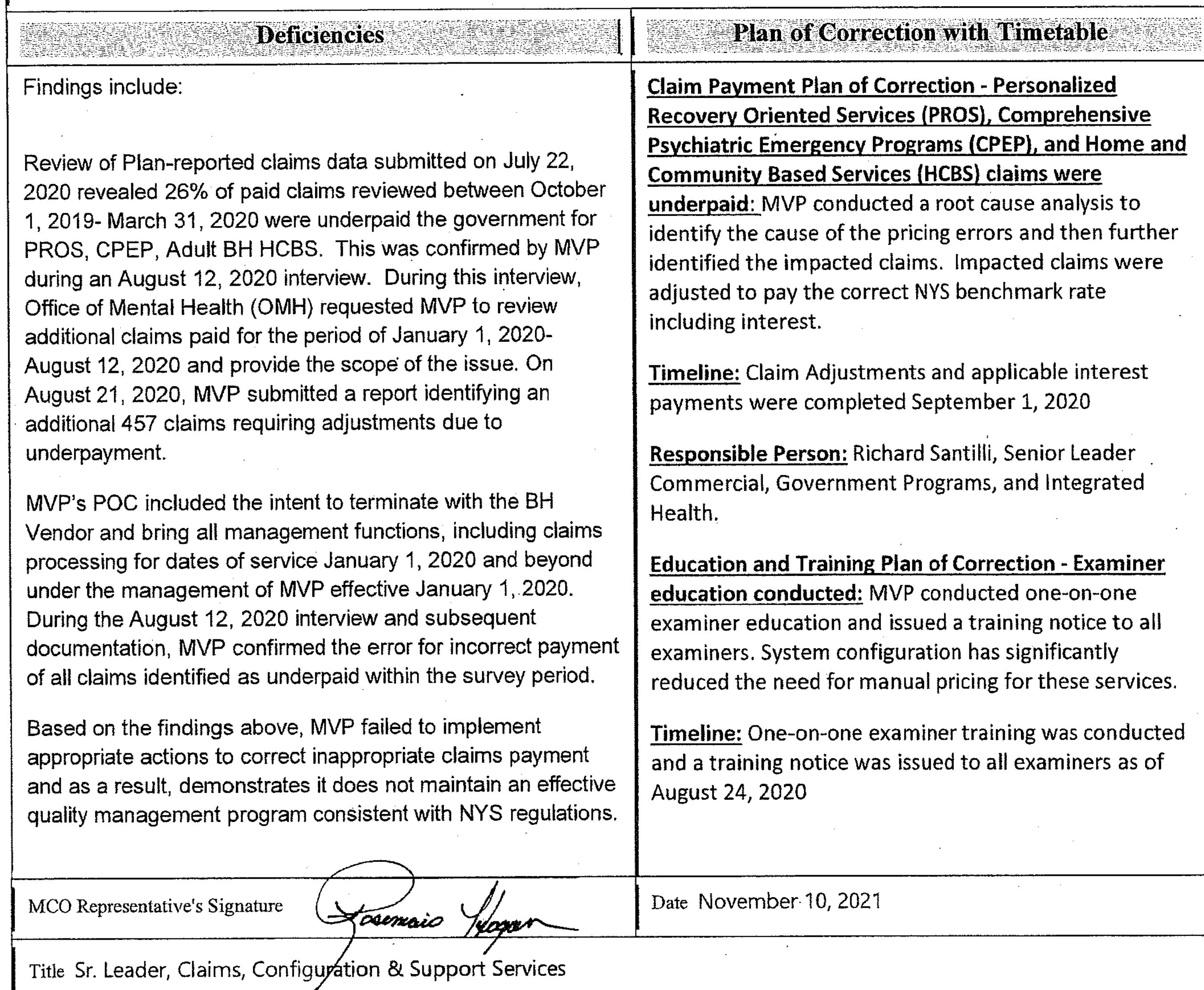

Deficiencies	Plan of Correction with Timetable
Findings include: Review of Plan-reported claims data submitted on July 22, 2020 revealed 26% of paid claims reviewed between October 1, 2019- March 31, 2020 were underpaid the government for PROS, CPEP, Adult BH HCBS. This was confirmed by MVP during an August 12, 2020 interview. During this interview, Office of Mental Health (OMH) requested MVP to review additional claims paid for the period of January 1, 2020- August 12, 2020 and provide the scope of the issue. On August 21, 2020, MVP submitted a report identifying an additional 457 claims requiring adjustments due to underpayment. MVP's POC included the intent to terminate with the BH Vendor and bring all management functions, including claims processing for dates of service January 1, 2020 and beyond under the management of MVP effective January 1, 2020. During the August 12, 2020 interview and subsequent documentation, MVP confirmed the error for incorrect payment of all claims identified as underpaid within the survey period. Based on the findings above, MVP failed to implement appropriate actions to correct inappropriate claims payment and as a result, demonstrates it does not maintain an effective quality management program consistent with NYS regulations.	**Claim Payment Plan of Correction - Personalized Recovery Oriented Services (PROS), Comprehensive Psychiatric Emergency Programs (CPEP), and Home and Community Based Services (HCBS) claims were underpaid:** MVP conducted a root cause analysis to identify the cause of the pricing errors and then further identified the impacted claims. Impacted claims were adjusted to pay the correct NYS benchmark rate including interest. **Timeline:** Claim Adjustments and applicable interest payments were completed September 1, 2020 **Responsible Person:** Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health. **Education and Training Plan of Correction - Examiner education conducted:** MVP conducted one-on-one examiner education and issued a training notice to all examiners. System configuration has significantly reduced the need for manual pricing for these services. **Timeline:** One-on-one examiner training was conducted and a training notice was issued to all examiners as of August 24, 2020

MCO Representative's Signature [signature]	Date November 10, 2021
Title Sr. Leader, Claims, Configuration & Support Services	

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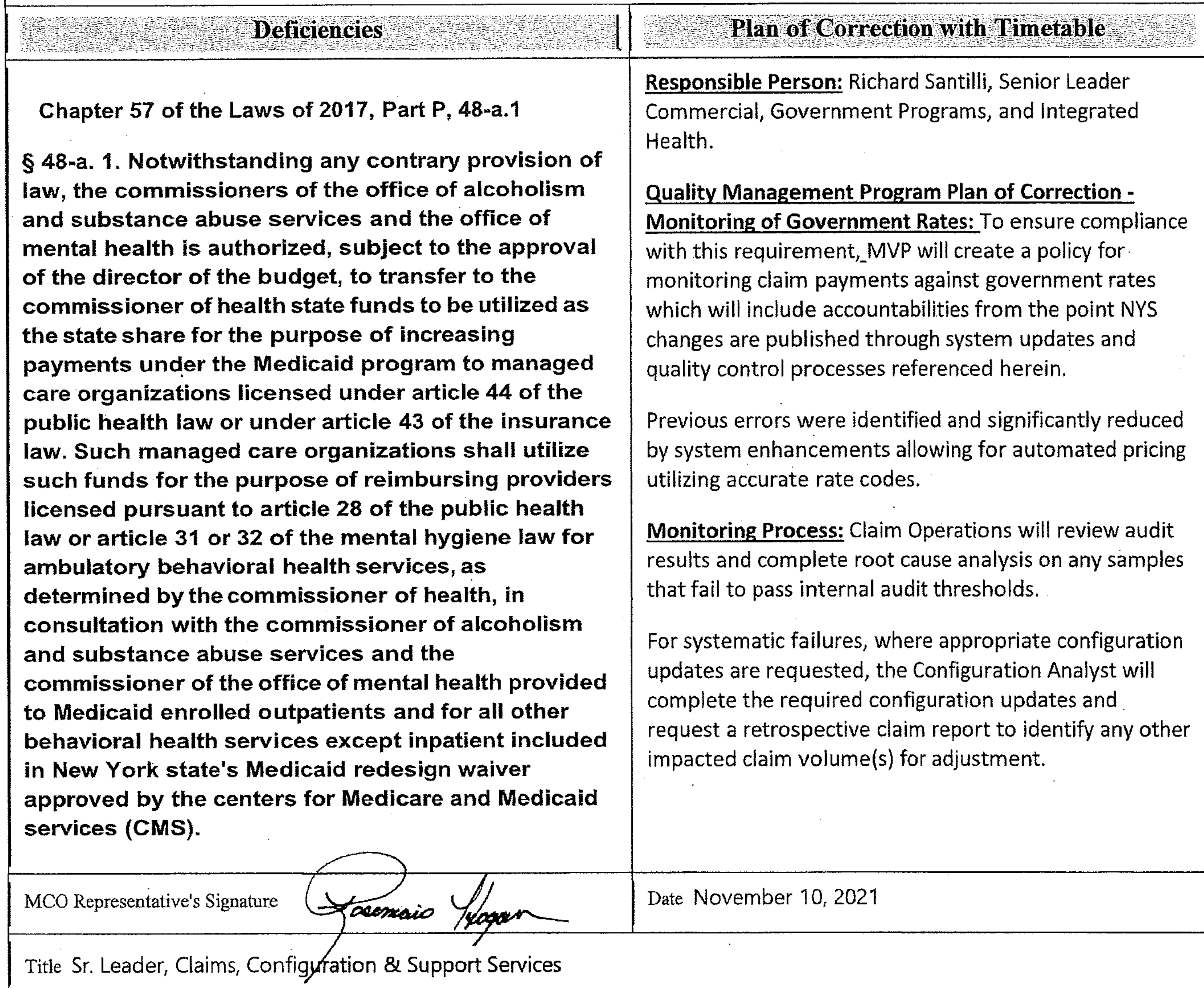

Deficiencies	Plan of Correction with Timetable
Chapter 57 of the Laws of 2017, Part P, 48-a.1 **§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health is authorized, subject to the approval of 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).**	<u>Responsible Person:</u> Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health. <u>Quality Management Program Plan of Correction - Monitoring of Government Rates:</u> To ensure compliance with this requirement, MVP will create a policy for monitoring claim payments against government rates which will include accountabilities from the point NYS changes are published through system updates and quality control processes referenced herein. Previous errors were identified and significantly reduced by system enhancements allowing for automated pricing utilizing accurate rate codes. <u>Monitoring Process:</u> Claim Operations will review audit results and complete root cause analysis on any samples that fail to pass internal audit thresholds. For systematic failures, where appropriate configuration updates are requested, the Configuration Analyst will complete the required configuration updates and request a retrospective claim report to identify any other impacted claim volume(s) for adjustment.
MCO Representative's Signature	Date November 10, 2021

Title Sr. Leader, Claims, Configuration & Support Services

Classified as Confidential

NEW YORK STATE DEPARTMENT OF HEALTH
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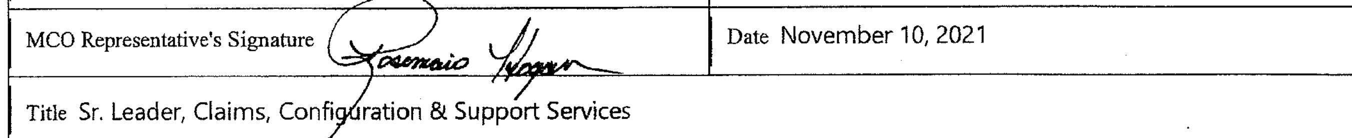
NOTE: The following list of deficiencies was identified by Health Department representatives during an Article 44 and/or Article 49 operational or focused survey of your Managed Care Organization (MCO). Correction of these deficiencies is required in order to bring your MCO into compliance with Article 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
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;...	For manual failures, appropriate examiner education will be performed to ensure a manual-process error is not repeated. A retrospective claim report will be generated by the Leader of Government Programs and Integrated Health to identify any other impacted claim volume(s) to be processed for adjustment. __Timeline:__ MVP has developed a policy effective 7/1/2021 and the quarterly monitoring of government rates is set to begin in the third quarter 2021, retrospective to August 12, 2020. __Responsible Person:__ Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health. __Compliance Oversight of Quality Management Program:__ Corporate Compliance will conduct a review of claims self-monitoring reports and conduct a corrective action validation audit beginning November 8, 2021. __Timeline:__ Audit will be completed by December 12, 2021 __Responsible Person:__ Sylvia Rowlands, Leader Compliance Audits/Mental Health Parity Compliance Officer



MCO Representative's Signature	Date November 10, 2021
Title Sr. Leader, Claims, Configuration & Support Services	

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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:
MVP Health Plan, Inc.	Behavioral Health Claims Denial Root Cause Analysis Target Survey
STREET ADDRESS, CITY, STATE, ZIP CODE 625 State Street Schenectady, NY 12305	**SURVEY DATES:** August 12, 2020 – January 15, 2021 Survey ID #: 1594144341

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
Deficiency: Based on interviews with MVP staff on August 12, 2020, review of documents, and Plan-reported claims data, the Plan failed to reimburse providers at Medicaid Fee for Service and/or Ambulatory Patient Group (APG) rates for 26% of ambulatory BH services (PROS, CPEP, HCBS) claims paid between October 1, 2019- March 31, 2020. **This is a repeat citation.** Review of Plan-reported claims data submitted on July 22, 2020, revealed 26% of paid claims for PROS, CPEP, Adult BH HCBS reviewed between October 1, 2019- March 31, 2020 were paid less than the government rate. This was confirmed by MVP during an August 12, 2020, interview when MVP reported the underpayment of claims was due to MVP systems not updated to pay providers at the required contracted rate. During this interview, OMH requested MVP to review additional claims paid for the period of January 1, 2020-August 12, 2020, and provide the scope of the issue. On August 21, 2020 MVP submitted a report identifying an additional 457 claims requiring adjustments due to underpayment.	

MCO Representative's Signature	Date November 10, 2021
Title Sr. Leader, Claims, Configuration & Support Services	

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Statement of Findings
MVP HealthPlan, Inc.
Behavioral Health Claims Denial Root Cause Analysis Target Survey
August 12, 2020 – January 15, 2021
Survey ID# 1594144341

35.1 Contractor and SDOH Compliance With Applicable Laws

Notwithstanding any inconsistent provisions in this Agreement, the Contractor and SDOH shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; the State Finance Law; the State Mental Hygiene Law; the State Insurance Law; Title XIX of the Social Security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 84, as amended; the Age Discrimination Act of 1975 and 45 CFR Part 91, as amended; the ADA; Title XIII of the Federal Public Health Services Act, 42 U.S.C § 300e et seq., regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; the Federal False Claims Act, 31 U.S.C. § 3729 et seq.; Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345);for Contractors operating in New York City, the New York City Health Code; and all other applicable legal and regulatory requirements in effect at the time that this Agreement is signed and as adopted or amended during the term of this Agreement. The parties agree that this Agreement shall be interpreted according to the laws of the State of New York.

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 interviews with MVP staff on August 12, 2020, review of documents, and Plan-reported claims data, the Plan failed to reimburse providers at Medicaid Fee for Service or Ambulatory Patient Group (APG) rates for 26% of ambulatory BH services (PROS, CPEP, HCBS) claims paid between October 1, 2019- March 31, 2020.

This is a repeat citation.

Review of Plan-reported claims data submitted on July 22, 2020 revealed 26% of paid claims for PROS, CPEP, Adult BH HCBS reviewed between October 1, 2019- March 31, 2020 were paid less than the government rate.

This was confirmed by MVP during an August 12, 2020 interview when MVP reported the underpayment of claims was due to MVP systems not updated to pay providers at the required contracted rate. During this interview, OMH requested MVP to review additional claims paid for the period of January 1, 2020- August 12, 2020 and provide the scope of the issue. On August 21, 2020 MVP submitted a report identifying an additional 457 claims requiring adjustments due to underpayment.

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Response:

1. **Claim Payment Plan of Correction - Personalized Recovery Oriented Services (PROS), Comprehensive Psychiatric Emergency Programs (CPEP), and Home and Community Based Services (HCBS) claims were underpaid:** MVP conducted a root cause analysis to identify the cause of the pricing errors and then further identified the impacted claims. Impacted claims were adjusted to pay the correct NYS benchmark rate including interest. MVP conducted one-on-one examiner education and issued a training notice to all examiners. System configuration has significantly reduced the need for manual pricing for these services.
   Timeline: Claim Adjustments and applicable interest payments were completed September 1, 2020, One-on-one examiner training was conducted and a training notice was issued to all examiners as of August 24, 2020

   Responsible Person: Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health.

2. **Quality Management Program Plan of Correction - Monitoring of Government Rates:** To ensure compliance with this requirement, MVP will create a policy for monitoring claim payments against government rates which will include accountabilities from the point NYS changes are published through system updates and quality control processes referenced herein. Previous errors were identified and significantly reduced by system enhancements allowing for automated pricing utilizing accurate rate codes.
   Monitoring Process: Claim Operations will review audit results and complete root cause analysis on any samples that fail to pass internal audit thresholds.

   For systematic failures, where appropriate configuration updates are requested, the Configuration Analyst will complete the required configuration updates and request a retrospective claim report to identify any other impacted claim volume(s) for adjustment.

   For manual failures, appropriate examiner education will be performed to ensure a manual-process error is not repeated. A retrospective claim report will be generated by the Leader of Government Programs and Integrated Health to identify any other impacted claim volume(s) to be processed for adjustment.

   Timeline: MVP has developed a policy effective 7/1/2021 and the quarterly monitoring of government rates is set to begin in the third quarter 2021, retrospective to August 12, 2020.

   Responsible Person: Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health.

3. **Compliance Oversight of Quality Management Program:** Corporate Compliance will conduct a review of claims self-monitoring reports and conduct a corrective action validation audit beginning November 8, 2021.
   Timeline: Audit will be completed by December 12, 2021

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Responsible Person: Sylvia Rowlands, Leader Compliance Audits/Mental Health Parity Compliance Officer

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