


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

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| <b>NAME OF MANAGED CARE ORGANIZATION</b><br><br>MVP Health Plan, Inc.                     | <b>TYPE OF SURVEY:</b><br><br>Behavioral Health Claims Denial Root Cause Analysis Target Survey |
| <b>STREET ADDRESS, CITY, STATE, ZIP CODE</b><br>625 State Street<br>Schenectady, NY 12305 | <b>SURVEY DATES:</b><br>August 12, 2020 – January 15, 2021<br><br>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   |
|---|---|
| <p><b>Part 98-1.12(i)</b><br/>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.</p> <p><b>Deficiency:</b></p> <p>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.</p> | <p><b>MVP will be taking all the following actions as part of this Plan of Correction:</b></p> <p><b><u>System Configuration Plan of Correction – System configuration has been updated to reimburse the mandated government rates:</u></b> 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.</p> <p><b><u>Timeline:</u></b> Configuration updates were completed September 23, 2020</p> <p><b><u>Responsible Person:</u></b> Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health.</p> |


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

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| Deficiencies   | Plan of Correction with Timetable  |
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| <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> | <p><b><u>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:</u></b> 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.</p> <p><b><u>Timeline:</u></b> Claim Adjustments and applicable interest payments were completed September 1, 2020</p> <p><b><u>Responsible Person:</u></b> Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health.</p> <p><b><u>Education and Training Plan of Correction - Examiner education conducted:</u></b> 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.</p> <p><b><u>Timeline:</u></b> One-on-one examiner training was conducted and a training notice was issued to all examiners as of August 24, 2020</p> |

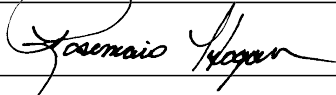
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| Deficiencies   | Plan of Correction with Timetable  |
|--|--|
| <p><b>Chapter 57 of the Laws of 2017, Part P, 48-a.1</b></p> <p><b>§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance 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).</b></p> | <p><b>Responsible Person:</b> Richard Santilli, Senior Leader Commercial, Government Programs, and Integrated Health.</p> <p><b>Quality Management Program Plan of Correction - Monitoring of Government Rates:</b> 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.</p> <p>Previous errors were identified and significantly reduced by system enhancements allowing for automated pricing utilizing accurate rate codes.</p> <p><b>Monitoring Process:</b> Claim Operations will review audit results and complete root cause analysis on any samples that fail to pass internal audit thresholds.</p> <p>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.</p> |

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MVP Health Plan, Inc.

**TYPE OF SURVEY:**

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**STREET ADDRESS, CITY, STATE, ZIP CODE**

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**Deficiencies**

**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;...**

**Plan of Correction with Timetable**

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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| Deficiencies | Plan of Correction with Timetable |
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**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.

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Title Sr. Leader, Claims, Configuration & Support Services

**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.

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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

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