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:**
Affinity Health Plan, Inc.	Behavioral Health Claims Denial Root Cause Analysis Target Survey
STREET ADDRESS, CITY, STATE, ZIP CODE 1776 Eastchester Road Bronx, NY 10461	**SURVEY DATES:** September 24, 2020 – January 19, 2021 SURVEY ID #: 1580500827

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 interviews with Affinity staff, review of documents, and Plan-reported claims data, the Plan failed to effectively implement their Plan of Correction (POC), developed in response to the Statement of Deficiency (SOD) and Statement of Findings (SOF) issued on May 23, 2019 for inappropriate claims denials due to configuration errors within the Behavioral Health (BH) Vendor's claims platform. Affinity's failure to implement appropriate actions to correct inappropriate claims denials demonstrates it does not maintain an effective quality management program consistent with New York State (NYS) regulations. CONTINUE TO NEXT PAGE	**Description of Correction** **The following actions shall address the Deficiency under Part 98-1.12(1) pertaining to the Plan's quality assurance activities. Specifically, inappropriate denying by Affinity's BH Vendor of ACT, Comprehensive Psychiatric Emergency Programs (CPEP), Home and Community Based Services (HCBS), Physical Health (PH), and PROS claims for No Rate Code.** **Affinity shall ensure that the Plan reimburses providers at the appropriate Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services. These additional actions will focus upon ensuring that the three situations identified by the auditors are being addressed on an ongoing basis.** **Education and Training** **Affinity's BH vendor has taken a number of actions, to educate and train its staff regarding the following requirements:**

MCO Representative's Signature	Date
Title	

Description

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: • Affinity's BH Vendor failed to pay the government rate during the survey lookback period from January 1, 2020 - June 30, 2020 for Assertive Community Treatment (ACT) (41 out of 621) and Personalized Recovery Oriented Services (PROS) claims (65 out 65). • Affinity's BH Vendor failed to pay the government rate by inappropriately denying 127 out of 208 (61%) of ACT, Comprehensive Psychiatric Emergency Programs (CPEP), Home and Community Based Services (HCBS), Physical Health (PH), and PROS claims for No Rate Code and Not allowed/Non-covered Provider as a result of provider profile set up issues. The above issues were further discussed and confirmed by Affinity during interviews held on September 24, 2020 and November 12, 2020. Affinity's original Plan of Correction identified actions to remediate inappropriate claims denials such as: • Sampling of weekly claims processed by the BH Vendor for review • Monthly review of claims denials and review of denial reasons to determine appropriateness of denials • Updating to 536 provider fee schedules to ensure that contracted providers had New York State (NYS) mandated rates correctly loaded CONTINUE TO NEXT PAGE	**1. The need to utilize the most current government rates on single case agreements (SCA) for out of network providers.** **2. The need to identify and reimburse providers eligible for the capitol rate add-on.** **3. The need to properly identify and configure provider rate codes.** **This training began following the September 24, 2020 audit and continues when new situations are identified. The plan shall provide the dates of such training.** **In addition, the Plan educated and trained those staff responsible for validating the behavioral health vendors actions (see below) to ensure they are aware of the appropriate NY State reimbursement policies as well the location of the current rates for purposes of validation. This training was completed October 22, 2021.** **<u>Monitoring and Auditing</u>** **Effective November 2020 the Plan's BH vendor took action to ensure that all SCAs for**
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH PLAN CONTRACTING AND OVERSIGHT
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Deficiencies	**Plan of Correction with Timetable**
• Enhancing systems testing to ensure timely updates when there are rate changes to Office of Mental Health (OMH) behavioral health services Such remediation actions by Affinity were ineffective due to the State identifying inappropriate claims denials and underpayment for claims reviewed between January 1, 2020-June 30, 2020.	**Medicaid diversionary services (ACT, PROS, etc.) are offered at the established government rates using the OMH website as the source of truth.** **In order to ensure that the vendor is properly paying such claims, the Plan shall select a quarterly sample of 25 SCAs and compare the rates listed against the OMH website listed rates. At least 95% (24 out of 25 SCAs) will need to have the correct rate. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.** **Effective November 2020 on a weekly basis the Plan's Behavioral Health vendor reviews all paid Diversionary claims, including PROS, to ensure it is reimbursing at the correct government rate. This includes the subset of providers that have Capital rate add-ons.**

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Deficiencies	**Plan of Correction with Timetable**
• Enhancing systems testing to ensure timely updates when there are rate changes to Office of Mental Health (OMH) behavioral health services Such remediation actions by Affinity were ineffective due to the State identifying inappropriate claims denials and underpayment for claims reviewed between January 1, 2020-June 30, 2020.	**If the vendor identifies claims not paying the correct rate it performs a root cause analysis, update its system, and adjusts claims as needed. The Plan shall ensure that the vendor reports such errors and is sharing the root cause analyses for Plan review.** **In addition, in order to ensure the vendor is properly paying such claims the Plan shall select a quarterly sample of 25 PROs claims for providers due the Capitol Rate add-on. At least 95% (24 out of 25 claims) will need to have the correct rate. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.** **Effective October 2020 the Plan's BH Health vendor identified 20 providers with setup issues requiring corrective action, which was rectified 12/31/20. In addition, the vendor has implemented the following proactive monitoring and reporting actions.**

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Deficiencies	**Plan of Correction with Timetable**
• Enhancing systems testing to ensure timely updates when there are rate changes to Office of Mental Health (OMH) behavioral health services Such remediation actions by Affinity were ineffective due to the State identifying inappropriate claims denials and underpayment for claims reviewed between January 1, 2020-June 30, 2020.	**Effective March 2021 the Plan's BH vendor provides the Plan with a monthly summary of all diversionary service processing, which includes the number of claims as denied for no rate. The Plan tracks those numbers for any unusual increase in those percentages, and follows up with the vendor as appropriate.** **Effective May 2021 the vendor provides a monthly rate summary demonstrating percentage of claims paid correctly, which includes the number of claims identified by the vendor with incorrect rates. The Plan tracks these numbers for any unusual increase in such denials and follows up with the vendor as appropriate.** **In order to ensure the vendor is properly denying claims for "No Rate" loaded, the Plan shall select a quarterly sample of 25 "No Rate" denials and review them to ensure that the rates should not have been loaded. At least 95% (24 out of 25 denials) will need to have been correctly denied. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets**
MCO Representative's Signature *Julie Emerson*	Date 11/15/2021
Title Molina Healthcare of New York, Inc. Compliance Officer	

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Deficiencies	Plan of Correction with Timetable
	the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency. **The Plan shall continue to perform its weekly audit of vendor denied claims to ensure that they are being properly processed.** **<u>Person Responsible</u>** **Scott Levine, Director of Vendor Management, shall be responsible for ensuring that the indicated monitoring is being performed.** **<u>Date Certain for Completion</u>** **As indicated above, the Plan's Behavioral Health Vendor has previously implemented corrective actions based upon the verbal feedback provided by the auditors during and following the audit. The Plan's enhanced monitoring began October 22, 2021 and shall be completed no later than December 31, 2021.**

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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).**	**Description of Correction** **The following actions shall address the Deficiency under Chapter 57 of the Laws of 2017, Part P, 48-a-1 pertaining to the failure to reimburse Part 98-1.12(1) pertaining to the Plan's failure to reimburse providers at Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services at Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services.** **Affinity shall ensure that the Plan reimburses providers at the appropriate Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services. These additional actions will focus upon ensuring that the three situations identified by the auditors are being addressed on an ongoing basis.** **Education and Training** **Affinity's BH vendor has taken a number of actions, to educate and train its staff regarding the following requirements:**
MCO Representative's Signature *Julie Emerson*	Date 11/15/2021
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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;... **Deficiency:** Based on interviews with Affinity staff, review of documents, and Plan-reported claims data, the Plan failed to reimburse providers at Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services due to a configuration error in their behavioral health vendor's FlexCare claims platform which led to the inappropriate set-up of provider profiles. **This is a repeat citation.**	**1. The need to utilize the most current government rates on single case agreements (SCA) for out of network providers.** **2. The need to identify and reimburse providers eligible for the capitol rate add-on.** **3. The need to properly identify and configure provider rate codes.** **This training began following the September 24, 2020 audit and continues when new situations are identified. The plan shall provide the dates of such training.** **In addition, the Plan educated and trained those staff responsible for validating the behavioral health vendors actions (see below) to ensure they are aware of the appropriate NY State reimbursement policies as well the location of the current rates for purposes of validation. This training was completed October 22, 2021.** **Monitoring and Auditing** **Effective November 2020 the Plan's BH vendor took action to ensure that all SCAs for**

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Deficiencies	**Plan of Correction with Timetable**
Specifically, the following issues were identified for claims reviewed during the survey lookback period from January 1, 2020 - June 30, 2020: • 41 out of 621 ACT claims were underpaid the government rate. This was a result of Affinity's BH Vendor's Single Case Agreement (SCA) department utilizing historical rates when processing the agreements. • 65 out of 65 PROS claims were underpaid the government rate due to the capital rate add-on not configured for the applicable provider. • 127 out of 208 of ACT, CPEP, HCBS, PH, and PROS claims were inappropriately denied for the reasons No Rate Code and Not allowed/Non-covered Provider. This was due to provider profile set up issues. A response provided by Affinity's BH Vendor outlined a process for correcting future inappropriate denials through the development of a workflow and reports to take effect in October 2020. Therefore, demonstrating remediation activities and actions were only taken after the State requested a review of claims denied for these reasons within the survey look back period. The above issues were further discussed and confirmed by Affinity during interviews held on September 24, 2020 and November 12, 2020. Based on the findings above, Affinity failed to effectively implement the plan of correction to ensure compliance with applicable NYS law regarding claims payment for behavioral health services.	**Medicaid diversionary services (ACT, PROS, etc.) are offered at the established government rates using the OMH website as the source of truth.** **In order to ensure that the vendor is properly paying such claims, the Plan shall select a quarterly sample of 25 SCAs and compare the rates listed against the OMH website listed rates. At least 95% (24 out of 25 SCAs) will need to have the correct rate. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.** **Effective November 2020 on a weekly basis the Plan's Behavioral Health vendor reviews all paid Diversionary claims, including PROS, to ensure it is reimbursing at the correct government rate. This includes the subset of providers that have Capital rate add-ons.**

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Deficiencies	Plan of Correction with Timetable
	If the vendor identifies claims not paying the correct rate it performs a root cause analysis, update its system, and adjusts claims as needed. The Plan shall ensure that the vendor reports such errors and is sharing the root cause analyses for Plan review. **In addition, in order to ensure the vendor is properly paying such claims the Plan shall select a quarterly sample of 25 PROs claims for providers due the Capitol Rate add-on. At least 95% (24 out of 25 claims) will need to have the correct rate. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.** **Effective October 2020 the Plan's BH Health vendor identified 20 providers with setup issues requiring corrective action, which was rectified 12/31/20. In addition, the vendor has implemented the following proactive monitoring and reporting actions.**
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Deficiencies	Plan of Correction with Timetable
	Effective March 2021 the Plan's BH vendor provides the Plan with a monthly summary of all diversionary service processing, which includes the number of claims as denied for no rate. The Plan tracks those numbers for any unusual increase in those percentages, and follows up with the vendor as appropriate. **Effective May 2021 the vendor provides a monthly rate summary demonstrating percentage of claims paid correctly, which includes the number of claims identified by the vendor with incorrect rates. The Plan tracks these numbers for any unusual increase in such denials and follows up with the vendor as appropriate.** **In order to ensure the vendor is properly denying claims for "No Rate" loaded, the Plan shall select a quarterly sample of 25 "No Rate" denials and review them to ensure that the rates should not have been loaded. At least 95% (24 out of 25 denials) will need to have been correctly denied. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets**
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Deficiencies	Plan of Correction with Timetable
	the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency. **The Plan shall continue to perform its weekly audit of vendor denied claims to ensure that they are being properly processed.** **<u>Person Responsible</u>** **Scott Levine, Director of Vendor Management, shall be responsible for ensuring that the indicated monitoring is being performed.** **<u>Date Certain for Completion</u>** **As indicated above, the Plan's Behavioral Health Vendor has previously implemented corrective actions based upon the verbal feedback provided by the auditors during and following the audit. The Plan's enhanced monitoring began October 22, 2021 and shall be completed no later than December 31, 2021.**

MCO Representative's Signature *Julie Emerson*	Date 11/15/2021

Title Molina Healthcare of New York, Inc. Compliance Officer

Affinity Health Plan, Inc.
Behavioral Health Claims Denial Root Cause Analysis Target Survey
September 24, 2020 – January 19, 2021
Survey ID# 1580500827

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 Affinity staff, review of documents, and Plan-reported claims data, the Plan failed to reimburse providers at Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services due to a configuration error in the behavioral health vendor's FlexCare claims platform which led to the inappropriate set-up of provider profiles.

This is a repeat citation.

Specifically, the following issues were identified for claims reviewed during the survey lookback period from January 1, 2020 - June 30, 2020:

- 41 out of 621 ACT claims were underpaid the government rate. This was a result of Affinity's BH Vendor's Single Case Agreement department utilizing historical rates when processing the agreements.
- 65 out of 65 PROS claims were underpaid the government rate due to the capital rate add-on not configured for the applicable provider.
- 127 out of 208 of ACT, CPEP, HCBS, PH, and PROS claims were inappropriately denied for the reasons No Rate Code and Not allowed/Non-covered Provider. This was due to provider profile set up issues. A response provided by Affinity's BH Vendor outlined a process for correcting future inappropriate denials through the development of a workflow and reports to take effect in October 2020. Therefore, demonstrating remediation activities and actions were only taken after

the State requested a review of claims denied for these reasons within the survey look back period.

The above issues were further discussed and confirmed by Affinity during interviews held on September 24, 2020 and November 12, 2020.

Based on the findings above, Affinity failed to effectively implement the plan of correction to ensure compliance with applicable NYS law regarding claims payment for behavioral health services.

Description of Correction

The following actions shall address the Finding under 35.1 Contractor and SDOH Copmpliance With Applicable Laws. Specifically, the Plan failed to reimburse providers at Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services.

Affinity shall ensure that the Plan reimburses providers at the appropriate Medicaid Fee for Service (FFS) or Ambulatory Patient Group (APG) rates for ambulatory behavioral health services. These additional actions will focus upon ensuring that the three situations identified by the auditors are being addressed on an ongoing basis.

Education and Training

Affinity's BH vendor has taken a number of actions, to educate and train its staff regarding the following requirements:

1. **The need to utilize the most current government rates on single case agreements (SCA) for out of network providers.**
2. **The need to identify and reimburse providers eligible for the capitol rate add-on.**
3. **The need to properly identify and configure provider rate codes.**

This training began following the September 24, 2020 audit and continues when new situations are identified. The plan shall provide the dates of such training.

In addition, the Plan educated and trained those staff responsible for validating the behavioral health vendors actions (see below) to ensure they are aware of the appropriate NY State reimbursement policies as well the location of the current rates for purposes of validation. This training was completed October 22, 2021.

Monitoring and Auditing

Effective November 2020 the Plan's BH vendor took action to ensure that all SCAs for Medicaid diversionary services (ACT, PROS, etc.) are offered at the established government rates using the OMH website as the source of truth.

In order to ensure that the vendor is properly paying such claims, the Plan shall select a quarterly sample of 25 SCAs and compare the rates listed against the OMH website listed rates. At least 95% (24 out of 25 SCAs) will need to have the correct rate. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.

Effective November 2020 on a weekly basis the Plan's Behavioral Health vendor reviews all paid Diversionary claims, including PROS, to ensure it is reimbursing at the correct government rate. This includes the subset of providers that have Capital rate add-ons.

If the vendor identifies claims not paying the correct rate it performs a root cause analysis, update its system, and adjusts claims as needed. The Plan shall ensure that the vendor reports such errors and is sharing the root cause analyses for Plan review.

In addition, in order to ensure the vendor is properly paying such claims the Plan shall select a quarterly sample of 25 PROs claims for providers due the Capitol Rate add-on. At least 95% (24 out of 25 claims) will need to have the correct rate. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.

Effective October 2020 the Plan's BH Health vendor identified 20 providers with setup issues requiring corrective action, which was rectified 12/31/20. In addition, the vendor has implemented the following proactive monitoring and reporting actions.

Effective March 2021 the Plan's BH vendor provides the Plan with a monthly summary of all diversionary service processing, which includes the number of claims as denied for no rate. The Plan tracks those numbers for any unusual increase in those percentages, and follows up with the vendor as appropriate.

Effective May 2021 the vendor provides a monthly rate summary demonstrating percentage of claims paid correctly, which includes the number of claims identified by the vendor with incorrect rates. The Plan tracks these numbers for any unusual increase in such denials and follows up with the vendor as appropriate.

In order to ensure the vendor is properly denying claims for "No Rate" loaded, the Plan shall select a quarterly sample of 25 "No Rate" denials and review them to ensure that the rates should not have been loaded. At least 95% (24 out of 25 denials) will need to have been correctly denied. If the vendor fails to achieve this level, the Plan shall increase the frequency of sampling to monthly until the vendor meets the required 95% level for at least two consecutive months, at which time the monitoring shall return to a quarterly frequency.

The Plan shall continue to perform its weekly audit of vendor denied claims to ensure that they are being properly processed.

<u>Person Responsible</u>
Scott Levine, Director of Vendor Management, shall be responsible for ensuring that the indicated monitoring is being performed.

<u>Date Certain for Completion</u>
As indicated above, the Plan's Behavioral Health Vendor has previously implemented corrective actions based upon the verbal feedback provided by the auditors during and following the audit. The Plan's enhanced monitoring began October 22, 2021 and shall be completed no later than December 31, 2021.