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 Health Insurance Plan of Greater New York, Inc. (EmblemHealth)	**TYPE OF SURVEY:** Behavioral Health Claims Denial Root Cause Analysis Target Survey
STREET ADDRESS, CITY, STATE, ZIP CODE 55 Water Street New York, NY 10041	**SURVEY DATES:** August 5, 2020 – March 8, 2021 Survey ID #: 1397868801

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
98-1.12 Quality management program **(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 Plan staff on August 5, 2020, review of documents, and Plan-reported claims data, EmblemHealth failed to effectively implement their Plan of Correction (POC) developed in response to the previous survey, to correct inappropriate claims denials due to human processor error. EmblemHealth'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.	**Corrective Actions for Citation 98-1.12 Quality Management Program:** **1. For corrective actions regarding findings pertaining to incorrect claim denials finding for citation 98-1.12 Quality Management Program:** **A. Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) Claims Monitoring:** Related to Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) claims denied due to administrative error, the Plan worked with Beacon in implementing a quality assurance program that began in September 2020 to review 100% of claim denials for appropriateness. A report is run daily for all diversionary services (which specifically includes PH, ACT, and PROS) to ensure accuracy of claims processing for denied claims. An analyst reviews 100% of those claims to ensure they were processed correctly, including the use of the correct denial reason. Any errors are corrected, and all processing staff involved are coached for each occurrence. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. As a part of Beacons Standard Operating Procedure (SOP), a monthly audit is conducted by their audit team which reviews 3% of all Emblem claims for accuracy, including ensuring that the appropriate denial reason was selected.
MCO Representative's Signature 	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	

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Deficiencies	Plan of Correction with Timetable
Findings included: Review of Plan-reported claims data workbook and narrative provided by EmblemHealth on July 29, 2020, inappropriate claims denials for no prior authorization were reported for the following services for 43 out of 318 total claims reviewed for Partial Hospital (PH), Comprehensive Psychiatric Emergency Program (CPEP), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS). During the August 5, 2020 interview with EmblemHealth and the Behavioral Health (BH) Vendor, the BH Vendor confirmed that claims were denied inappropriately due to human processer error. EmblemHealth's original POC stated denials related to human processor error were being corrected by requiring their BH Vendor to conduct training for their claims staff on January 22, 2019. The Plan was unable to provide documentation demonstrating training and attendance had taken place to address inappropriate claims denials due to processor error. The Plan failed to provide effective training which resulted in continued human processer error for payment of behavioral health claims. The Plan failed to implement the Plan of correction to resolve the identified noncompliance.	**(Corrective Actions for Citation 98-1.12 Quality Management Program continued)** **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. Comprehensive Psychiatric Emergency Program (CPEP) Claims Monitoring:** To ensure Beacon's Comprehensive Psychiatric Emergency Program (CPEP) training (noted below in Section 2.A for citation 98-1.12 Quality Management Program) effectively ensures no further CPEP claims errors, 100% of CPEP claims are monitored and reviewed for errors weekly. Similar to Section 1.A above, this process includes review of claims denied for no prior authorization or due to human processor or reporting errors. In addition, Beacon meets with the Plan monthly to audit claims. As a result of this monitoring process, 100% of CPEP claims flagged as denied inappropriately are corrected and reprocessed to pay. **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **2. For corrective actions regarding findings pertaining to human processor error for citation 98-1.12 Quality Management Program:** **A. CPEP Training:**

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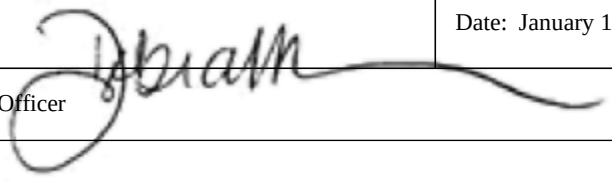
Deficiencies	Plan of Correction with Timetable
	(Corrective Actions for Citation 98-1.12 Quality Management Program continued) In addition to Beacon's 2019 CPEP training for Claims Processors, the Plan instructed Beacon to complete an updated and refreshed training for claim examiners on September 10, 2020. Since then, Beacon has memorialized this training on Beacon's learning management system, and it is available on-demand as issues are identified. Beacon claims processing staff are required to complete the training twice a year. Beacon claim processors were required and completed CPEP training during period August 1, 2021, through August 12, 2021. **Implementation Date:** October 1, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. ACT, PROS, PH Training:** In addition to the Beacon quality assurances described under Section 1 of the POC, Beacon is in the process of formalizing a training for ACT, PROS, and PH services that will mirror the structure, frequency and requirements established for CPEP described in Section 2.A above. Beacon is targeting roll out by end of Q4 2021. **Implementation Date:** March 31, 2022 **Responsible Party:** Shameka Grant, Director of Vendor Management
MCO Representative's Signature 	Date: January 12, 2022
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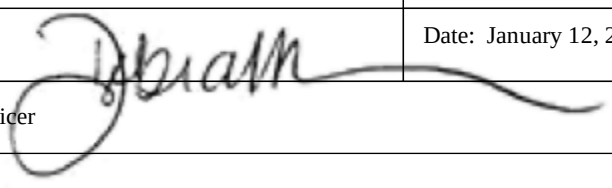
Deficiencies	Plan of Correction with Timetable
	(Corrective Actions for Citation 98-1.12 Quality Management Program continued) **3. For corrective actions regarding failure to conduct plan oversight and to maintain an effective quality management program for citation 98-1.12 Quality Management Program:** **A. Plan Oversight – Beacon Denied Claims Review:** The following Medicaid claims reports are received from Beacon monthly: • EHMD NYC and ROS Monthly Children's Behavioral Health Reporting • EHMD NYC and ROS Monthly Adults Behavioral Health Reporting All CPEP claims denied for no-prior authorization are sent directly back to Beacon for review and reprocessing. A selection of an additional 18 claims is then made from the above reports by the EmblemHealth Claims Oversight team for audit. The sample includes 10 random denied claims and 8 claims diversionary claims denied for no preauthorization. These samples are audited in detail by EmblemHealth and are part of the Plan's monthly WebEx claims review with Beacon. As a result of the State's survey and this POC the Plan made the following enhancements to the above oversight process to include: • Expansion of encounter data reports to include all data elements transmitted by Beacon for high level oversight of potential missing elements.
MCO Representative's Signature 	Date: January 12, 2022
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Deficiencies	Plan of Correction with Timetable
	(Corrective Actions for Citation 98-1.12 Quality Management Program continued) • Service specific targeted reviews on 8 diversionary services claims denied for no prior authorization, which will begin in October 2021. **Implementation Date:** Expansion of encounter data: January 29, 2021 / Targeted reviews for 8 diversionary services: November 10, 2021 **Responsible Party:** Linda Henderson, VP Claims Operations **B. Plan Enhancements to Quality Committees:** The EmblemHealth Behavioral Health Sub-Committees meet on a quarterly basis to review key utilization metrics, quality issues, HARP, and children's issues. Every quarter there is a presentation by the Behavioral Health delegates on their claims processing metrics including total number of claims received, total number of claims denied and the denial reasons. The Committees review the claims trends to identify if progress is being made in reducing the volume of claims denied. Minutes of the BH Sub-Committees are then reported to the EmblemHealth Quality Improvement Committee (QIC) and the QIC then presents these minutes to the Board of Directors of EmblemHealth. In addition on June 2, 2021, the EmblemHealth Claims Department, responsible for reviewing on a monthly basis the accuracy of claims determinations and reasons for denial, made a presentation to the Behavioral Health Quality and Advisory

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Deficiencies	Plan of Correction with Timetable
	(Corrective Actions for Citation 98-1.12 Quality Management Program continued) Committee an analysis of denial rate trends from October 2020 to March 2021, a description of EmblemHealth oversight and findings on Beacon processed claims and a corrective action summary. The Quality Committee of the Board is scheduled to meet on October 20th, 2021 and minutes of the BH Quality and Advisory Meeting shall be presented. **Implementation Date:** October 20, 2021 **Responsible Party:** Kelly McGuire, Medical Director Behavioral Health

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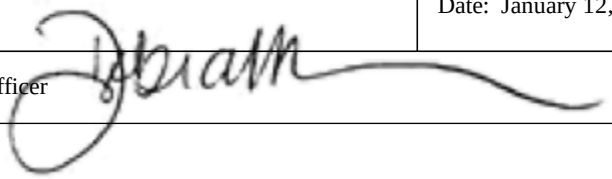
Deficiencies	Plan of Correction with Timetable
98-1.11 Operational and financial requirements for MCOs. **(h) The governing authority of the MCO shall be responsible for establishment and oversight of the MCO's policies, management and overall operation, regardless of the existence of any management contract.** **Deficiency:** Based on review of documents, Plan-reported claims data, and interviews with Plan staff on August 5, 2020, EmblemHealth failed to oversee the behavioral health vendors, to correct inappropriate claims denials due to human processor error and to pay claims for behavioral health services at required minimum rates as originally cited in the May 23, 2019 SOD and SOF. Because these issues have persisted since the submission of EmblemHealth's Plan of Correction, EmblemHealth continues to perform ineffective vendor oversight as required by NYS regulations. **This is a repeat citation.** Findings included: 1. Review of claims data workbook and narrative provided by EmblemHealth on July 29, 2020, incorrect claims denials for no prior authorization were reported for the following services based on for 43 out of 318 total claims reviewed for PH, CPEP (does not require prior authorization per NYS PHL 4902), ACT, and PROS.	**Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs.** **1. For corrective actions regarding incorrect denial finding noted in number 1 for citation 98-1.11:** **A. Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) Claims Monitoring:** Related to Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) claims denied due to administrative error, the Plan worked with Beacon in implementing a quality assurance program that began in September 2020 to review 100% of claim denials for appropriateness. A report is run daily for all diversionary services (which specifically includes PH, ACT, and PROS) to ensure accuracy of claims processing for denied claims. An analyst reviews 100% of those claims to ensure they were processed correctly, including the use of the correct denial reason. Any errors are corrected, and all processing staff involved are coached for each occurrence. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. As a part of Beacons Standard Operating Procedure (SOP), a monthly audit is conducted by their audit team which reviews 3% of all Emblem claims for accuracy, including ensuring that the appropriate denial reason was selected.

MCO Representative's Signature 	Date: January 12, 2022
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Deficiencies	**Plan of Correction with Timetable**
During the interview held on 8/5/2020, EmblemHealth and the BH Vendor confirmed that the BH Vendor denied a proportion of claims due to human processor error. 2. Review of the claims data workbook and narrative provided by EmblemHealth on October 14, 2020, revealed that the Plan failed to pay at the government rate during the October 1, 2019-January 31, 2020 survey lookback period, resulting in the underpayment of 20 out of 61 ACT claims paid during that time period. During a Quality Assurance interview between NYS and EmblemHealth on March 2, 2021, EmblemHealth confirmed that claims from the time period above were not paid at Medicaid Fee for Service rates, as required by NYS law. As a result of the findings above, the Plan failed to effectively oversee and monitor the BH vendor in the performance of operational and financial MCO requirements.	**(Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs continued.)** **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. Comprehensive Psychiatric Emergency Program (CPEP) Claims Monitoring:** To ensure Beacon's Comprehensive Psychiatric Emergency Program (CPEP) training (noted below in Section 2.A for citation 98-1.11 of this POC) effectively ensures no further CPEP claims errors, 100% of CPEP claims are monitored and reviewed for errors weekly. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. In addition, Beacon meets with the Plan monthly to audit claims. As a result of this monitoring process, 100% of CPEP claims flagged as denied inappropriately are corrected and reprocessed to pay. **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **C. Plan Oversight – Beacon Denied Claims Review:** The following Medicaid claims reports are received from Beacon monthly: • EHMD NYC and ROS Monthly Children's Behavioral Health Reporting
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Deficiencies	**Plan of Correction with Timetable**
	(Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs continued.) • EHMD NYC and ROS Monthly Adults Behavioral Health Reporting All CPEP claims denied for no-prior authorization are sent directly back to Beacon for review and reprocessing. A selection of an additional 18 claims is then made from the above reports by the EmblemHealth Claims Oversight team for audit. The sample includes 10 random denied claims and 8 claims diversionary claims denied for no preauthorization. These samples are audited in detail by EmblemHealth and are part of the Plan's monthly WebEx claims review with Beacon. As a result of the State's survey and this POC the Plan made the following enhancements to the above oversight process to include: • Expansion of encounter data reports to include all data elements transmitted by Beacon for high level oversight of potential missing elements. • Service specific targeted reviews on 8 diversionary services claims denied for no prior authorization, which will begin in October 2021. **Implementation Date:** Expansion of encounter data: January 29, 2021 / Targeted reviews for 8 diversionary services: November 10, 2021 **Responsible Party:** Linda Henderson, VP Claims Operations
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Deficiencies	Plan of Correction with Timetable
	(Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs continued.) **2. For corrective actions regarding human processor error noted in finding number 1 for citation 98-1.11:** **A. CPEP Training:** In addition to Beacon's 2019 CPEP training for Claims Processors, the Plan instructed Beacon to complete an updated and refreshed training for claim examiners on September 10, 2020. Since then, Beacon has memorialized this training on Beacon's learning management system, and it is available on-demand as issues are identified. Beacon claims processing staff are required to complete the training twice a year. Beacon claim processors were required and completed CPEP training during period August 1, 2021, through August 12, 2021. **Implementation Date:** October 1, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. ACT, PROS, PH Training:** In addition to the Beacon quality assurances described under Section 1.A for citation 98-1.11 of this POC, Beacon is in the process of formalizing a training for ACT, PROS, and PH services that will mirror the structure, frequency and requirements established for CPEP described in Section 2.A for citation 98-1.11 of this POC. Beacon is targeting roll out by end of Q4 2021.
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Deficiencies	**Plan of Correction with Timetable**
	(Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs continued.) **Implementation Date:** March 31, 2022 **Responsible Party:** Shameka Grant, Director of Vendor Management **3. For corrective actions regarding failure to pay claims at the government rate noted in finding number 2 for citation 98-1.11:** **A. Beacon Claims Rate Monitoring:** To address any rate errors in claims payment the Plan has worked with Beacon in revising its SOP to ensure Beacon reviews weekly paid claims for diversionary services prior to final processing to ensure the provider is receiving the correct payment. See supporting documentation regarding this Beacon SOP enclosed below. In addition to adjusting its current process to include monthly rate audits, Beacon also recently completed an internal audit, reviewing all providers on their claims system to ensure every Medicaid provider is loaded with current rates. **Implementation Date:** December 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. CMO Claims Rate Monitoring:** The Plan has also worked with CMO to remediate the cited
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Deficiencies	Plan of Correction with Timetable
	(Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs continued.) deficiency. CMO reviews the OMH website each month to determine if updates have been posted and, if so, updates the Claim Editor pricing tables according to the effective/termination dates of the new/old rate codes affected. To correct the identified claims issues from the 2020-2021Targeted Survey, in May 2021, CMO executed an auto-adjust process to identify and reprocess all underpaid BH claims. On June 28, 2021, CMO provided the rate sheets for Emblem documenting the updates. **Implementation Date:** March 16, 2021 **Responsible Party:** Gabriel Medley, VP Provider Network Management **4. For corrective actions regarding failure to conduct Plan oversight of BH vendor claims performance noted in finding number 2 for citation 98-1.11:** **A. Plan Oversight – Beacon and CMO Paid Claims Review:** EmblemHealth receives the following Medicaid reports from CMO and Beacon monthly: • EHMD NYC and ROS Monthly Children's Behavioral Health Reporting • EHMD NYC and ROS Monthly Adults Behavioral Health Reporting

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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
	(Corrective Action(s) for Citation 98-1.11 Operational and Financial Requirements for MCOs continued.) From these reports EmblemHealth's Claims Oversight team randomly selects five (5) paid claims from each delegate and conducts a pricing review (10 total). The amount paid on the claim is crosschecked with the Medicaid Reimbursement Rates posted on the OMH website: https://omh.ny.gov/omhweb/medicaid_reimbursement/. Identified pricing discrepancies are documented and sent to CMO and Beacon with a request for each delegate to review noted discrepancies. The monthly audit findings are discussed at the quarterly Administrative Oversight Committee meetings with CMO, and during a monthly WebEx with Beacon. Upon audit discovery, claims that are paid incorrectly are reviewed and reprocessed by CMO/Beacon on a claim by claim basis. EmblemHealth receives notice of the corrected claim number and corrected amount paid. When EmblemHealth identifies an incorrect rate payment claim, the Plan requires Beacon and CMO to perform a system sweep to identify and reprocess any other claims that may have paid the incorrect rate. To demonstrate correction, EmblemHealth requires Beacon and CMO to provide narratives summarizing how many claims were impacted and reprocessed as well as a description of the internal system corrections that were made to prevent future occurrences. **Implementation Date:** Beacon: November 1, 2020 CMO: December 1, 2020 **Responsible Party:** Linda Henderson, VP Claims Operations
MCO Representative's Signature	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	

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:**
Health Insurance Plan of Greater New York, Inc. (EmblemHealth)	Behavioral Health Claims Denial Root Cause Analysis Target Survey
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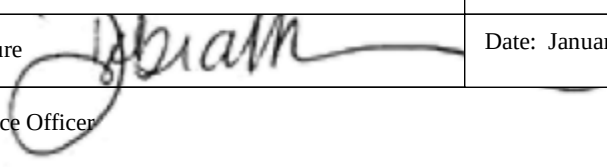
Deficiencies	**Plan of Correction with Timetable**
Chapter 57 of the Laws of 2017, Part P, 48-a.1 **§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health is authorized, subject to the approval 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).**	**Corrective Action(s) for Citation Chapter 57 of the Laws of 2017, Part P, 48-a.1.** **1. For corrective actions regarding incorrect denial finding noted in citation Chapter 57 of the Laws of 2017, Part P, 48-a.1:** **A. Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) Claims Monitoring:** Related to Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) claims denied due to administrative error, the Plan worked with Beacon in implementing a quality assurance program that began in September 2020 to review 100% of claim denials for appropriateness. A report is run daily for all diversionary services (which specifically includes PH, ACT, and PROS) to ensure accuracy of claims processing for denied claims. An analyst reviews 100% of those claims to ensure they were processed correctly, including the use of the correct denial reason. Any errors are corrected, and all processing staff involved are coached for each occurrence. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. As a part of Beacons Standard Operating Procedure (SOP), a monthly audit is conducted by their audit team which reviews 3% of all Emblem claims for accuracy, including ensuring that the appropriate denial reason was selected.
MCO Representative's Signature 	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH PLAN CONTRACTING AND OVERSIGHT
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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;…	**(Corrective Action(s) for Citation Chapter 57 of the Laws of 2017, Part P, 48-a.1. continued)** **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. Comprehensive Psychiatric Emergency Program (CPEP) Claims Monitoring:** To ensure Beacon's Comprehensive Psychiatric Emergency Program (CPEP) training (noted below in Section 2.A for citation Chapter 57 of the Laws of 2017, Part P, 48-a.1 of this POC) effectively ensures no further CPEP claims errors, 100% of CPEP claims are monitored and reviewed for errors weekly. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. In addition, Beacon meets with the Plan monthly to audit claims. As a result of this monitoring process, 100% of CPEP claims flagged as denied inappropriately are corrected and reprocessed to pay. **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **C. Plan Oversight – Beacon Denied Claims Review:** The following Medicaid claims reports are received from Beacon monthly:

MCO Representative's Signature	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	

NEW YORK STATE DEPARTMENT OF HEALTH
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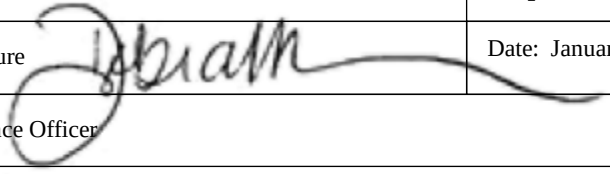
Deficiencies	**Plan of Correction with Timetable**
Deficiency: Based on interviews with Plan staff on August 5, 2020, review of documents, and Plan-reported claims data, EmblemHealth and the BH Vendors failed to pay government rates as a result of inappropriate claims denials and failure to properly configure the claims adjudication system during the October 1, 2019-January 31, 2020 survey lookback period. This issue persisted for additional claims reviewed through August 31, 2020. **This is a repeat citation.** Findings include: • Review of the claims data workbook and narrative provided by EmblemHealth and the BH Vendor Beacon on July 29, 2020, revealed incorrect claims denials for no prior authorization for the following services based on 318 claims reviewed. Specifically, 25% of Partial Hospital (PH) claims and 100% of Comprehensive Psychiatric Emergency Program (CPEP) claims were incorrectly denied due to processor error for no prior authorization. In addition, EmblemHealth also identified claims incorrectly denied for Assertive Community Treatment (ACT) and Personalized Recovery Oriented Services (PROS). On September 30, 2020, NYS Office of Mental Health (OMH) requested EmblemHealth to review additional claims denied for no prior authorization for the period of January 1, 2020-August 31, 2020 for ACT, PROS, PH, CPEP and Adult BH HCBS and provide the scope of the issue. CONTINUE ON NEXT PAGE	**(Corrective Action(s) for Citation Chapter 57 of the Laws of 2017, Part P, 48-a.1. continued)** • EHMD NYC and ROS Monthly Children's Behavioral Health Reporting • EHMD NYC and ROS Monthly Adults Behavioral Health Reporting All CPEP claims denied for no-prior authorization are sent directly back to Beacon for review and reprocessing. A selection of an additional 18 claims is then made from the above reports by the EmblemHealth Claims Oversight team for audit. The sample includes 10 random denied claims and 8 claims diversionary claims denied for no preauthorization. These samples are audited in detail by EmblemHealth and are part of the Plan's monthly WebEx claims review with Beacon. As a result of the State's survey and this POC the Plan made the following enhancements to the above oversight process to include: • Expansion of encounter data reports to include all data elements transmitted by Beacon for high level oversight of potential missing elements. • Service specific targeted reviews on 8 diversionary services claims denied for no prior authorization, which will begin in October 2021. **Implementation Date:** Expansion of encounter data: January 29, 2021 / Targeted reviews for 8 diversionary services: November 10, 2021 **Responsible Party:** Linda Henderson, VP Claims Operations
MCO Representative's Signature 	Date: January 12, 2022
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NEW YORK STATE DEPARTMENT OF HEALTH
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Deficiencies	**Plan of Correction with Timetable**
EmblemHealth and the BH Vendor identified an additional 5% of claims that were inappropriately denied during this expanded look back period. OMH review of EmblemHealth claims data, revealed additional claims in excess of 5% which were not paid due to a reporting error or incorrectly denied based on human processor error. • Review of the claims data workbook provided by EmblemHealth and the BH Vendor Montefiore Care Management Organization (CMO) on July 29, 2020 revealed, CMO failed to pay the government rate during the October 1, 2019-January 31, 2020 survey lookback period, resulting in the underpayment of 20 out of 61 ACT claims. On September 30, 2020, additional claims were requested within the period of January 1, 2020-August 31, 2020 to identify further underpaid claims. EmblemHealth and the BH Vendor reported an additional 89 claims were underpaid because rates were not loaded into the system as well as other configuration issues. Based on the findings above, EmblemHealth failed to oversee the BH vendors as well as effectively implement the plan of correction to ensure compliance with applicable NYS law regarding claims payment for behavioral health services.	**(Corrective Action(s) for Citation Chapter 57 of the Laws of 2017, Part P, 48-a.1. continued)** **2. For corrective actions regarding human processor error noted in citation Chapter 57 of the Laws of 2017, Part P, 48-a.1:** **A. CPEP Training:** In addition to Beacon's 2019 CPEP training for Claims Processors, the Plan instructed Beacon to complete an updated and refreshed training for claim examiners on September 10, 2020. Since then, Beacon has memorialized this training on Beacon's learning management system, and it is available on-demand as issues are identified. Beacon claims processing staff are required to complete the training twice a year. Beacon claim processors were required and completed CPEP training during period August 1, 2021, through August 12, 2021. **Implementation Date:** October 1, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. ACT, PROS, PH Training:** In addition to the Beacon quality assurances described under Section 1.A for citation Chapter 57 of the Laws of 2017, Part P, 48-a.1 of this POC, Beacon is in the process of formalizing a training for ACT, PROS, and PH services that will mirror the structure, frequency and requirements established for CPEP described in Section 2.A for citation 98-1.11 of this POC. Beacon is targeting roll out by end of Q4 2021.

MCO Representative's Signature 

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MCO Representative's Signature 	Date: January 12, 2022
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MCO Representative's Signature  Date: January 12, 2022

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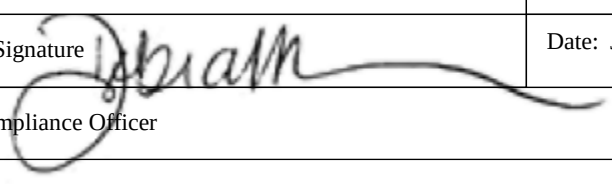
MCO Representative's Signature 	Date: January 12, 2022
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Deficiencies	**Plan of Correction with Timetable**
NYS PHL § 4902(1)(h) **Establishment of a requirement that emergency services rendered to an enrollee shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.** **Deficiency:** Based on interviews with Plan staff on August 5, 2020, review of documents, and Plan-reported claims data submitted on July 29, 2020, EmblemHealth failed to comply with New York State requirements for emergency services, including Comprehensive Psychiatric Emergency Program (CPEP) services, by allowing the BH Vendor to inappropriately deny CPEP claims for no prior authorization due to human processor error between the survey period of October 1, 2019-January 31, 2020. This requirement had been reiterated to the plan in a Memo entitled, *CPEP MMCP Guidance 04.16.18_* distributed on April 16, 2018.	**Corrective Action(s) for Citation NYS PHL § 4902(1)(h).** **1. For corrective actions regarding findings pertaining to denied CPEP claims for citation NYS PHL § 4902(1)(h):** **A. Comprehensive Psychiatric Emergency Program (CPEP) Claims Monitoring:** To ensure Beacon's Comprehensive Psychiatric Emergency Program (CPEP) training (noted below in Section 1.B for citation NYS PHL § 4902(1)(h)) effectively ensures no further CPEP claims errors, 100% of CPEP claims are monitored and reviewed for errors weekly. Similar to Section 1 above, this process includes review of claims denied for no prior authorization or due to human processor or reporting errors. In addition, Beacon meets with the Plan monthly to audit claims. As a result of this monitoring process, 100% of CPEP claims flagged as denied inappropriately are corrected and reprocessed to pay. **Implementation Date:** September 7, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **B. CPEP Training:** In addition to Beacon's 2019 CPEP training for Claims Processors, the Plan instructed Beacon to complete an updated and refreshed training for claim examiners on September 10, 2020. Since then, Beacon has memorialized this training on Beacon's learning management system, and it is available on-

MCO Representative's Signature  Date: January 12, 2022

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Deficiencies	**Plan of Correction with Timetable**
NYS PHL § 4902(1)(h) **Establishment of a requirement that emergency services rendered to an enrollee shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.** **Deficiency:** Based on interviews with Plan staff on August 5, 2020, review of documents, and Plan-reported claims data submitted on July 29, 2020, EmblemHealth failed to comply with New York State requirements for emergency services, including Comprehensive Psychiatric Emergency Program (CPEP) services, by allowing the BH Vendor to inappropriately deny CPEP claims for no prior authorization due to human processor error between the survey period of October 1, 2019-January 31, 2020. This requirement had been reiterated to the plan in a Memo entitled, *CPEP MMCP Guidance 04.16.18_* distributed on April 16, 2018.	**(Corrective Action(s) for Citation NYS PHL § 4902(1)(h). continued.)** demand as issues are identified. Beacon claims processing staff are required to complete the training twice a year. Beacon claim processors were required and completed CPEP training during period August 1, 2021, through August 12, 2021. **Implementation Date:** October 1, 2020 **Responsible Party:** Shameka Grant, Director of Vendor Management **C. Plan Oversight – Beacon Denied Claims Review:** The following Medicaid claims reports are received from Beacon monthly: • EHMD NYC and ROS Monthly Children's Behavioral Health Reporting • EHMD NYC and ROS Monthly Adults Behavioral Health Reporting All CPEP claims denied for no-prior authorization are sent directly back to Beacon for review and reprocessing. A selection of an additional 18 claims is then made from the above reports by the EmblemHealth Claims Oversight team for audit. The sample includes 10 random denied claims and 8 claims diversionary claims denied for no preauthorization. These samples are audited in detail by EmblemHealth and are part of the Plan's monthly WebEx claims review with Beacon.

MCO Representative's Signature

Date: January 12, 2022

Title: SVP & Chief Compliance Officer

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:**
Health Insurance Plan of Greater New York, Inc. (EmblemHealth)	Behavioral Health Claims Denial Root Cause Analysis Target Survey
STREET ADDRESS, CITY, STATE, ZIP CODE 55 Water Street New York, NY 10041	**SURVEY DATES:** August 5, 2020 – March 8, 2021 Survey ID #: 1397868801

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.

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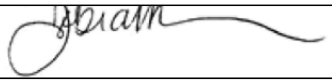
MCO Representative's Signature 	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	

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 Plan staff on August 5, 2020, review of documents, and Plan-reported claims data, EmblemHealth and the BH Vendors failed to pay government rates as a result of inappropriate claims denials and failure to properly configure the claims adjudication system during the October 1, 2019-January 31, 2020 survey lookback period. This issue persisted for additional claims reviewed through August 31, 2020.

This is a repeat citation.

Findings include:

- Review of the claims data workbook and narrative provided by EmblemHealth and the BH Vendor Beacon on July 29, 2020, revealed incorrect claims denials for no prior authorization for the following services based on 318 claims reviewed. Specifically, 25% of Partial Hospital (PH) claims and 100% of Comprehensive Psychiatric Emergency Program (CPEP) claims were incorrectly denied due to processor error for no prior authorization. In addition, EmblemHealth also identified claims incorrectly denied for Assertive Community Treatment (ACT) and Personalized Recovery Oriented Services (PROS).

  On September 30, 2020, NYS Office of Mental Health (OMH) requested EmblemHealth to review additional claims denied for no prior authorization for the period of January 1, 2020-August 31, 2020 for ACT, PROS, PH, CPEP and Adult BH HCBS and provide the scope of the issue. EmblemHealth and the BH Vendor identified an additional 5% of claims that were inappropriately denied during this expanded look back period. OMH review of EmblemHealth claims data, revealed

additional claims in excess of 5% which were not paid due to a reporting error or incorrectly denied based on human processor error.

- Review of the claims data workbook provided by EmblemHealth and the BH Vendor Montefiore Care Management Organization (CMO) on July 29, 2020 revealed, CMO failed to pay the government rate during the October 1, 2019-January 31, 2020 survey lookback period, resulting in the underpayment of 20 out of 61 ACT claims.

  On September 30, 2020, additional claims were requested within the period of January 1, 2020-August 31, 2020 to identify further underpaid claims. EmblemHealth and the BH Vendor reported an additional 89 claims were underpaid because rates were not loaded into the system as well as other configuration issues.

Based on the findings above, EmblemHealth failed to oversee the BH vendors as well as effectively implement the plan of correction to ensure compliance with applicable NYS law regarding claims payment for behavioral health services.

Plan Corrective Action(s) for Citations 35.1- Contractor and SDOH Compliance With Applicable Laws and 10.21 – Mental Health Services:

1. Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) Claims Monitoring:

Related to Partial Hospital (PH), Assertive Community Treatment (ACT), and Personalized Recovery Oriented Services (PROS) claims denied due to administrative error, the Plan worked with Beacon in implementing a quality assurance program that began in September 2020 to review 100% of claim denials for appropriateness.

A report is run daily for all diversionary services (which specifically includes PH, ACT, and PROS) to ensure accuracy of claims processing for denied claims. An analyst reviews 100% of those claims to ensure they were processed correctly, including the use of the correct denial reason.

Any errors are corrected, and all processing staff involved are coached for each occurrence. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. As a part of Beacons Standard Operating Procedure (SOP), a monthly audit is conducted by their audit team which reviews 3% of all Emblem claims for accuracy, including ensuring that the appropriate denial reason was selected.

Implementation Date: September 7, 2020
Responsible Party: Shameka Grant, Director of Vendor Management

2. Comprehensive Psychiatric Emergency Program (CPEP) Claims Monitoring:

To ensure Beacon's Comprehensive Psychiatric Emergency Program (CPEP) training (noted below in Section 3) effectively ensures no further CPEP claims errors, 100% of CPEP claims are monitored and reviewed for errors weekly. Similar to Section 1 above, this process includes review of claims denied for no prior authorization or due to human processor or reporting errors. In addition, Beacon meets with the Plan monthly to audit claims. As a result of this monitoring process, 100% of CPEP claims flagged as denied inappropriately are corrected and reprocessed to pay.

Implementation Date: September 7, 2020

Responsible Party: Shameka Grant, Director of Vendor Management

3. CPEP Training:

In addition to Beacon's 2019 CPEP training for Claims Processors, the Plan instructed Beacon to complete an updated and refreshed training for claim examiners on September 10, 2020. Since then, Beacon has memorialized this training on Beacon's learning management system, and it is available on-demand as issues are identified. Beacon claims processing staff are required to complete the training twice a year. Beacon claim processors were required and completed CPEP training during period August 1, 2021, through August 12, 2021.

Implementation Date: October 1, 2020
Responsible Party: Shameka Grant, Director of Vendor Management

4. ACT, PROS, PH Training:

In addition to the Beacon quality assurances described under Section 1 of the POC, Beacon is in the process of formalizing a training for ACT, PROS, and PH services that will mirror the structure, frequency and requirements established for CPEP described in Section 3. Beacon is targeting roll out by end of Q4 2021.

Implementation Date: March 31, 2022
Responsible Party: Shameka Grant, Director of Vendor Management

5. Plan Oversight – Beacon Denied Claims Review:

The following Medicaid claims reports are received from Beacon monthly:

- EHMD NYC and ROS Monthly Children's Behavioral Health Reporting
- EHMD NYC and ROS Monthly Adults Behavioral Health Reporting

All CPEP claims denied for no-prior authorization are sent directly back to Beacon for review and reprocessing. A selection of an additional 18 claims is then made from the above reports by the EmblemHealth Claims Oversight team for audit. The sample includes 10 random denied claims and 8 claims diversionary claims denied for no preauthorization. These samples are audited in detail by EmblemHealth and are part of the Plan's monthly WebEx claims review with Beacon.

As a result of the State's survey and this POC the Plan made the following enhancements to the above oversight process to include:

- Expansion of encounter data reports to include all data elements transmitted by Beacon for high level oversight of potential missing elements.
- Service specific targeted reviews on 8 diversionary services claims denied for no prior authorization, which will begin in November 2021.

Implementation Date: Expansion of encounter data: January 29, 2021
Targeted reviews for 8 diversionary services: November 10, 2021
Responsible Party: Linda Henderson, VP Claims Operations

6. Plan Enhancements to Quality Committees:

The EmblemHealth Behavioral Health Sub-Committees meet on a quarterly basis to review key utilization metrics, quality issues, HARP, and children's issues. Every quarter there is a presentation by the Behavioral Health delegates on their claims processing metrics including total number of claims received, total number of claims denied and the denial reasons. The Committees review the claims trends to identify if progress is being made in reducing the volume of claims denied. Minutes of the BH Sub-Committees are then reported to the EmblemHealth Quality Improvement Committee (QIC) and the QIC then presents these minutes to the Board of Directors of EmblemHealth.

In addition on June 2, 2021, the EmblemHealth Claims Department, responsible for reviewing on a monthly basis the accuracy of claims determinations and reasons for denial, made a presentation to the Behavioral Health Quality and Advisory Committee an analysis of denial rate trends from October 2020 to March 2021, a description of EmblemHealth oversight and findings on Beacon processed claims and a corrective action summary. The Quality Committee of the Board is scheduled to meet on October 20th, 2021 and minutes of the BH Quality and Advisory Meeting shall be presented.

Implementation Date: October 20, 2021
Responsible Party: Kelly McGuire, Medical Director Behavioral Health

MCO's Representative Signature:	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	

10.21 Mental Health Services

(i) The Contractor agrees that it will not require prior authorization for Comprehensive Psychiatric Emergency Program or Crisis intervention services.

Finding:

Based on interviews with Plan staff on August 5, 2020, review of documents, and Plan-reported claims data submitted on July 29, 2020, EmblemHealth failed to comply with New York State requirements for emergency services, including Comprehensive Psychiatric Emergency Program (CPEP) services, by allowing the BH Vendor to inappropriately deny CPEP claims for no prior authorization due to human processor error between the survey period of October 1, 2019-January 31, 2020. This requirement had been reiterated to the plan in a Memo entitled, CPEP MMCP Guidance 04.16.18_ distributed on April 16, 2018.

Plan Corrective Action(s) for Citation 10.21 – Mental Health Services:

1. Comprehensive Psychiatric Emergency Program (CPEP) Claims Monitoring:

To ensure Beacon's Comprehensive Psychiatric Emergency Program (CPEP) training (noted below in Section 2) effectively ensures no further CPEP claims errors, 100% of CPEP claims are monitored and reviewed for errors weekly. This process includes review of claims denied for no prior authorization or due to human processor or reporting errors. In addition, Beacon meets with the Plan monthly to audit claims. As a result of this monitoring process, 100% of CPEP claims flagged as denied inappropriately are corrected and reprocessed to pay.

Implementation Date: September 7, 2020
Responsible Party: Shameka Grant, Director of Vendor Management

2. CPEP Training:

In addition to Beacon's 2019 CPEP training for Claims Processors, the Plan instructed Beacon to complete an updated and refreshed training for claim examiners on September 10, 2020. Since then, Beacon has memorialized this training on Beacon's learning management system, and it is available on-demand as issues are identified. Beacon claims processing staff are required to complete the training twice a year. Beacon claim processors were required and completed CPEP training during period August 1, 2021, through August 12, 2021.

Implementation Date: October 1, 2020
Responsible Party: Shameka Grant, Director of Vendor Management

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The following Medicaid claims reports are received from Beacon monthly:

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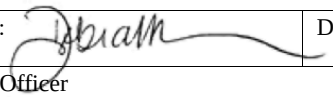
Implementation Date: Expansion of encounter data: January 29, 2021
Targeted reviews for 8 diversionary services: November 10, 2021
Responsible Party: Linda Henderson, VP Claims Operations

MCO's Representative Signature: 	Date: January 12, 2022
Title: SVP & Chief Compliance Officer	