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

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

NOTE: The following list of deficiencies was identified by Health Department representatives during an Article 44 and/or Article 49 operational or focused survey of your Managed Care Organization (MCO). Correction of these deficiencies is required in order to bring your MCO into compliance with Article 44 and/or 49 of the New York State Public Health Law and the New York State Official Compilation of Codes, Rules, and Regulations (10NYCRR). In the column headed Provider Plan of Correction, describe the Plan of Corrective Action and anticipated date of corrections. The Plan of Correction should be returned within 15 business days.

Deficiencies	Plan of Correction with Timetable
98-1.11 Operational and financial requirements for MCOs. **(h) The governing authority of the MCO shall be responsible for establishment and oversight of the MCO's policies, management and overall operation, regardless of the existence of any management contract.** **Deficiency:** Based on the review of Plan-submitted monthly claims reports which demonstrated persistently high claim denials for behavioral health services (ACT, PROS, HCBS, Partial Hospitalization, and CPEP) over a period of six months from 12/1/17-5/31/18, as well as information contained in the subsequent August and December 2018 Root-Cause analysis submissions which were requested by New York State to explain the reasons for such high denial rates, the Plan failed to provide adequate oversight of delegated management function, claims adjudication, by allowing their Behavioral Health vendor, Beacon, to deny a proportion of claims without being able to determine cause for those denials.	On December 19, 2018, MVP Health Plan, Inc. issued a Corrective Action Plan ("CAP") to Beacon Health Options, Inc. ("Beacon") to address the persistently high claim denials. MVP monitored Beacon's status of the required actions addressed in the CAP. As of April 12, 2019, all claims were reprocessed and the CAP is now closed. In addition to the CAP referenced above, MVP has taken the following steps to resolve the persistently high claim denials for behavioral health services identified in the DOH survey for December 1, 2017 – May 31, 2018: Commencing in September, 2018, MVP began requiring Beacon to develop and provide MVP with weekly reports detailing denial rates, denial volume and denial reasons for ACT, PROS, HCBS, Partial Hospitalization, and CPEP services. These reports also show results of quality reviews performed for each denial and any required actions for incorrect denials. In September, 2018 MVP also implemented a requirement for Beacon's leadership to meet with MVP staff on a weekly basis to discuss the reports, any findings and any action that is required.

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

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

NEW YORK STATE DEPARTMENT OF HEALTH

ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CONTINUATION SHEET

Name of Managed Care Organization MVP Health Plan, Inc.	**Survey Dates** December 1, 2017-May 31, 2018 **Survey ID #** 590754451
Deficiencies	Provider Plan of Correction with Timetable
Based on the review of Plan-submitted monthly claims reports which demonstrated persistently high claim denials for behavioral health services (ACT, PROS, HCBS, Partial Hospitalization, and CPEP) over a period of six months from 12/1/17-5/31/18, as well as information contained in the subsequent August and December 2018 Root-Cause analysis submissions which were requested by New York State to explain the reasons for such high denial rates, the Plan failed to reimburse providers at Medicaid Fee for Service and/or APG rates for ambulatory behavioral health services due to a configuration error in their Behavioral Health vendor Beacon's FlexCare claims platform which led to the inappropriate set-up of provider profiles.	MVP's management services agreement with Beacon will terminate on December 31, 2019. **Timeframe for Implementation**: MVP is terminating the Management Services Agreement with Beacon and bringing all management functions for behavioral health, including claims processing for dates of service January 1, 2020 and beyond and utilization management in house effective January 1, 2020. MVP and Beacon are negotiating an agreement for transition services. MVP has been working closely with Beacon and all affected claims for ACT, PROS, HCBS, Partial Hospitalization, and CPEP from 12/1/17-5/31/18 have been reprocessed. **Responsible Party**: Rosemarie Hogan, Senior Leader, Claims, Configuration and Support Services. **Date Certain**: April 12, 2019

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Deficiencies	Provider Plan of Correction with Timetable
Chapter 57 of the Laws of 2017, Part P, 48-a.1 **§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health is authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the Medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health provided to Medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for Medicare and Medicaid services (CMS).**	

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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;…	

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

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

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

10.21 Mental Health Services.
d) The Contractor shall reimburse any OMH licensed provider, including out of network providers, at Medicaid Fee for Services rates for 24 months form the effective date of the Behavioral Health Benefit Inclusion in each geographic service area for ambulatory mental health services provided to Enrollees.

Finding:

Based on the review of the Plan-submitted monthly claims reports which demonstrated persistently high claim denials for behavioral health services (ACT, PROS, HCBS, Partial Hospitalization and CPEP) over a period of six months from 12/1/27-5/31/18, as well as information contained in the subsequent August and December 2018 Root-Cause analysis submissions which were requested by New York State to explain the reasons for such high denial rates, the Plan failed to reimburse providers at Medicaid Fee for Service and/or APG rates for ambulatory behavioral health services due to a configuration error in their Behavioral Health vendor Beacon's FlexCare claims platform which led to the inappropriate set-up for provider profiles.

MVP Response

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

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