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:**
Empire Blue Cross Blue Shield HealthPlus	Focus Survey: MHPAEA Testing Phase I and Phase II Workbooks
STREET ADDRESS, CITY, STATE, ZIP CODE	**SURVEY DATES:**
9 Pine Street New York, NY 10005	August 22, 2018 – September 22, 2020

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
10 CRR-NY 98-1.16 Disclosure and filing. **(h) In the event an MCO does not provide substantially complete reports or other information required under this Subpart by the due date, or provide requested information within 30 days of any written request for a specific analysis or report by the superintendent or commissioner, the superintendent or commissioner is authorized to levy a civil penalty, after notice and hearing, pursuant to section 12 of the Public Health Law or sections 307 and 308 of the Insurance Law.** **<u>Deficiency:</u>** Based on the review of Empire Blue Cross Blue Shield HealthPlus' (HealthPlus) Phase I and Phase II nonquantitative treatment limitation (NQTL) workbook submissions, the MCO failed to provide all required information and comparative analyses demonstrating compliance with the Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345; MHPAEA) for 6 of 9 NQTLS examined; prior authorization, concurrent review, medical necessity criteria, formulary design, coding edits, and out of network coverage standards. • Specifically, in Phase I, HealthPlus failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug prior authorization. For concurrent review, HealthPlus failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent	Phase I -Deficiency: Phase I, HealthPlus failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug prior authorization. Plan Response: Plan is not required to respond to deficiencies related to the Prescription Drug Classification or formulary design NQTL. Phase I -Deficiency: For concurrent review, HealthPlus failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent stringency for outpatient. Plan Response: The exact date for the implementation of the formal POC is June 29, 2021. Method to Revise and Remediate: Factors triggering the NQTL for Inpatient Concurrent Review Our process for identifying members to review for IP concurrent review has changed since our initial submission. We do not conduct reviews for any IP Substance Use admissions unless someone remains IP after 28 days. Members less than 18 who are inpatient for psychiatric services are not reviewed unless their length of stay exceeds 14 days. Based on the Guiding Principles for IP psychiatric reviews shared by OMH, we submitted revised workflows for adults who are IP psych to the state for review on January 8, 2021. When we receive feedback from OMH on our proposed workflows related to the IP Concurrent review process we will make the needed changes and update our processes within 45 days. Associates will be trained on the revised processes no later than 30 days of finalization. This training will be completed at weekly staff meetings held every Friday. Additionally, all teams within BH will again review their focused process at smaller team meetings. Documentation of training will be maintained and tracked for completion at least annually.

MCO Representative's Signature Michael S. Hofer	Date 8/26/21
Title President & CEO	

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In instances where the medical necessity for the service is not met Medical Director review is required (UR – medical necessity review) The clinicians in both PH and BH teams are Nurses or other Licensed Clinicians The workbook was updated to include these changes and was completed on April 19, 2021 Responsible Parties to review workbooks: UM IP Manager - Virginia Nagiec - primary, Mainstream - Dr. Martha Ruff – secondary in conjunction with a PH designee Staff Training: In addition to the training outlined within the SOD/SOF, additional training will be provided annually within the IP and OP Team meetings and each time processes are updated. Ongoing Monitoring: Complaints are reviewed, analyzed and reported by BH and Med/Surg to the QMC. Particular attention is paid if there are complaints related to OON IP denials. Non UR denials (administrative denials for OON) are also reviewed and BH Non UR denials for OON coverage and PH denials for OON coverage are compared to ensure parity. In addition workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity. Note: 2021 data indicates that BH has not issued any denials for IP –OON requests. Status of parity findings will be reported in quarterly Quality Management Committee beginning August 23, 2021. The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH. The status of the parity findings will include the results of the ongoing analysis and if the BH processes are more stringent then a plan of action to ensure parity compliance will be developed. Plan of Action will include the following: • Identify any processes that appear to be more stringent • Identify changes that need to be implemented to ensure parity • Identify specific due dates and business owners for tracking • Identify the methodology to complete a parity analysis once the changes are implemented to ensure parity compliance • Staff training and dates of training will be included within the action plan. Updates and findings from the QMC will be reported to executive leadership at the Plan Compliance Committee which meets no less than six times per year. Compliance with state and federal requirements for provision of comparable coverage for benefits to treat mental health and substance use disorder is monitored via the Mental Health and Substance Use Disorder Parity Compliance Program. Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2020 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the NY Board of Managers. Responsible Parties: Sami Widdi, Director, GBD Quality Management Revised 8/25/2021 Plan Response: Method to Revise and Remediate: Outpatient Out of Network Coverage Standards Plan has multiple integrated P&Ps that speaks to out of network coverage. Related policies that speak to out of network coverage include: Continuity of Care - Core process; Practitioner appointment and access standards and Out Of Network Coverage.

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Title President & CEO	

stringency for outpatient. Additionally, HealthPlus failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review. The MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug medical necessity criteria and (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug formulary design. • Specifically, in Phase II, HealthPlus failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits. For outpatient, emergency care, and prescription drug coding edits, the MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency. Additionally, the MCO failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL (inpatient only), (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient out of network coverage standards.	Phase II - Deficiency: Coding Edits - Failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits. For outpatient, emergency care, and prescription drug coding edits, failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency. Method to Revise and Remediate: Coding Edits - OMH's definition of NQTL is: "which otherwise limit the scope or duration of benefits for treatment". Given this definition HealthPlus holds the position the category of claim edits do not limit the scope or duration of benefits for treatment. Prepayment correct coding edits administered through our vendors are designed to identify and address correct coding edits in addition to supporting existing reimbursement policy. During the discussion with the OMH and through the subsequent email received from the state, NCCI edits have been recognized as an exclusion from this analysis. Additionally, other correct coding edits would also be out of scope of this analysis. This corrective plan of action does not identify a known deficiency causing non-compliance with Mental health parity benefits. It will identify steps to continue to analyze prepayment correct coding edits to ensure compliance. Prepayment claim edits administered through ClaimsXten and Cotiviti for outpatient facility and professional claims (we do not have any edits for inpatient claims) utilize industry standard coding principles to establish edits. These edits can come from multiple sources including CMS, AMA, Specialty societies and the FDA to name a few. Also, we use these editing tools to implement edits supported by the New York state guidelines. Edits are not distinguished by their categorizations (i.e. MH/SUD vs. medical/surgical). It is based on how the service should correctly be coded. We do have edits that require claims to pend for review. We will evaluate those claim pends to determine whether they are being treated differently for MH/SUD vs. Medical/surgical. For program integrity purposes all claims are subject to pre-pay and post-pay review and recoupment in accordance to established billing, utilization and/or reimbursement policies. HealthPlus' Special Investigation's Unit (SIU) processes apply equally to providers paid under fee-for-service arrangements as well as providers paid under a shared savings or risks bearing agreement or through any government programs. When appropriate, we will include an analysis of our pre/post pay review processes.

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stringency for outpatient. Additionally, HealthPlus failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review. The MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug medical necessity criteria and (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug formulary design. • Specifically, in Phase II, HealthPlus failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits. For outpatient, emergency care, and prescription drug coding edits, the MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency. Additionally, the MCO failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL (inpatient only), (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient out of network coverage standards.	As a part of the overall analysis we will: 1. Describe the code editing protocols for both MH/SUD benefits and medical/surgical benefits. 2. Identify factors 3. Identify and describe evidentiary standards and other evidence relied upon 4. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits. 5. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits. 6. Updates on the above steps will be shared at the first QMC meeting with Parity included. Monitoring the Implementation: • Identify and evaluate correct coding claim edits that create a pend by May 1, 2021. • Review the edits that are pended to assess the process for adjudicating the pend by June 30, 2021. • Create a process annually to reassess new edits July 19, 2021. • Educate Claims Editing Services team on new process July 31, 2021.

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Statement of Findings
Empire Blue Cross Blue Shield HealthPlus MHPAEA
Testing Phase I and Phase II Workbooks August 22, 2018- September 22, 2020

Parity Compliance

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.

(42 CFR 438.910(d) *Nonquantitative treatment limitations.*)
(42 CFR 438.920(b) *State Responsibilities*.)

Finding:

Based on the review of Empire Blue Cross Blue Shield HealthPlus' (HealthPlus) Phase I and Phase II nonquantitative treatment limitation (NQTL) workbook submissions, the MCO failed to provide all required information and comparative analyses demonstrating compliance with the Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345; MHPAEA) for 6 of 9 NQTLS examined; prior authorization, concurrent review, medical necessity criteria, formulary design, coding edits, and out of network coverage standards.

- Specifically, in Phase I, HealthPlus failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug prior authorization. For concurrent review, HealthPlus failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent stringency for outpatient. Additionally, HealthPlus failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review.

The MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug medical necessity criteria and (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug formulary design.

Plan Response:

Plan is not required to respond to deficiencies related to the Prescription Drug Classification or formulary design NQTL.

The exact date for the implementation of the formal POC is June 29, 2021.

Method to Revise and Remediate: Factors triggering the NQTL for Inpatient Concurrent Review

Our process for identifying members to review for IP concurrent review has changed since our initial submission. We do not conduct reviews for any IP Substance Use admissions unless someone remains IP after 28 days. Members less than 18 who are inpatient for psychiatric services are not reviewed unless their length of stay exceeds 14 days. Based on the Guiding Principles for IP psychiatric reviews shared by OMH, we submitted revised workflows for adults who are IP psych to the state for review on January 8, 2021. When we receive feedback from OMH on our proposed workflows related to the IP Concurrent review process we will make the needed changes and update our processes within 45 days. Associates will be trained on the revised processes no later than 30 days of finalization. This training will be completed at weekly staff meetings held every Friday. Additionally, all teams within BH will again review their focused process at smaller team meetings.

Documentation of training will be maintained and tracked for completion at least annually.

Evidentiary Standards for the Comparative Analysis: The PH team conducts concurrent review on an ongoing basis.

There are no triggers for concurrent reviews. The BH process is not more stringent than the physical health process.

The workbook was updated to reflect these changes on April 19, 2021.

Responsible Parties: UM IP Manager - Virginia Nagiec - primary, Mainstream - Dr. Martha Ruff - secondary

Staff Training: In addition to the training outlined above, as part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. This is our plan to educate/train staff of any necessary changes to address potential noncompliance. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. The exact date for the implementation of the formal POC is June 29, 2021.

Ongoing Monitoring: Compliance with state and federal requirements for provision of comparable coverage for benefits to treat mental health and substance use disorder is monitored via the Mental Health and Substance Use Disorder Parity Compliance Program.

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing

assessment of parity compliance. By December 31, 2020 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the NY Board of Managers.

Status of parity findings will be reported in quarterly Quality Management Committee beginning August 23, 2021. The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH.

Plan of Action will include the following:

- Identify any processes that appear to be more stringent
- Identify changes that need to be implemented to ensure parity
- Identify specific due dates and business owners for tracking
- Identify the methodology to complete a parity analysis once the changes are implemented to ensure parity compliance
- Staff training and dates of training will be included within the action plan.

Updates and findings from the QMC will be reported to executive leadership at the Plan Compliance Committee which meets no less than six times per year. The previous memo stated that licensure of these Youth ACT teams was anticipated for July 1, 2021 however due to delays, the new ACT teams may not be licensed by this date.

Responsible Parties: Sami Widdi, Director, GBD Quality Management

Method to Revise and Remediate: Evidentiary Standards for the Comparative Analysis
Triggers for review were included in step 2 within the workbook. The workbook was updated to include these on April 19, 2021.

Empire (BH and PH) uses standard reports that identify gaps in medication fills, gaps in services (i.e. possible need for specialized care, reports identifying need for Case Management due to complexity), and members that may need linkage to CBOs to address SDH. These reports are used to identify members for concurrent reviews. The triggers are compatible for both PH and BH.

The workbook was updated to include these on April 19, 2021.

Responsible Parties: Mainstream - Dr. Martha Ruff (primary);
Director II HCMS - BH Radhika Vars - secondary

Staff Training: In addition to the training outlined above, as part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation.

Finding:

- Specifically, in Phase II, HealthPlus failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits. For outpatient, emergency care, and prescription drug coding edits, the MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only),

and (Step 5) in operation comparability and equivalent stringency.

Additionally, the MCO failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL (inpatient only), (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient out of network coverage standards.

Revised Plan Response 8/25/2021:

Method to Revise and Re-mediate: Inpatient Out of Network Coverage Standards

OON Post stabilization services that are a result of an emergency are covered by both PH and BH for all products – Medicaid, HARP, CHP and EP. OON services for acute inpatient care are covered for both PH and BH services. Neither the PH nor the BH team redirect members to an In Network provider when a member accesses IP services as a result of an emergency.

Non-acute inpatient BH services (Inpatient Substance Use Rehab, Substance Use Residential Services, Crisis Residential Services) and PH services (non urgent surgery,) are approved to OON providers if the network does not have an adequate number of providers to meet the needs of the member. Members may obtain services from an out of network provider when medically necessary care cannot be obtained within the provider network or to ensure continuity of care (transitional care). Both PH and BH teams cannot consider inpatient services as out of network solely on the basis that the admitting physician or treating physician is a non-participating provider. They cannot consider services rendered by a participating provider as out of network services solely on the basis that the services are rendered in a non-participating hospital.

Out of network IP services are also approved when the needed non acute IP service and/or provider are not available within the network and the services are part of a treatment plan approved by a Utilization Management Nurse and/or Medical Director in consultation with the PCP.

The OON provider must agree to accept reimbursement at rates established by Empire as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the Empire network for the same/similar services. The non-participating provider must agree to adhere to Empire's quality assurance requirements and agree to provide the necessary medical information related to the care. The non-participating provider must agree to adhere to Empire's policies and procedures including but not limited to procedures regarding obtaining pre-certification.

Before a medical necessity decision (UR) is rendered, both BH and PH clinicians assess the guidelines outlined above and consult with the Manager if needed. The Physical Health team considers the same factors/ guidelines for OON OP services as does BH Once a benefit decision (whether to approve the OON request – non UR) is made the clinician assesses for medical necessity. If guidelines for out of network approval and medical necessity are met, an authorization number is given to the PCP or non-participating provider and member. In instances where the medical necessity for the service is not met Medical Director review is required (UR – medical necessity review)

The clinicians in both PH and BH teams are Nurses or other Licensed Clinicians
The workbook was updated to include these changes. This was completed on April 19, 2021

Responsible Parties to review workbooks: UM IP Manager - Virginia Nagiec - primary, Mainstream - Dr. Martha Ruff – secondary in conjunction with a PH designee

Staff Training: In addition to the training outlined within the SOD/SOF, additional training will be

provided annually within the IP and OP Team meetings and each time processes are updated.

Ongoing Monitoring:

Complaints are reviewed, analyzed and reported by BH and Med/Surg to the QMC. Particular attention is paid if there are complaints related to OON IP denials. Non UR denials (administrative denials for OON) are also reviewed and BH Non UR denials for OON coverage and PH denials for OON coverage are compared to ensure parity. In addition workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity.

Note: 2021 data indicates that BH has not issued any denials for IP –OON requests.

Status of parity findings will be reported in quarterly Quality Management Committee beginning August 23, 2021.

The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH. The status of the parity findings will include the results of the ongoing analysis and if the BH processes are more stringent then a plan of action to ensure parity compliance will be developed.
Plan of Action will include the following:

- Identify any processes that appear to be more stringent
- Identify changes that need to be implemented to ensure parity
- Identify specific due dates and business owners for tracking
- Identify the methodology to complete a parity analysis once the changes are implemented to ensure parity compliance
- Staff training and dates of training will be included within the action plan.

Updates and findings from the QMC will be reported to executive leadership at the Plan Compliance Committee which meets no less than six times per year.

Compliance with state and federal requirements for provision of comparable coverage for benefits to treat mental health and substance use disorder is monitored via the Mental Health and Substance Use Disorder Parity Compliance Program.

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2020 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the NY Board of Managers.

Responsible Parties: Sami Widdi, Director, GBD Quality Management

Revised Plan Response 8/25/2021:

Method to Revise and Remediate: Outpatient Out of Network Coverage Standards

Plan has multiple integrated P&Ps that speaks to out of network coverage. Related policies that speak to out of network coverage include: Continuity of Care - Core process; Practitioner appointment and access standards and Out Of Network Coverage.
Out of network Outpatient services are approved by both BH and PH for Continuity of care - when a

member signs up with our plan or when an INN provider terminates their contract and continues to be in good standing.
In addition, both teams approve OON OP care if
• A member is unable to locate an INN provider - lack of appointment availability that meets member's need). When an appointment with the appropriate specialist/service is not available within the appointment availability standards or the member requires the visit sooner than is available within network.

• A member's clinical needs cannot be met by INN providers and needs a specialist who is not in network – member may need CBT, or TMS and plan does not have an adequate number of these specialists in network; or member needs to be seen by a Child and Adolescent psychiatrist and plan does not have a specialist available close to where the member lives and is able see the member at a time when member is available (specialist – time and distance)
• A member has cultural, language/linguistic needs that cannot be met by an INN provider – a member may need a therapist who speaks Mandarin and plan does not have a provider available to see the member (time and distance); member may need services by a provider who has a same religious belief as the member or same ethnic background as the member or be part of the same cultural group as the member but plan does not have any INN providers to meet member's needs.

The OON provider must agree to accept reimbursement at rates established by Empire as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the Empire network for the same/similar services. The non-participating provider must agree to adhere to Empire's quality assurance requirements and agree to provide the necessary medical information related to the care. The non-participating provider must agree to adhere to Empire's policies and procedures including but not limited to procedures regarding obtaining pre-certification.

Before a medical necessity decision (UR) is rendered, both BH and PH clinicians assess the guidelines outlined above and consult with the Manager if needed. The Physical Health team considers the same factors/ guidelines for OON OP services as does BH Once a benefit decision (whether to approve the OON request – non UR) is made the clinician assesses for medical necessity. If guidelines for out of network approval and medical necessity are met, an authorization number is given to the PCP or non-participating provider and member. In instances where the medical necessity for the service is not met Medical Director review is required (UR – medical necessity review)

The clinicians in both PH and BH teams are Nurses or other Licensed Clinicians

The workbook was updated to include these changes. This was be completed on April 19, 2021

Responsible Parties to review workbooks Mainstream Lead - Dr. Martha Ruff –primary; Director II HCMS –BH Radhika Vars – secondary

Staff Training: In addition to the training outlined within the SOD/SOF, additional training will be provided annually within the IP and OP Team meetings and each time processes are updated.

Ongoing Monitoring:

Complaints are reviewed, analyzed and reported by BH and Med/Surg to the QMC. Particular attention is paid if there are complaints related to OON OP denials. Non UR denials (administrative denials for OON) are also reviewed and BH Non UR denials for OON coverage and PH denials for OON coverage are compared to ensure parity. In addition, workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity.

Status of parity findings will be reported in quarterly Quality Management Committee beginning August

23, 2021.

The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH. The status of the parity findings will include the results of the ongoing analysis and if the BH processes are more stringent then a plan of action to ensure parity compliance will be developed.
Plan of Action will include the following:

- Identify any processes that appear to be more stringent
- Identify changes that need to be implemented to ensure parity
- Identify specific due dates and business owners for tracking
- Identify the methodology to complete a parity analysis once the changes are implemented to ensure parity compliance
- Staff training and dates of training will be included within the action plan.

Updates and findings from the QMC will be reported to executive leadership at the Plan Compliance Committee which meets no less than six times per year.

Compliance with state and federal requirements for provision of comparable coverage for benefits to treat mental health and substance use disorder is monitored via the Mental Health and Substance Use Disorder Parity Compliance Program.

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2020 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the NY Board of Managers.

Responsible Parties: Sami Widdi, Director, GBD Quality Management

Method to Revise and Remediate: Coding Edits - OMH's definition of NQTL is: "which otherwise limit the scope or duration of benefits for treatment". Given this definition HealthPlus holds the position the category of claim edits do not limit the scope or duration of benefits for treatment. Prepayment correct coding edits administered through our vendors are designed to identify and address correct coding edits in addition to supporting existing reimbursement policy.

During the discussion with the OMH and through the subsequent email received from the state, NCCI edits have been recognized as an exclusion from this analysis. Additionally, other correct coding edits would also be out of scope of this analysis.

This corrective plan of action does not identify a known deficiency causing non-compliance with Mental health parity benefits. It will identify steps to continue to analyze prepayment correct coding edits to ensure compliance.

Prepayment claim edits administered through ClaimsXten and Cotiviti for outpatient facility and professional claims (we do not have any edits for inpatient claims) utilize industry standard coding principles to establish edits. These edits can come from multiple sources including CMS, AMA, Specialty societies and the FDA to name a few. Also, we use these editing tools to implement edits supported by the New York state guidelines. Edits are not distinguished by their categorizations (i.e. MH/SUD vs. medical/surgical). It is based on how the service should correctly be coded. We do have edits that require claims to pend for review. We will evaluate those claim pends to determine whether they are being treated differently for MH/SUD vs. Medical/surgical. For program integrity purposes all claims are

subject to pre-pay and post-pay review and recoupment in accordance to established billing, utilization and/or reimbursement policies. HealthPlus' Special Investigation's Unit (SIU) processes apply equally to providers paid under fee-for-service arrangements as well as providers paid under a shared savings or risks bearing agreement or through any government programs. When appropriate, we will include an analysis of our pre/post pay review processes.

As a part of the overall analysis we will:

1. Describe the code editing protocols for both MH/SUD benefits and medical/surgical benefits.

2. Identify factors

3. Identify and describe evidentiary standards and other evidence relied upon

4. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits.

5. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits.

6. Updates on the above steps will be shared at the first QMC meeting with Parity included.

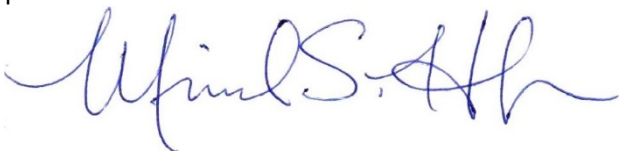
Monitoring the Implementation:

- Identify and evaluate correct coding claim edits that create a pend by May 1, 2021.
- Review the edits that are pended to assess the process for adjudicating the pend by June 30, 2021.
- Create a process annually to reassess new edits July 19, 2021.
- Educate Claims Editing Services team on new process July 31, 2021.

Responsible Parties: Reimbursement Policy Management- Beth Wright; Janie Leo.

Date of Implementation: May 1, 2021

Staff Training: As part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation.



8/26/21

Mike Hofer, Interim President, HealthPlus HP, LLC Date