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 HealthPlus, LLC	**TYPE OF SURVEY:** OMH Outpatient Services: Government Rate Compliance **Survey ID # 1852363880**
STREET ADDRESS, CITY, STATE, ZIP CODE PENN 1 35th Floor, New York, NY 10119	**SURVEY DATES:** **October 1, 2021- June 29, 2023**

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 :
Chapter 57 of the Laws of 2022, Part LL, 48-a.1 § 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of addiction services and supports and the office of mental health are 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 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 36, 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 addiction services and supports 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). 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	

MCO Representatives Signature: Mark Levy, MD, MPH Date: 10/24/2023

NEW YORK STATE DEPARTMENT OF HEALTH
ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
CONTINUATION SHEET

Name of Managed Care Organization HealthPlus, LLC	**Survey Dates: October 1, 2021- June 29, 2023** **Survey ID # 1852363880**
Deficiencies	**Plan of Correction with Timetable**
methodology as utilized by the department of health, the office of addiction services and supports, 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 18 of part E of chapter 57 of the laws of 2019 through March 31, 2027 for patients in the city of New York, for all rate periods on and after the effective date of section 18 of part E of chapter 57 of the laws of 2019 through March 31, 2027 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, 2027 for all services provided to persons under the age of twenty-one; ... **Deficiency:** Based on the review of Medicaid Managed Care Plan (MMCP) reported service delivery data, hereafter referred to as encounter data, and subsequent documentation including the Government Rate Compliance Attestation Letter, herein referred to as "Attestation", the Office of Mental Health (OMH) identified Empire Blue Cross Blue Shield HealthPlus, hereafter referred to as HealthPlus, failed to pay the required government rates for behavioral health (BH) services. Specifically, claims for Assertive Community Treatment, Personalized Recovery Oriented Services, Adult Behavioral Health Home and Community Based Services, Community Oriented Recovery and Empowerment Services, and Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) were not paid at the government rate, resulting in the underpayment of 217,436 claims.	**Plan Response:** Empire Health Plus conducted and completed a review of the underpayments for dates of services between October 1, 2021, and December 31, 2022, for Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS), Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Adult Behavioral Health Home and Community Based Services (BH HCBS) & Community Oriented Recovery and Empowerment (CORE) services. Based on our review the systems were updated timely by November 2022 and an initial claims reconciliation project to reconcile impacted claims was initiated. However due to the complexity of the criteria claims were missed from the initial project. Once the plan was informed of the underpayment through the OMH Compliance Memo, the plan performed a throughout review to identify all impacted claims, which was completed on January 23, 2023. Between January 23, 2023, and June 23, 2023, the plan worked on several projects to reprocessed 217,436 impacted claims. The plan also paid $408,000 in interest on the reprocessed claims. The plan was not able to reprocess all impacted claims by February 1, 2023, as requested by OMH, due to the short turnaround time of 25 days to perform the research, identification, claims reprocessing and payment. **Plan of Action** Empire Health Plus established a tighter End-to End oversight process to monitor compliance and completion of BH Rate Updates within 90 days from Notification of rate updates.

NEW YORK STATE DEPARTMENT OF HEALTH
ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
CONTINUATION SHEET

Name of Managed Care Organization HealthPlus, LLC	**Survey Dates: October 1, 2021- June 29, 2023** **Survey ID # 1852363880**
Deficiencies	**Plan of Correction with Timetable**
HealthPlus failed to follow the directive to configure their systems to pay the government rates for dates of services back to October 1, 2021 by the original due date of November 30, 2022 and the final extended due date of February 1, 2023. OMH and the Department of Health jointly issued the Government Rate Compliance Memo, herein referred to as "Memo", and the Government Rates Underpayment Summary to HealthPlus on January 5, 2023 notifying them of their failure to comply with the NYS Government Rate Law. The Memo directed HealthPlus to configure systems and reconcile all identified underpayments by February 1, 2023. Additionally, on March 30, 2023, OMH sent the Attestation request to verify compliance with the Memo issued on January 5, 2023. Based on review of the Attestation, the State identified that the MCO failed to pay the required government rates due to not configuring systems to comply with the rate changes for Enhanced Federal Medical Assistance Percentage (eFMAP) and Cost of Living Adjustments (COLA), which are required by New York State (NYS) Government Rate Law. HealthPlus reported the reprocessing of underpaid claims for MHOTRS, ACT, and PROS services did not begin until February 1, 2023, which is the extended final deadline to complete all the reconciliation and payments. For MHOTRS, which has the most volume and impacted dollar amount, the MCO did not begin reprocessing underpaid claims until April 1, 2023. The anticipated completion date of reprocessing and payment for impacted MHOTRS claims was June 29, 2023, 148 days past the final extended due date of February 1, 2023.	**End-to-End Oversight:** The BH Medicaid Ops team is responsible for conducting end-to-end oversight of all Behavioral Health Rate Update/ Changes issued by OMH and OASAS. • Day 1-30 from Notification Receipt Date o Upon issuance of an OMH/OASAS Rate Update Memo/Notification, the BH Ops team engages and works closely with the cross-functional areas including Pricing and Configuration and Claims operations team to bring awareness of the update and timeline for completion. B o BH Medicaid Ops conducts weekly workgroup meetings with the cross-functional teams to discuss the progress on the system updates. • Day 30-70 from Notification Receipt Date o Once the system is updated, the BH Medicaid Ops coordinates with our Claims Research and Resolution Team to review the criteria used to identify underpaid clean claims. o Claims Research and Resolution works on the reconciliation and reprocess clean claims for additional payment. • Day 70-90 from Notification Receipt Day o Once the claim reprocessing project is completed, the BH Team review and validate all clean claims were reprocessed correctly. **Responsible Parties:** Alma Duhanxhiu, Director II Medicaid State Ops Karla D. Velez, Manager II Medicaid State Ops o

Statement of Findings
HealthPlus, LLC
OMH Outpatient Services: Government Rate Compliance
Survey ID# 1852363880
October 1, 2021- June 29, 2023

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 the review of Medicaid Managed Care Plan (MMCP) reported service delivery data, hereafter referred to as encounter data, and subsequent documentation including the Government Rate Compliance Attestation Letter, herein referred to as "Attestation", the Office of Mental Health (OMH) identified Empire Blue Cross Blue Shield HealthPlus, hereafter referred to as HealthPlus, failed to pay the required government rates for behavioral health (BH) services. Specifically, claims for Assertive Community Treatment, Personalized Recovery Oriented Services, Adult Behavioral Health Home and Community Based Services, Community Oriented Recovery and Empowerment Services, and Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) were not paid at the government rate, resulting in the underpayment of 217,436 claims.

HealthPlus failed to follow the directive to configure their systems to pay the government rates for dates of services back to October 1, 2021 by the original due date of November 30, 2022 and the final extended due date of February 1, 2023.

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Plan Response (Issue):

Empire Health Plus conducted and completed a review of the underpayments for dates of services between October 1, 2021, and December 31, 2022, for Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS), Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Adult Behavioral Health Home and Community Based Services (BH HCBS) & Community Oriented Recovery and Empowerment (CORE) services.

Based on our review the systems were updated timely by November 2022 and an initial claims reconciliation project to reconcile impacted claims was initiated. However due to the complexity of the criteria claims were missed from the initial project. Once the plan was informed of the underpayment through the OMH Compliance Memo, the plan performed a throughout review to identify all impacted claims, which was completed on January 23, 2023.

Between January 23, 2023, and June 23, 2023, the plan worked on several projects to reprocessed 217,436 impacted claims. The plan also paid $408,000 in interest on the reprocessed claims. The plan was not able to reprocess all impacted claims by February 1, 2023, as requested by OMH, due to the short turnaround time of 25 days to perform the research, identification, claims reprocessing and payment.

Plan of Action

Empire Health Plus established a tighter End-to End oversight process to monitor compliance and completion of BH Rate Updates within 90 days from Notification of rate updates.

End-to-End Oversight:

The BH Medicaid Ops team is responsible for conducting end-to-end oversight of all Behavioral Health Rate Update/Changes issued by OMH and OASAS.

- *Day 1-30 from Notification Receipt Date*

    - Upon issuance of an OMH/OASAS Rate Update Memo/Notification, the BH Ops team engages and works closely with the cross-functional areas including Pricing and Configuration and Claims operations team to bring awareness of the update and timeline for completion.
    - BH Medicaid Ops conducts weekly workgroup meetings with the cross-functional teams to discuss the progress on the system updates.
- *Day 30-70 from Notification Receipt Date*
    - Once the system is updated, the BH Medicaid Ops coordinates with our Claims Research and Resolution Team to review the criteria used to identify underpaid clean claims.
    - Claims Research and Resolution works on the reconciliation and reprocess clean claims for additional payment.
- *Day 70-90 from Notification Receipt Day*
    - Once the claim reprocessing project is completed, the BH Team review and validate all clean claims were reprocessed correctly.

Responsible Parties:
Alma Duhanxhiu, Director II Medicaid State Ops
Karla D. Velez, Manager II Medicaid State Ops