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:
Healthfirst PHSP, Inc	Focus Survey: MHPAEA Testing Phase I and Phase II Workbooks
STREET ADDRESS, CITY, STATE, ZIP CODE	**SURVEY DATES:**
100 Church Street, 17th Floor New York, NY 10007	August 22, 2018 – September 8, 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.** **Deficiency:** Based on the review of Healthfirst PHSP, Inc. 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 8 of 9 NQTLS examined; prior authorization, concurrent review, medical necessity criteria, formulary design, coding edits, out of network coverage standards, geographic restrictions and reimbursement. • Specifically, in Phase I, Healthfirst PHSP, Inc. (Healthfirst) reported conflicting information in inpatient prior authorization and medical necessity criteria (Steps 2 through 5). For outpatient and prescription drug prior authorization, Healthfirst failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency and provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent	**Deficiency Overview:** In the statement of deficiency noted in the first column, the Department has annotated 5 key factors that contributed to the overall deficiency, which Healthfirst summarizes as follows: *1- Inpatient – Conflicting information* *2-* Outpatient and prescription drugs – Undefined factors *3-* Concurrent review (inpatient and outpatient) – undefined factors triggering NQTL and evidentiary standards *4- Inpatient and Outpatient - Lack of comparative analyses for evidentiary standards and factors* *5- Inpatient, Outpatient, Emergency and Out-of-Network coverage standards – Lack of comparative analyses for coding edits, reimbursement, operation comparability and equivalent stringency* *6- Prescription Drugs – Lack of comparative analyses for reimbursement and equivalent stringency for formulary design.* **Corrective Action Plan:** ***Phase I-related corrections:*** A. Issue: We provided conflicting information in inpatient prior authorization and medical necessity criteria (Steps 2 through 5) Resolution Plan: In order to resolve the inconsistencies, we have planned to, and at this date have essentially completed, a review

stringency, (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency. For concurrent review, Healthfirst failed to (Step 2) identify factors triggering the NQTL (inpatient and outpatient), define factors in (Step 3) evidentiary standards comparability and equivalent stringency and provide substantive comparative analyses for (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, outpatient, and prescription drugs. Healthfirst failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency (inpatient and outpatient) and provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency (inpatient and outpatient), (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for inpatient, outpatient, and prescription drug medical necessity criteria. Additionally, Healthfirst failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 4) as written comparability and equivalent stringency for prescription drug formulary design. • Specifically, in Phase II, Healthfirst failed to provide all information and substantive comparative analyses (Steps 1 through 5) for inpatient and outpatient coding edits and inpatient, outpatient and prescription drug reimbursement. Healthfirst failed to provide a substantive comparative analysis for (Step 5) in operation comparability and equivalent stringency for inpatient, outpatient, and emergency care out of network coverage standards. Additionally, the MCO failed to provide all information and substantive comparative analyses (Steps 2 through 5) for inpatient geographic restrictions.	of our relevant policies to identify points of comparison to ensure we are consistent in our stated UR criteria for inpatient prior authorization requests. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section. B. Issue: For outpatient and prescription drug prior authorization, we failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency and provide substantive comparative analyses for (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. Resolution Plan: In an effort to pull in the evidentiary standards we rely on, we have begun to review the standards that we rely on from our clinical vendors so that we can ensure the standards they have tested match our criteria across the medical and behavioral health spectrum, ensuring equivalent stringency (or less stringency for behavioral health), for each step within outpatient and prescription drug prior authorization. The comparative analyses will be performed by Healthfirst using a tool we are implementing in June 2021, and results should be available for our review during the summer of 2021 to ensure compliance by the end of our project associated with this corrective action plan. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section.

	C. Issue: For concurrent review, we failed to (Step 2) identify factors triggering the NQTL (inpatient and outpatient), define factors in (Step 3) evidentiary standards comparability and equivalent stringency and provide substantive comparative analyses for (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, outpatient, and prescription drugs. Resolution Plan: Within the categories of inpatient and outpatient, for concurrent review, we have begun an effort to compare our policies, pull in information we rely on from our vendor resources, and identify and define clear factors that we rely on, and evidentiary standards, to ensure we can accurately cite the level of stringency across the medical / behavioral health spectrum. Furthermore, we are working on a plan to implement a case selection tool that will assist us in determining equivalent stringency in operational comparability for inpatient, outpatient and prescription drugs. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section. D. Issue: We failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency (inpatient and outpatient) and provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency (inpatient and outpatient), (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for inpatient, outpatient, and prescription drug medical necessity criteria.

	Resolution Plan: In an effort to pull in the evidentiary standards we rely on for inpatient and outpatient services, we have begun to review the standards that we rely on from our clinical vendors so that we can ensure the standards they have tested match our criteria across the medical and behavioral health spectrum, ensuring equivalent stringency (or less stringency for behavioral health), for each step and factor. The comparative analyses for this portion will be performed by Healthfirst using a tool we are implementing in June 2021, and results should be available for our review during the summer of 2021 to ensure compliance by the end of our project associated with this corrective action plan. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section. E. Issue: We failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 4) as written comparability and equivalent stringency for prescription drug formulary design. Resolution Plan: The comparative analyses for our prescription drug formulary design, which will not include the Medicaid population due to the impending carve-out effective 5/1/21, will be performed by Healthfirst with our PBM. We expect results from this analysis to be available during the summer of 2021 to ensure compliance by the end this project. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section. ***Phase II-related corrections:***

	A. Issue: We failed to provide all information and substantive comparative analyses (Steps 1 through 5) for inpatient and outpatient coding edits and inpatient, outpatient and prescription drug reimbursement. Healthfirst failed to provide a substantive comparative analysis for (Step 5) in operation comparability and equivalent stringency for inpatient, outpatient, and emergency care out of network coverage standards. Resolution Plan: The comparative analyses for inpatient and outpatient coding edits will be performed by Healthfirst using a tool we are implementing in June 2021, and results should be available for our review during the summer of 2021 to ensure compliance by the end of our project associated with this corrective action plan. The analyses to be performed on the inpatient, outpatient and prescription drug reimbursement methodologies will be performed by Healthfirst and our PBM with assistance from our Claims Department and Analytics, the results of which will allow us to provide evidence of equivalent stringency for these areas. Similarly, the aforementioned tool will also be used to establish an analysis record pertaining to operational comparability for our inpatient, outpatient, emergency care and OON coverage standards. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section. B. Issue: We failed to provide all information and substantive comparative analyses (Steps 2 through 5) for inpatient geographic restrictions. Resolution Plan: The comparative analyses for inpatient geographic restrictions within our service area will be performed by Healthfirst using a tool we are implementing in June 2021, and results should be available for our review during the summer of 2021 to ensure

	compliance by the end of our project associated with this corrective action plan. This will also help us to determine impact of a hospital closure and plan for continuity of care across the spectrum. We have now established a framework, referred to as the "Compliance Monitoring Program" as outlined at the end of this response. This framework will be used to monitor the Corrective Action Plan including the comparative analysis process and any remediation efforts, including reporting and tracking as needed. A statement regarding our commitment to update the workbooks is included in that section. This corrective action plan is currently being managed as a formal project, with defined milestones to confirm each deliverable remains on target as we establish our analysis program. We will also include comparative analyses that encompass reimbursement standards, and non-contracted or emergency coverage standards as applicable. Throughout the development of our compliance program and implementation of this corrective action plan, we will disclose to the State (Department of Health and Office of Mental Health) scenarios that are identified and addressed that impact parity compliance. As part of the corrective action plan, we will perform a data assessment and comparative analysis beginning in July 2021 as outlined in the Compliance Monitoring Program below. Once results are determined, we will identify any disparities impacting comparability or stringency equivalence between Behavioral Health and Medical Services. If there is a reasonable explanation based on category or service that is considered a "natural" disparity due to the nature of the services compared, these will continue to be monitored but will not be deemed actionable for remediation. For those disparities identified, we will assign risk scores to prioritize remediation based on ranking scores, which are based on member impact and controls. Once the prioritized list is complete, we will perform Root Cause Analysis (RCA) for each of the identified disparities beginning with the highest scored deficiencies. Once root cause is determined we will require Remediation Action Plans from appropriate

	business owners. These remediation plans will require business owners to consider both short-term and long-term remediation action steps. The target for remediation will be within 60 days of identification. This timeframe can be adapted with senior departmental leadership as necessary, with Compliance Officer approval. Post-implementation review for each Remediation Action Plan will require a monthly report for at least 3 months to ensure remediation is achieved and sustained. Timing of reports may vary based on content of disparity or issue. Results will be reviewed by Compliance to oversee the monitoring process. **Compliance Monitoring Program** **Following initial July 2021 data assessment, comparative analysis and remediation steps, Healthfirst will do the following:** • Each business area will perform data assessment and comparative analysis using HF data tool on a consistent basis, on a Quarterly schedule; this frequency may be adjusted as appropriate. • Identify any disparity risks between BH and Medical Services • Identify Root Cause Analysis (RCA) of identified disparity risks • Require Remediation Action Plans from appropriate business owners (NOTE: Remediation Plan owner should consider both short term and long-term remediation action steps that should be included to ensure issue is remediated within 60 days of identification. The Senior Leadership of the department responsible for remediating the issue may request for the Chief Compliance Officer and the VP Regulatory Affairs to consider a different timeframe as reasonable based on the disparity risk and root cause(s)) • Collect monitoring evidence of remediation of risks • Monitor and review results to ensure remediation achieved and sustained (example 3 months monitoring) **SAMPLE SCHEDULE**

- Utilizing the tool quarterly to complete data assessment and comparative analysis
- Start date is Q1 2022
- Identify parity risks including consideration of member impact and controls.
    - Communicate with appropriate business owners the risks which need a remediation plan
    - Collect the remediation plans from each business owners
    - Begin monitoring as defined in the remediation plan

Remediation Escalation Process

If a remediation plan fails based on monitoring results, the disparity issue will be escalated to Senior Leadership, Corporate Compliance Committee and the Board-level Audit, Risk and Compliance Committee as appropriate.

Commitment to Retain Updated Workbooks

Healthfirst remains committed to update and maintain the Phase 1 & 2 workbooks as required. Furthermore, as we develop our compliance program we will include the elements of Phase 3 and any supporting data elements to augment these workbooks in support of our comparative analysis results. This may add information to these workbooks but will not detract from or remove any of the required elements.

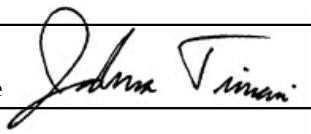
Responsible Parties

The roles listed below represent the individuals defined as the principal point of accountability for their area. We have included a list of the names of individuals currently in those roles outside of this formal document.

Leading this initiative will be:

- **Behavioral Health Medical Director**
- **Physical Health Medical Director**
- **VP Claims**
- **VP Payment Integrity**
- **VP Pharmacy**
- **VP Enterprise Analytics**

	Date Certain We will have a program in place to perform comparative analyses by the beginning of **October 31, 2021**. **Monitoring / Auditing** The **Healthfirst Chief Compliance Officer** will monitor and provide assurance oversight of the comparative analysis program. Monitoring for the establishment of the Compliance Program will be completed by 11/30/21. Ongoing recurrent monitoring processes have been established as part of the Compliance Monitoring Program described above. Internal Auditing will be initiated as deemed necessary. **Education** Corporate training will be developed to educate employees responsible for establishing and maintaining parity during any policy changes, system updates or document edits throughout the year. This training roll-out will be completed by July 2021.

MCO Representative's Signature 	Date 7/13/2021
Title Director, Regulatory Affairs	