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:**
Amida Care, Inc.	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Virtual Focus Survey **Survey ID #** 1663075122
STREET ADDRESS, CITY, STATE, ZIP CODE 14 Penn Plaza, 2nd Floor New York, NY 10122	**SURVEY DATES:** September 14, 2022 – November 1, 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**
10 NYCRR 98- 4.4 Mental health and substance use disorder parity compliance program (a) Every MCO shall adopt and implement a compliance program that shall include at a minimum: (1) designation of an appropriately experienced individual who shall: (i) be responsible for assessing, monitoring, and managing parity compliance; (ii) report directly to the MCO's chief executive officer or other senior manager; and (iii) report no less than annually to the MCO's board of directors or other governing body, or the appropriate committee thereof, on the activities of the compliance program; 2) written policies and procedures that implement the compliance program, and that describe how the MCO's parity compliance is assessed, monitored, and managed, including: (i) a system for assigning each benefit to the defined benefit classifications as required by MHPAEA; (ii) methodologies for the identification and testing of all financial requirements and quantitative treatment limitations; and (iii) methodologies for the identification and testing, including a comparative analysis, of all non-quantitative treatment limitations that are imposed on mental health or substance use disorder benefits; (3) methodologies for the identification and remediation of improper practices, as described in paragraph (1) of subdivision (b) of this section; (4) a system for the ongoing assessment of parity compliance….	**10 NYCRR 98- 4.4 Mental health and substance use disorder parity compliance program** I. Regarding the deficiency of failing to provide sufficient comparative analyses demonstrating compliance with MHPAEA, P.L. 110-343, for the prior authorization, concurrent review, and outlier review NQTLs, Amida Care offers the following: A. Amida Care will complete sufficient comparative analyses for these three (3) NQTLs. With the assistance of the MHPAEA consultants, Amida will update the state's prior authorization, concurrent review, and outlier review workbooks (e.g., Steps 1-4) by the assigned business owners to ensure they are current, accurate, and complete with an expectation that they are maintained accordingly. The comparative analysis will be based on the factors and required steps identified in the NQTL Checklist for business owners: • Step 1: Identify generally applied triggers, timelines, forms and requirements between MH/SUD and M/S across all benefit classifications. • Step 2: Identify the factors and triggers used by Amida Care and comparability between MH/SUD and M/S services. • Step 3: Identify any underlying evidentiary standards—including objective standards used for the factors identified in Step 2 and other standards used for designing and applying protocols—and their comparability between MH/SUD and M/S. • Step 4: Compare processes and procedures for MH/SUD and M/S <u>as written</u>. • Step 5: Compare process and procedures for MH/SUD and M/S <u>in operation</u>, including relevant data. • Step 6: Provide a detailed summary explanation of how the analyses of all the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits are compliant with MHPAEA.

	In providing a comparative analysis for each of the three NQTLs, Amida Care will collaborate with the health plan's behavioral health delegate, Carelon. In addition, in the development of the comparative analyses, the factors set forth in the steps and NQTLs will be evaluated using the direction provided within each associated state workbook. Completion date 6/1/2024. Accountable parties: [redacted] Vice President of Integrated Care and Behavioral Health; [redacted], Vice President of Clinical Services and Programs; [redacted] Director of Vendor Performance; [redacted], Senior Director of Compliance/Compliance Officer B. Amida Care will complete structural enhancements to the health plan's current mental health parity compliance program as follows: 1. Amida Care will assign individual business owners to each NQTL who will remain accountable for ensuring ongoing NQTL parity compliance, including the maintenance of the prior authorization, concurrent review, and outlier review NQTL workbooks. Completion date 3/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer 2. Amida Care will implement an ongoing schedule for each assigned business owner for the health plan's NQTLs to annually present their full written comprehensive NQTL comparative analysis to Amida Care's parity oversight committee, the Benefits Management and Oversight Committee (BMOC). The presentations by the business owners are expected to demonstrate parity compliance or remediation needs for the health plan, utilizing comparisons of process details for M/S and MH/SUD, as well as comparisons of key metric data points. This detailed NQTL presentation is in addition to the ongoing quarterly data metric reporting by the business owner to the BMOC. The BMOC is expected to evaluate the NQTL details, including process and metric comparisons to assess for completeness and to identify any information gaps, as able, while providing guidance and/or direction to remedy comparative analyses, revise policies, or adjust procedures. Ad hoc NQTL revisions would also be reported to the BMOC as they occur. Ongoing monitoring by the BMOC will occur for any identified shortcomings to ensure remediation. In addition, the BMOC is obligated to timely report any mental health parity non-compliance to the health plan leadership upon identification so that noncompliance can be remedied more swiftly. Finally, BMOC parity compliance activities, including any parity remediation needs, will be reported quarterly to the Amida's Compliance Committee, which includes health plan leadership membership, for ongoing monitoring to ensure resolution. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer 3. Amida Care will formalize a Parity Dashboard to capture key NQTL metrics and facilitate committee review. Currently, the committee utilizes a data reporting schedule for quarterly reporting of information to the committee. This will be developed into a data dashboard for quarterly reporting and will include any health plan identified and certain state-level designated metrics for key NQTL functions. Any identified parity risks will be escalated to the health plan leadership for awareness and remediation. Further, the committee will provide remediation direction and monitor

resolution of any parity risks, while also reporting updates on same to the health plan Compliance Committee quarterly. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer

4. Amida Care will enhance its Parity Compliance Program and corresponding Parity Compliance Program Policy provided to DOH in connection with the Virtual Focus Survey to reflect enhancements reflected in this Plan of Correction. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer
5. Amida Care retained experienced MHPAEA consulting services on 1/31/24 to assist with NQTL parity compliance and completion of detailed comparative analyses according to state and federal expectations.

II. Regarding the state's concern that Amida Care reported that a comparative analysis was not possible for certain concurrent review processes, Amida Care offers the following:

Amida Care misstated that a comparative analysis was not possible for concurrent review of MH/SUD and M/S services. Amida Care will remedy this error by providing a comparative analysis for concurrent review processes, drawn from the information elicited through the steps above. Completion date 6/1/2024. Accountable parties: [redacted] Vice President of Integrated Care and Behavioral Health; [redacted], Vice President of Clinical Services and Programs; [redacted], Director of Vendor Performance; [redacted], Senior Director of Compliance/Compliance Officer

III. Regarding the deficiency that the outlier review NQTL demonstrated the factor of high dollar claims is being applied more stringently to MH/SUD services than to M/S services with a threshold $150,000 for M/S services and a $10,000 threshold for MH/SUD services, Amida Care will address this in its comparability analysis. Nevertheless, it offers the following:

Applying the state's clarifying position of the outlier review definition and in collaboration with Amida Care's behavioral health vendor to understand their process details, Amida Care was able to determine that the Carelon's $10,000 threshold should not have been included by Carelon in the health plan's outlier review NQTL workbook. This threshold is reported by Carelon as a process to ensure financial claim payment accuracy. Carelon has advised Amida Care that these claims are not subject to denial for coverage or medical necessity purposes.

The NYSDOH has advised that the outlier review workbook NQTL should include any algorithms and/or triggers that result in identifying outliers that can result in a claim being subject to secondary review and disposition (i.e., paid or denied). That is not the case with Carelon's $10,000 threshold. Carelon is pending these claims prior to payment only so that they can ensure proper payment (e.g., use of current codes, completion of all fields); it does not identify claims for further medical necessity review or to reduce or deny payment. Instead, the threshold is reported by Carelon as a process to ensure financial claim payment accuracy. This is an internal payment accuracy process. Carelon has

advised Amida Care that these claims are not subject to denial and the threshold does not limit or restrict any MH/SUD benefits.

M/S services are subject to a high-cost outlier review trigger of $150,000, while MH/SUD services are not. This high-cost trigger, which provides an additional basis for Amida Care to review the medical necessity of M/S services, is a more restrictive treatment limitation for M/S services relative to MH/SUD services and, thus, cannot be construed as a MHPAEA violation.

There is no high-cost medical necessity review trigger for MH/SUD services. Carelon performs a financial accuracy review on claims above $10,000 to verify accuracy of claims data, but such audit does not include an assessment of the medical record, a determination of medical necessity, or a denial of coverage for such claim. The $10,000 financial accuracy review is not a "utilization review" within the meaning of Article 49 of the New York Public Health Law and does not, at any point, trigger a "utilization review." Thus, the $10,000 claim threshold for MH/SUD services was misreported in the workbook and cannot be construed as a treatment limitation under the outlier review NQTL.

With this said, the M/S threshold should be interpreted as a more stringent standard for M/S than for MH/SUD services for this NQTL. Amida Care will ensure that during the comparative analysis cited as part of I.A. above for outlier reviews, the workbook will be corrected to reflect the processes correctly and accordingly. During this comparative analysis, Amida Care will also work on identifying triggering factors and will fully assess them for both M/S and MH/SUD that may impact the outlier review NQTL which will be reflected in the NQTL comparative analyses.

IV. Regarding the deficiency cited for Amida's Carelon which reflects a significantly higher percentage of mental health concurrent reviews for psychiatric inpatient (11.25%) subjected to second-level review than were performed for M/S services provided in skilled nursing facilities and inpatient hospitals (1.3%), Amida Care will address this more fully in its comparative analysis for concurrent review, but nonetheless offers the following:

A. Upon receipt of the deficiencies from the state, Amida Care required that Carelon evaluate the concurrent psychiatric inpatient review cases that were referred to second level review, which resulted in the state's numerical declaration of MH/SUD percentages referred, to determine root cause, appropriateness of referrals, and final member impact (covered or denied). Carelon completed their evaluation on 02/02/2024 with reporting of their results to the health plan

MCO Representatives Signature [redacted]	Date: 5/15/24
Title Senior Director of Compliance/Compliance Officer	

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

Name of Managed Care Organization Amida Care, Inc.	**Survey Dates:** September 14, 2022 – November 1, 2023 **Survey ID #** 1663075122
Deficiencies	**Plan of Correction with Timetable**
	Carelon reported that their evaluation revealed that they inadvertently and improperly included any concurrent review that was sent to a physician for review even if the referral to the physician was for a case consultation and was not for medical necessity determination purposes. Carelon had included physician case consultations in their data in "Attachment B." Case consultations are not made to reduce or deny coverage based on medical necessity and, therefore, are outside the scope of concurrent review. Carelon may offer a case consultation, but the facility attending physician is not required to participate. Case consultations offer an opportunity for a collaborative discussion with the attending physician for the purpose of: i. supporting the current treatment plan and ensuring quality care while targeting improving member outcomes; ii. discussing potential discharge planning options for complex cases or for members who have had frequent admissions/readmission; and iii. discussing medication options for members with complex needs, co-occurring disorders, and with a history of high utilization and lack of stability in the community setting. To reiterate, this optional case consultation is not a second level review that evaluates medical necessity or can result in a denial of coverage. Accordingly, it is not a "utilization review" under Article 49 of the Public Health Law and, thus, not a treatment limitation within the scope of the concurrent review NQTL. Below, Amida offers a corrected table of concurrent data with the case consultation data removed. During that period, there were no cases sent for a second level review for medical necessity as defined by the State. A corrected data table for the inpatient psychiatric hospital concurrent review cases is shown below. These corrected results reflect the second level referral percentage change from the state's prior calculated 11.25% to now 0%. **Finally, and most importantly, Amida Care confirmed that none of the members associated in these situations were denied coverage by Carelon. All requests were approved for the services under Carelon's review.**

Deficiency:

Based on review of the Phase I, Phase II, and Phase III nonquantitative treatment limitation (NQTL) workbooks, specific in-operation NQTL requests (Focus Survey Attachment A), and the Mental Health Prior Authorization Information Request (Attachment B) submitted in response to the Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Virtual Focus Survey, Amida Care Inc. (Amida Care) failed to provide a sufficient comparative analyses demonstrating compliance with MHPAEA, P.L. 110-343, for the following NQTLs:

- prior authorization,
- concurrent review, and
- outlier review.

Additionally, Amida Care failed to remediate improper practices identified for current review and outlier review.

Specifically, during the review of the prior authorization and concurrent review workbooks it was found that responses for Steps 1-4 were not updated. While Amida Care indicated zero percent denial rates for mental health/substance use disorder (MH/SUD) services, the MCO reported that a comparative analysis was not possible for certain processes.

For outlier review, Amida Care failed to submit a sufficient comparative analysis demonstrating in-operation comparability and no more stringent application of the NQTL. Additionally, the MCO's workbook submission demonstrated the factor of high dollar claims being applied more stringently to MH/SUD than to medical/surgical (M/S). The threshold for M/S was $150,000 and $10,000 for MH/SUD.

The Attachment B for concurrent review identified that the MCO's behavioral health vendor, Beacon Health Options (Beacon), has a significantly higher percentage of mental health concurrent reviews for psychiatric inpatient going to second-level review than Amida Care does for skilled nursing facilities and inpatient hospitals. For inpatient concurrent review, first-level review was not approved and sent to second-level review 11.25% of the time for MH/SUD services whereas this only occurred 1.3% of the time for M/S services.

Concurrent Review (CR)	INPATIENT Psychiatric Hospital
Number of CR Authorizations Requested	50
Number of Requests Approved	50
Number of Requests Denied Based on Medical Necessity	0
Number of Requests whereby coverage was approved but modified Based on Medical Necessity (i.e., approved for another level of care)	0
Total Number of first level reviews that resulted in approval	50
Total Number of first level reviews that are sent to second level review	0
Percentage of CR Claims that auto-adjudicate	32%
Percentage of CR Claims subject to post payment recoupment	0%

B. Amida Care will require Carelon to report inpatient concurrent review second level referral data to the health plan on an ongoing basis through the Parity Dashboard for monitoring by the BMOC. Once ongoing reporting is established, should the data reported reveal a concerning level of referrals to the second level of review and/or a resulting increase in denials, Amida Care will conduct an investigation of the associated casework to determine root cause of referrals, referral appropriateness, and whether any actions are needed for remediation. Consistent with the processes identified above, Amida Care will utilize data to remediate any concurrent review practices that do not promote parity compliance. Completion date 6/1/2024. Accountable party: [redacted], Director of Vendor Performance

C. Amida Care will deliver data element definitions to Carelon for any future data requested to ensure accuracy and consistency in reporting between M/S and MH/SUD information. This will be incorporated into the parity compliance program as part of the action cited as I.B.4 above.

PHL § 4406 Health maintenance organizations; regulation of contracts

I. Regarding the deficiency of failing to provide sufficient comparative analyses demonstrating compliance with MHPAEA, P.L. 110-343, for the prior authorization, concurrent review, and outlier review NQTLs, Amida Care offers the following:

A. Amida Care will complete sufficient comparative analyses for these three (3) NQTLs. With the assistance of the MHPAEA consultants, Amida will update the state's prior authorization, concurrent review, and outlier review workbooks (e.g., Steps 1-4) by the assigned business owners to ensure they are current, accurate, and complete with an expectation that they are maintained accordingly. The comparative analysis will be based on the factors and required steps identified in the NQTL Checklist for business owners:

- Step 1: Identify generally applied triggers, timelines, forms and requirements between MH/SUD and M/S across all benefit classifications.
- Step 2: Identify the factors and triggers used by Amida Care and comparability between MH/SUD and M/S services.
- Step 3: Identify any underlying evidentiary standards—including objective standards used for the factors identified in Step 2 and other standards used for designing and applying protocols—and their comparability between MH/SUD and M/S.

- Step 4: Compare processes and procedures for MH/SUD and M/S as written.
- Step 5: Compare process and procedures for MH/SUD and M/S in operation, including relevant data.
- Step 6: Provide a detailed summary explanation of how the analyses of all the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits are compliant with MHPAEA.

In providing a comparative analysis for each of the three NQTLs, Amida Care will collaborate with the health plan's behavioral health delegate, Carelon. In addition, in the development of the comparative analyses, the factors set forth in the steps and NQTLs will be evaluated using the direction provided within each associated state workbook. Completion date 6/1/2024. Accountable parties: [redacted] Vice President of Integrated Care and Behavioral Health; [redacted], Vice President of Clinical Services and Programs; [redacted], Director of Vendor Performance; [redacted]l, Senior Director of Compliance/Compliance Officer

B. Amida Care will complete structural enhancements to the health plan's current mental health parity compliance program as follows:

2. Amida Care will assign individual business owners to each NQTL who will remain accountable for ensuring ongoing NQTL parity compliance, including the maintenance of the prior authorization, concurrent review, and outlier review NQTL workbooks. Completion date 3/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer

2. Amida Care will implement an ongoing schedule for each assigned business owner for the health plan's NQTLs to annually present their full written comprehensive NQTL comparative analysis to Amida Care's parity oversight committee, the Benefits Management and Oversight Committee (BMOC). The presentations by the business owners are expected to demonstrate parity compliance or remediation needs for the health plan, utilizing comparisons of process details for M/S and MH/SUD, as well as comparisons of key metric data points. This detailed NQTL presentation is in addition to the ongoing quarterly data metric reporting by the business owner to the BMOC. The BMOC is expected to evaluate the NQTL details, including process and metric comparisons to assess for completeness and to identify any information gaps, as able, while providing guidance and/or direction to remedy comparative analyses, revise policies, or adjust procedures. Ad hoc NQTL revisions would also be reported to the BMOC as they occur. Ongoing monitoring by the BMOC will occur for any identified shortcomings to ensure remediation. In addition, the BMOC is obligated to timely report any mental health parity non-compliance to the health plan leadership upon identification so that noncompliance can be remedied more swiftly. Finally, BMOC parity compliance activities, including any parity remediation needs, will be reported quarterly to the Amida's Compliance Committee, which includes health plan leadership membership, for ongoing monitoring to ensure resolution. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer
3. Amida Care will formalize a Parity Dashboard to capture key NQTL metrics and facilitate committee review. Currently, the committee utilizes a data reporting schedule for quarterly reporting of information to the committee. This will be developed into a data dashboard for quarterly reporting and will include any health plan identified and

certain state-level designated metrics for key NQTL functions. Any identified parity risks will be escalated to the health plan leadership for awareness and remediation. Further, the committee will provide remediation direction and monitor resolution of any parity risks, while also reporting updates on same to the health plan Compliance Committee quarterly. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer

4. Amida Care will enhance its Parity Compliance Program and corresponding Parity Compliance Program Policy provided to DOH in connection with the Virtual Focus Survey to reflect enhancements reflected in this Plan of Correction. Completion date 6/1/2024. Accountable party: [redacted] Director of Compliance/Compliance Officer
5. Amida Care retained experienced MHPAEA consulting services on 1/31/24 to assist with NQTL parity compliance and completion of detailed comparative analyses according to state and federal expectations.

II. Regarding the state's concern that Amida Care reported that a comparative analysis was not possible for certain concurrent review processes, Amida Care offers the following:

Amida Care misstated that a comparative analysis was not possible for concurrent review of MH/SUD and M/S services. Amida Care will remedy this error by providing a comparative analysis for concurrent review processes, drawn from the information elicited through the steps above. Completion date 6/1/2024. Accountable parties: [redacted]-[redacted]ly, Vice President of Integrated Care and Behavioral Health; [redacted], Vice President of Clinical Services and Programs; [redacted], Director of Vendor Performance; [redacted], Senior Director of Compliance/Compliance Officer

III. Regarding the deficiency that the outlier review NQTL demonstrated the factor of high dollar claims is being applied more stringently to MH/SUD services than to M/S services with a threshold $150,000 for M/S services and a $10,000 threshold for MH/SUD services, Amida Care will address this in its comparability analysis. Nevertheless, it offers the following:

Applying the state's clarifying position of the outlier review definition and in collaboration with Amida Care's behavioral health vendor to understand their process details, Amida Care was able to determine that the Carelon's $10,000 threshold should not have been included by Carelon in the health plan's outlier review NQTL workbook. This threshold is reported by Carelon as a process to ensure financial claim payment accuracy. Carelon has advised Amida Care that these claims are not subject to denial for coverage or medical necessity purposes.

The NYSDOH has advised that the outlier review workbook NQTL should include any algorithms and/or triggers that result in identifying outliers that can result in a claim being subject to secondary review and disposition (i.e., paid or denied). That is not the case with Carelon's $10,000 threshold. Carelon is pending these claims prior to payment only so that they can ensure proper payment (e.g., use of current codes, completion of all fields); it does not identify claims for further medical necessity review or to reduce or deny payment. Instead, the threshold is reported by Carelon as a process to ensure financial claim payment accuracy. This is an internal payment accuracy process. Carelon has advised Amida Care that these claims are not subject to denial and the threshold does not limit or restrict any MH/SUD benefits.

M/S services are subject to a high-cost outlier review trigger of $150,000, while MH/SUD services are not. This high-cost trigger, which provides an additional basis for Amida Care to review the medical necessity of M/S services, is a more restrictive treatment limitation for M/S services relative to MH/SUD services and, thus, cannot be construed as a MHPAEA violation.

There is no high-cost medical necessity review trigger for MH/SUD services. Carelon performs a financial accuracy review on claims above $10,000 to verify accuracy of claims data, but such audit does not include an assessment of the medical record, a determination of medical necessity, or a denial of coverage for such claim. The $10,000 financial accuracy review is not a "utilization review" within the meaning of Article 49 of the New York Public Health Law and does not, at any point, trigger a "utilization review." Thus, the $10,000 claim threshold for MH/SUD services was misreported in the workbook and cannot be construed as a treatment limitation under the outlier review NQTL.

With this said, the M/S threshold should be interpreted as a more stringent standard for M/S than for MH/SUD services for this NQTL. Amida Care will ensure that during the comparative analysis cited as part of I.A. above for outlier reviews, the workbook will be corrected to reflect the processes correctly and accordingly. During this comparative analysis, Amida Care will also work on identifying triggering factors and will fully assess them for both M/S and MH/SUD that may impact the outlier review NQTL which will be reflected in the NQTL comparative analyses.

IV. Regarding the deficiency cited for Amida's Carelon which reflects a significantly higher percentage of mental health concurrent reviews for psychiatric inpatient (11.25%) subjected to second-level review than were performed for M/S services provided in skilled nursing facilities and inpatient hospitals (1.3%), Amida Care will address this more fully in its comparative analysis for concurrent review, but nonetheless offers the following:

A. Upon receipt of the deficiencies from the state, Amida Care required that Carelon evaluate the concurrent psychiatric inpatient review cases that were referred to second level review, which resulted in the state's numerical declaration of MH/SUD percentages referred, to determine root cause, appropriateness of referrals, and final member impact (covered or denied). Carelon completed their evaluation on 02/02/2024 with reporting of their results to the health plan

Carelon reported that their evaluation revealed that they inadvertently and improperly included any concurrent review that was sent to a physician for review even if the referral to the physician was for a case consultation and was not for medical necessity determination purposes.

Carelon had included physician case consultations in their data in "Attachment B." Case consultations are not made to reduce or deny coverage based on medical necessity and, therefore, are outside the scope of concurrent review. Carelon may offer a case consultation, but the facility attending physician is not required to participate. Case consultations offer an opportunity for a collaborative discussion with the attending physician for the purpose of:

i. supporting the current treatment plan and ensuring quality care while targeting improving member outcomes;
ii. discussing potential discharge planning options for complex cases or for members who have had frequent admissions/readmission; and
iii. discussing medication options for members with complex needs, co-occurring disorders, and with a history of high utilization and lack of stability in the community setting.

To reiterate, this optional case consultation is not a second level review that evaluates medical necessity or can result in a denial of coverage. Accordingly, it is not a "utilization review" under Article 49 of the Public Health Law and, thus, not a treatment limitation within the scope of the concurrent review NQTL.

Below, Amida offers a corrected table of concurrent data with the case consultation data removed. During that period, there were no cases sent for a second level review for medical necessity as defined by the State. A corrected data table for the inpatient psychiatric hospital concurrent review cases is shown below. These corrected results reflect the second level referral percentage change from the state's prior calculated 11.25% to now 0%. **Finally, and most importantly, Amida Care confirmed that none of the members associated in these situations were denied coverage by Carelon. All requests were approved for the services under Carelon's review.**

Concurrent Review (CR)	INPATIENT Psychiatric Hospital
Number of CR Authorizations Requested	50
Number of Requests Approved	50
Number of Requests Denied Based on Medical Necessity	0
Number of Requests whereby coverage was approved but modified Based on Medical Necessity (i.e., approved for another level of care)	0
Total Number of first level reviews that resulted in approval	50
Total Number of first level reviews that are sent to second level review	0
Percentage of CR Claims that auto-adjudicate	32%
Percentage of CR Claims subject to post payment recoupment	0%

B. Amida Care will require Carelon to report inpatient concurrent review second level referral data to the health plan on an ongoing basis through the Parity Dashboard for monitoring by the BMOC. Once ongoing reporting is established, should the data reported reveal a concerning level of referrals to the second level of review and/or a resulting increase in denials, Amida Care will conduct an investigation of the associated casework to determine root cause of referrals, referral appropriateness, and whether any actions are needed for remediation. Consistent with the processes identified above, Amida Care will utilize data to remediate any concurrent review practices that do not promote parity compliance. Completion date 6/1/2024. Accountable party: [redacted], Director of Vendor Performance

C. Amida Care will deliver data element definitions to Carelon for any future data requested to ensure accuracy and consistency in reporting between M/S and MH/SUD information. This will be incorporated into the parity compliance program as part of the action cited as I.B.4 above.

NEW YORK STATE DEPARTMENT OF HEALTH ARTICLE 44 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION CONTINUATION SHEET	
Name of Managed Care Organization Amida Care, Inc.	**Survey Dates:** September 14, 2022 – November 1, 2023 **Survey ID #** 1663075122
Deficiencies	**Plan of Correction with Timetable**

This was discussed with Amida Care during an exit conference call on November 1, 2023. **PHL § 4406 Health maintenance organizations; regulation of contracts** **1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of one hundred or fewer employees or members, exclusive of spouses and dependents, or to any employee or member of the group, including dependents, applying for such contract at any time throughout the year. An individual direct payment contract shall be issued only in accordance with section four thousand three hundred twenty-eight of the insurance law. The superintendent may, after giving consideration to the public interest, exempt a health maintenance organization from the requirements of this section provided that another health insurer or health maintenance organization within the health maintenance organization's same holding company system, as defined in article fifteen of the insurance law, including a health maintenance organization operated as a line of business of a health service corporation licensed under article forty-three of the insurance law, offers coverage that, at a minimum, complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to this chapter and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of this chapter. The requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled**	

pursuant to title eleven of article five of the social services law, 1 title eleven-D of article five of the social services law, 2 title one-A of article twenty-five of this chapter 3 or title eighteen of the federal Social Security Act, 4 and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four.

4303(g) 4303(k) and 4303(l) State Insurance Law

Deficiency:
Based on review of the Phase I, Phase II, and Phase III nonquantitative treatment limitation (NQTL) workbooks, specific in-operation NQTL requests (Focus Survey Attachment A), and the Mental Health Prior Authorization Information Request (Attachment B) submitted in response to the Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Virtual Focus Survey, Amida Care Inc. (Amida Care) failed to provide a sufficient comparative analyses demonstrating compliance with MHPAEA, P.L. 110-343, for the following NQTLs:

- prior authorization, • concurrent review, and
- outlier review.

Additionally, Amida Care failed to demonstrate compliance with MHPAEA for concurrent and outlier review.

Specifically, during the review of the prior authorization and concurrent review workbooks, it was found that responses for Steps 1-4 were not updated. While Amida Care indicated zero percent denial rates for mental health/substance use disorder (MH/SUD) services, the MCO reported that a comparative analysis was not possible for certain processes.

For outlier review, Amida Care failed to submit a sufficient comparative analysis demonstrating in-operation comparability and no more stringent application of the

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

Name of Managed Care Organization Amida Care, Inc.	**Survey Dates:** September 14, 2022 – November 1, 2023 **Survey ID #** 1663075122
Deficiencies	**Plan of Correction with Timetable**
NQTL. Additionally, the MCO's workbook submission demonstrated the factor of high dollar claims being applied more stringently to MH/SUD than to medical/surgical (M/S). The threshold for M/S was $150,000 and $10,000 for MH/SUD. The review of Attachment B for concurrent review identified that the MCO's behavioral health vendor, Beacon Health Options (Beacon), has a significantly higher percentage of mental health concurrent reviews for psychiatric inpatient going to second-level review than Amida Care does for skilled nursing facilities and inpatient hospitals. For inpatient concurrent review, first-level review was not approved and sent to second-level review 11.25% of the time for MH/SUD services whereas this only occurred 1.3% of the time for M/S services. This was discussed with Amida Care during an exit conference call on November 1, 2023.	

Statement of Findings
Amida Care, Inc.
Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance
Virtual Focus Survey
Survey Dates: September 14, 2022 – November 1, 2023
Survey ID: 1663075122

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations
h.) Mental Health and Substance Use Disorder Benefits Parity Requirements ii.) The Contractor shall comply with mental health and substance use disorder benefits parity requirements for financial requirements and treatment limitations specified in 42 CFR 438.910.

18.5 Reporting Requirements
a) The Contractor shall submit the following reports to SDOH (unless otherwise specified). The Contractor will certify the data submitted pursuant to this section as required by SDOH. The certification shall be in the manner and format established by SDOH and must attest, based on best knowledge, information, and belief to the accuracy, completeness and truthfulness of the data being submitted. xxii) Mental Health and Substance Use Disorder Parity Reporting Requirements Upon request by the SDOH, OMH or OASAS the Contractor shall prepare and submit documentation and reports, in a form and format specified by SDOH, OMH or OASAS, necessary for the SDOH, OMH or OASAS to establish and demonstrate compliance with 42 CFR 438 Subpart K, and applicable State statute, rules and guidance.

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.

Findings:
Based on review of the Phase I, Phase II, and Phase III nonquantitative treatment limitation (NQTL) workbooks, specific in-operation NQTL requests (Focus Survey Attachment A), and the Mental Health Prior Authorization Information Request (Attachment B) submitted in response to the Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Virtual Focus Survey, Amida Care Inc. (Amida Care) failed to provide a sufficient comparative analyses demonstrating compliance with MHPAEA, P.L. 110-343, for the following NQTLs:
- prior authorization,
- concurrent review, and
- outlier review.

Additionally, Amida Care failed to demonstrate compliance with MHPAEA for concurrent and outlier review.

Specifically, during the review of the prior authorization and concurrent review workbooks, it was found that responses for Steps 1-4 were not updated. While Amida Care indicated zero percent denial rates for mental health/substance use disorder (MH/SUD) services, the MCO reported that a comparative analysis was not possible for certain processes.

For outlier review, Amida Care failed to submit a sufficient comparative analysis demonstrating in-operation comparability and

no more stringent application of the NQTL. Additionally, the MCO's workbook submission demonstrated the factor of high dollar claims being applied more stringently to MH/SUD than to medical/surgical (M/S). The threshold for M/S was $150,000 and $10,000 for MH/SUD.

The review of Attachment B for concurrent review identified that the MCO's behavioral health vendor, Beacon Health Options (Beacon), has a significantly higher percentage of mental health concurrent reviews for psychiatric inpatient going to second-level review than Amida Care does for skilled nursing facilities and inpatient hospitals. For inpatient concurrent review, first-level review was not approved and sent to second-level review 11.25% of the time for MH/SUD services whereas this only occurred 1.3% of the time for M/S services.

This was discussed with Amida Care during an exit conference call on November 1, 2023.

Amida Care's Response:

I. Regarding the deficiency of failing to provide sufficient comparative analyses demonstrating compliance with MHPAEA, P.L. 110-343, for the prior authorization, concurrent review, and outlier review NQTLs, Amida Care offers the following:

A. Amida Care will complete sufficient comparative analyses for these three (3) NQTLs. With the assistance of the MHPAEA consultants, Amida will update the state's prior authorization, concurrent review, and outlier review workbooks (e.g., Steps 1-4) by the assigned business owners to ensure they are current, accurate, and complete with an expectation that they are maintained accordingly. The comparative analysis will be based on the factors and required steps identified in the NQTL Checklist for business owners:

- Step 1: Identify generally applied triggers, timelines, forms and requirements between MH/SUD and M/S across all benefit classifications.
- Step 2: Identify the factors and triggers used by Amida Care and comparability between MH/SUD and M/S services.
- Step 3: Identify any underlying evidentiary standards—including objective standards used for the factors identified in Step 2 and other standards used for designing and applying protocols—and their comparability between MH/SUD and M/S.
- Step 4: Compare processes and procedures for MH/SUD and M/S as written.
- Step 5: Compare process and procedures for MH/SUD and M/S in operation, including relevant data.
- Step 6: Provide a detailed summary explanation of how the analyses of all the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits are compliant with MHPAEA.

In providing a comparative analysis for each of the three NQTLs, Amida Care will collaborate with the health plan's behavioral health delegate, Carelon. In addition, in the development of the comparative analyses, the factors set forth in the steps and NQTLs will be evaluated using the direction provided within each associated state workbook. Completion date 6/1/2024. Accountable parties: [redacted], Vice President of Integrated Care and Behavioral Health; [redacted], Vice President of Clinical Services and Programs; [redacted], Director of Vendor Performance; [redacted], Senior Director of Compliance/Compliance Officer

B. Amida Care will complete structural enhancements to the health plan's current mental health parity compliance program as follows:

1. Amida Care will assign individual business owners to each NQTL who will remain accountable for ensuring ongoing NQTL parity compliance, including the maintenance of the prior authorization, concurrent review, and outlier review NQTL workbooks. Completion date 3/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer
2. Amida Care will implement an ongoing schedule for each assigned business owner for the health plan's NQTLs to annually present their full written comprehensive NQTL comparative analysis to Amida Care's parity oversight committee, the Benefits Management and Oversight Committee (BMOC). The presentations by the business owners are expected to demonstrate parity compliance or remediation needs for the health plan, utilizing comparisons of process details for M/S and MH/SUD, as well as comparisons of key metric data points. This detailed NQTL presentation is in addition to the ongoing quarterly data metric reporting by the business owner to the BMOC. The BMOC is expected to evaluate the NQTL details, including process and metric comparisons to assess for completeness and to identify any information gaps, as able, while providing guidance and/or direction to remedy comparative analyses, revise policies, or adjust procedures. Ad hoc NQTL revisions would also be reported to the BMOC as they occur. Ongoing monitoring by the BMOC will occur for any identified shortcomings to ensure remediation. In addition, the BMOC is obligated to timely report any mental health parity non-compliance to the health plan leadership upon identification so that noncompliance can be remedied more swiftly. Finally, BMOC parity compliance activities, including any parity remediation needs, will be reported quarterly to the Amida's Compliance Committee, which includes health plan leadership membership, for ongoing monitoring to ensure resolution. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer
3. Amida Care will formalize a Parity Dashboard to capture key NQTL metrics and facilitate committee review. Currently, the committee utilizes a data reporting schedule for quarterly reporting of information to the committee. This will be developed into a data dashboard for quarterly reporting and will include any health plan identified and certain state-level designated metrics for key NQTL functions. Any identified parity risks will be escalated to the health plan leadership for awareness and remediation. Further, the committee will provide remediation direction and monitor resolution of any parity risks, while also reporting updates on same to the health plan Compliance Committee quarterly. Completion date 6/1/2024. Accountable party: [redacted], Senior Director of Compliance/Compliance Officer
4. Amida Care will enhance its Parity Compliance Program and corresponding Parity Compliance Program Policy provided to DOH in connection with

the Virtual Focus Survey to reflect enhancements reflected in this Plan of Correction. Completion date 6/1/2024. Accountable party: [redacted] Senior Director of Compliance/Compliance Officer

5. Amida Care retained experienced MHPAEA consulting services on 1/31/24 to assist with NQTL parity compliance and completion of detailed comparative analyses according to state and federal expectations.

II. Regarding the state's concern that Amida Care reported that a comparative analysis was not possible for certain concurrent review processes, Amida Care offers the following:

Amida Care misstated that a comparative analysis was not possible for concurrent review of MH/SUD and M/S services. Amida Care will remedy this error by providing a comparative analysis for concurrent review processes, drawn from the information elicited through the steps above. Completion date 6/1/2024. Accountable parties: [redacted], Vice President of Integrated Care and Behavioral Health; [redacted], Vice President of Clinical Services and Programs; [redacted], Director of Vendor Performance; [redacted], Senior Director of Compliance/Compliance Officer

III. Regarding the deficiency that the outlier review NQTL demonstrated the factor of high dollar claims is being applied more stringently to MH/SUD services than to M/S services with a threshold $150,000 for M/S services and a $10,000 threshold for MH/SUD services, Amida Care will address this in its comparability analysis. Nevertheless, it offers the following:

Applying the state's clarifying position of the outlier review definition and in collaboration with Amida Care's behavioral health vendor to understand their process details, Amida Care was able to determine that the Carelon's $10,000 threshold should not have been included by Carelon in the health plan's outlier review NQTL workbook. This threshold is reported by Carelon as a process to ensure financial claim payment accuracy. Carelon has advised Amida Care that these claims are not subject to denial for coverage or medical necessity purposes.

The NYSDOH has advised that the outlier review workbook NQTL should include any algorithms and/or triggers that result in identifying outliers that can result in a claim being subject to secondary review and disposition (i.e., paid or denied). That is not the case with Carelon's $10,000 threshold. Carelon is pending these claims prior to payment only so that they can ensure proper payment (e.g., use of current codes, completion of all fields); it does not identify claims for further medical necessity review or to reduce or deny payment. Instead, the threshold is reported by Carelon as a process to ensure financial claim payment accuracy. This is an internal payment accuracy process. Carelon has advised Amida Care that these claims are not subject to denial and the threshold does not limit or restrict any MH/SUD benefits.

M/S services are subject to a high-cost outlier review trigger of $150,000, while MH/SUD services are not. This high-cost trigger, which provides an additional basis for Amida Care to review the medical necessity of M/S services, is a more restrictive treatment limitation for M/S services relative to MH/SUD services and, thus, cannot be construed as a MHPAEA violation.

There is no high-cost medical necessity review trigger for MH/SUD services. Carelon performs a financial accuracy review on claims above $10,000 to verify accuracy of claims data, but such audit does not include an assessment of the medical record, a determination of medical necessity, or a denial of coverage for such claim. The $10,000 financial accuracy review is not a "utilization review" within the meaning of Article 49 of the New York Public Health Law and does not, at any point, trigger a "utilization review." Thus, the $10,000 claim threshold for MH/SUD services was misreported in the workbook and cannot be construed as a treatment limitation under the outlier review NQTL.

With this said, the M/S threshold should be interpreted as a more stringent standard for M/S than for MH/SUD services for this NQTL. Amida Care will ensure that during the comparative analysis cited as part of I.A. above for outlier reviews, the workbook will be corrected to reflect the processes correctly and accordingly. During this comparative analysis, Amida Care will also work on identifying triggering factors and will fully assess them for both M/S and MH/SUD that may impact the outlier review NQTL which will be reflected in the NQTL comparative analyses.

IV. Regarding the deficiency cited for Amida's Carelon which reflects a significantly higher percentage of mental health concurrent reviews for psychiatric inpatient (11.25%) subjected to second-level review than were performed for M/S services provided in skilled nursing facilities and inpatient hospitals (1.3%), Amida Care will address this more fully in its comparative analysis for concurrent review, but nonetheless offers the following:

A. Upon receipt of the deficiencies from the state, Amida Care required that Carelon evaluate the concurrent psychiatric inpatient review cases that were referred to second level review, which resulted in the state's numerical declaration of MH/SUD percentages referred, to determine root cause, appropriateness of referrals, and final member impact (covered or denied). Carelon completed their evaluation on 02/02/2024 with reporting of their results to the health plan.

Carelon reported that their evaluation revealed that they inadvertently and improperly included any concurrent review that was sent to a physician for review even if the referral to the physician was for a case consultation and was not for medical necessity determination purposes.

Carelon had included physician case consultations in their data in "Attachment B." Case consultations are not made to reduce or deny coverage based on medical necessity and, therefore, are outside the scope of concurrent review. Carelon may offer a case consultation, but the facility attending physician is not required to participate. Case consultations offer an opportunity for a collaborative discussion with the attending physician for the purpose of:

i. supporting the current treatment plan and ensuring quality care while targeting improving member outcomes;
ii. discussing potential discharge planning options for complex cases or for members who have had frequent admissions/readmission; and
iii. discussing medication options for members with complex needs, co-occurring disorders, and with a history of high utilization and lack of stability in the community setting.

To reiterate, this optional case consultation is not a second level review that evaluates medical necessity or can result in a denial of coverage. Accordingly, it is not a "utilization review" under Article 49 of the Public Health Law and, thus, not a treatment limitation within the scope of the concurrent review NQTL.

Below, Amida offers a corrected table of concurrent data with the case consultation data removed. During that period, there were no cases sent for a second level review for medical necessity as defined by the State. A corrected data table for the inpatient psychiatric hospital concurrent review cases is shown below. These corrected results reflect the second level referral percentage change from the state's prior calculated 11.25% to now 0%. **Finally, and most importantly, Amida Care confirmed that none of the members associated in these situations were denied coverage by Carelon. All requests were approved for the services under Carelon's review.**

Concurrent Review (CR)	INPATIENT Psychiatric Hospital
Number of CR Authorizations Requested	50
Number of Requests Approved	50
Number of Requests Denied Based on Medical Necessity	0
Number of Requests whereby coverage was approved but modified Based on Medical Necessity (i.e., approved for another level of care)	0
Total Number of first level reviews that resulted in approval	50
Total Number of first level reviews that are sent to second level review	0
Percentage of CR Claims that auto-adjudicate	32%
Percentage of CR Claims subject to post payment recoupment	0%

B. Amida Care will require Carelon to report inpatient concurrent review second level referral data to the health plan on an ongoing basis through the Parity Dashboard for monitoring by the BMOC. Once ongoing reporting is established, should the data reported reveal a concerning level of referrals to the second level of review and/or a resulting increase in denials, Amida Care will conduct an investigation of the associated casework to determine root cause of referrals, referral appropriateness, and whether any actions are needed for remediation. Consistent with the processes identified above, Amida Care will utilize data to remediate any concurrent review practices that do not promote parity compliance. Completion date 6/1/2024. Accountable party: JaVita Moreira, Director of Vendor Performance

C. Amida Care will deliver data element definitions to Carelon for any future data requested to ensure accuracy and consistency in reporting between M/S and MH/SUD information. This will be incorporated into the parity compliance program as part of the action cited as I.B.4 above.