# 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: |
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| HealthNow of New York, Inc | Submission of completed non-quantitative treatment limitations workbooks to demonstrate compliance with the Mental Health Parity and Addiction Equity Act |
| **STREET ADDRESS, CITY, STATE, ZIP CODE** | **SURVEY DATES:** |
| 257 West Genesee Street<br>Buffalo, NY 14202 | October 30, 2019<br>Survey ID# 704246651 |

**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 |
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| **98-1.16 Disclosure and filing.**<br>**(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.**<br><br>**Deficiency:**<br><br>Required updated and completed phase 1 resubmission of non-quantitative treatment limitations workbooks to demonstrate compliance with the Mental Health Parity and Addiction Equity Act were not received by the State issued due date of October 30, 2019. | [redacted], the Health Plan Behavioral Health (BH) Manager was new to the role and was not part of the first phase 1 submission. The BH manager believed the Phase 2 workbook submission was in response to Phase 1 corrections needed. This was found to not be the case. A follow up meeting with Milliman was requested to clarify what corrections were necessary. The meeting was not scheduled due to Milliman staffing issues. An updated Phase 1 Parity workbook was submitted to the State for review on 11/26/19. |

| MCO Representative's Signature | Date 11/27/2019 |
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| Title Manager of Behavioral Health Services LMHC | |

# 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: |
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| HealthNow of New York, Inc | Focus Survey: MHPAEA Testing Phase I and Phase II Workbooks |
| **STREET ADDRESS, CITY, STATE, ZIP CODE** | **SURVEY DATES:** |
| 257 West Genesee Street<br>Buffalo, NY 14202 | 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 |
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| **10 CRR-NY 98-1.16 Disclosure and filing.**<br>**(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.**<br><br>**Deficiency:**<br><br>Based on the review of HealthNow of New York, Inc.'s (HealthNow) Phase I and Phase II nonquantitative treatment limitation (NQTL) workbook submissions, the MCO failed to provide all required information and comparative analyses demonstrating compliance with the Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345; MHPAEA) for 6 of 9 NQTLS examined; prior authorization, concurrent review, medical necessity criteria, formulary design, coding edits, and out of network coverage standards.<br><br>• Specifically, in Phase I, HealthNow failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug prior authorization. For concurrent review, HealthNow failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent stringency for outpatient. Additionally, HealthNow | Phase I -Deficiency:<br>HealthNow of New York, Inc.'s, now "Highmark Blue Cross Blue Shield of Western New York" (Highmark BCBS WNY) failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug prior authorization.<br><br>Plan Response: Plan is not required to respond to deficiencies related to the Prescription Drug Classification or formulary design NQTL.<br><br>Phase I -Deficiency: For concurrent review, Highmark BCBS WNY -Amerigroup failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent stringency for outpatient.<br><br>Plan Response: The exact date for the implementation of the formal POC is June 29, 2021.<br><br>Method to Revise and Remediate: Factors triggering the NQTL for Inpatient Concurrent Review<br><br>Our process for identifying members to review for IP concurrent review has changed since our initial submission. We do not conduct reviews for any IP Substance Use admissions unless someone remains IP after 28 days. Members less than 18 who are inpatient for psychiatric services are not reviewed unless their length of stay exceeds 14 days. Based on the Guiding Principles for IP psychiatric reviews shared by OMH, we submitted revised workflows for adults who are IP psych to the state for review on January 8, 2021. When we receive feedback from OMH on our proposed workflows related to the IP Concurrent review process we will make |

| MCO Representative's Signature [redacted] | Date June 29, 2021 |
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| failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review.<br><br>The MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug medical necessity criteria and (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug formulary design.<br><br>• Specifically, in Phase II, HealthNow failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits. For outpatient, emergency care, and prescription drug coding edits, the MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency.<br><br>Additionally, the MCO failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL (inpatient only), (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient out of network coverage standards. | the needed changes and update our processes within 45 days.<br><br>Associates will be trained on the revised processes no later than 30 days of finalization. This training will be completed at weekly staff meetings held every Wednesday. Additionally, all teams within BH will again review their focused process at smaller team meetings.<br><br>Documentation of training will be maintained and tracked for completion at least annually.<br><br>Evidentiary Standards for the Comparative Analysis: The PH team conducts concurrent review on an ongoing basis.<br><br>There are no triggers for concurrent reviews. The BH process is not more stringent than the physical health process.<br><br>The workbook was updated to reflect these changes on April 19, 2021.<br><br>Responsible Parties: UM IP Manager – [redacted] - primary, BH Program Manager - [redacted] - secondary<br><br>Staff Training: In addition to the training outlined above, as part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. This is our plan to educate/train staff of any necessary changes to address potential noncompliance. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. The exact date for the implementation of the formal POC is June 29, 2021.<br><br>Ongoing Monitoring: Compliance with state and federal requirements for provision of comparable coverage for benefits to treat mental health and substance use disorder is monitored via the Mental Health and Substance Use Disorder Parity Compliance Program. |

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| | Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.<br><br>Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.<br><br>The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH.<br><br>Plan of Action will include the following:<br>• Identify any processes that appear to be more stringent<br>• Identify changes that need to be implemented to ensure parity<br>• Identify specific due dates and business owners for tracking<br>• Identify the methodology to complete a parity analysis once the changes are implemented to ensure parity compliance<br>• Staff training and dates of training will be included within the action plan.<br><br>Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.<br><br>Milestones for Implementation and Responsible Parties: P[redacted] Director, GBD Quality Management; BH Program Manager - [redacted] secondary |

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| | The next BH QMC meeting is scheduled for August 31, 2021.<br><br>Phase I - Deficiency: Additionally, HealthNow failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review.<br><br>Plan Response: Method to Revise and Remediate: Evidentiary Standards for the Comparative Analysis<br><br>Triggers for review were included in step 2 within the workbook. The workbook was updated to include these on April 19, 2021.<br><br>Highmark BCBS WNY-Amerigroup (BH and PH) uses standard reports that identify gaps in medication fills, gaps in services (i.e. possible need for specialized care, reports identifying need for Case Management due to complexity), and members that may need linkage to CBOs to address SDH. These reports are used to identify members for concurrent reviews. The triggers are compatible for both PH and BH.<br><br>The workbook was updated to include these on April 19, 2021.<br><br>Responsible Parties: BH Program Manager-[redacted] (primary); Director I HCMS – [redacted] (secondary)<br><br>Staff Training: In addition to the training outlined above, as part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. |

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| | Phase I - Deficiency: The MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug medical necessity criteria and (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug formulary design.<br><br>Plan Response: Plan is not required to respond to deficiencies related to the Prescription Drug Classification or formulary design NQTL.<br><br>Phase II - Deficiency: Specifically, in Phase II, HealthNow failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits. For outpatient, emergency care, and prescription drug coding edits, the MCO failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency.<br><br>Additionally, the MCO failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL (inpatient only), (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient out of network coverage standards.<br><br>Finding from 8/19/2021: (see below sections for OP and IP OON steps 2-6): Medicaid Managed Care Model Contract 35.1 Contract and SDOH Compliance with Applicable Laws-The MCO failed to provide methods to revise and remediate (operational activities) the identified deficiencies and a plan, with milestones, to monitor the implementation of the POC and for ongoing monitoring that ensures corrections are adequately executed and maintained for out of network coverage standards.<br><br>**Inpatient Out of Network Standards**<br><br>Plan Response: Method to Revise and Re-mediate: Inpatient Out of Network Coverage– Revise/Re-Mediate and Monitoring steps below are inclusive of Steps 2 through 6 |

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| MCO Representative's Signature | Date<br>June 29, 2021 |
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| [redacted] | Step 2: OON Post stabilization services resulting from an emergency are covered by both PH and BH for all products- Medicaid, CHP. OON services for acute inpatient care are covered for both PH and BH services. Neither the PH nor the BH team redirect members to an In-Network provider when a member accesses IP services as a result of an emergency. Non-acute inpatient BH services (Inpatient Substance Use Rehab, Substance Use Residential Services, Crisis Residential Services) and PH services (non urgent surgery) are approved fo rOON providers if the network does not have an adequate number of providers to meet the clinical, cultural and linguistic needs of the member. Members may obtain services from an out of network provider when medically necessary care cannot be obtained within the provider network or to ensure continuity of care (transitional care). Both PH and BH teams cannot consider inpatient services as out of network solely on the basis that the admitting physician or treating physician is a non-participating provider. They cannot consider services rendered by a participating provider as out of network services solely on the basis that the services are rendered in a non-participating hospital.<br>Out of network IP services are also approved when the needed non acute IP service and/or provider are not available within the network and the services are part of a treatment plan approved by a Utilization Management Nurse and/or Medical Director in consultation with the PCP.<br><br>The OON provider must agree to accept reimbursement at rates established by HealthNow as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the HealthNow network for the same/similar services. The non-participating provider must agree to adhere to HealthNow's quality assurance requirements and agree to provide the necessary medical information related to the care. The non-participating provider must agree to adhere to HealthNow's policies and procedures including but not limited to procedures regarding obtaining pre-certification.<br><br>Before a medical necessity decision (UR) is rendered, both BH and PH clinicians assess the guidelines outlined above and consult with the Manager if needed. The Physical Health team considers the same factors/ guidelines for OON OP services as oes BH. Once a benefit decision (whether to approve the OON equest – non UR) is made the clinician assesses for medical ecessity. If guidelines for out of network approval and medical ecessity are met, an authorization number is given to the PCP or non-participating provider and member. In instances where the medical necessity for the service is not met Medical Director |

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| | review is required (UR – medical necessity review).<br><br>Step 3: The PH team considers the same factors (clinical specialty and cultural and linguistic needs) for OON non acute IP services as BH. Plan has an integrated policy that includes OON services. The PH team considers the same factors (clinical specialty and cultural and linguistic needs) for OON non acute IP services as does BH. Before a medical necessity decision is rendered, both BH and PH clinicians assess these needs and consult with the Manager if needed. Once a benefit decision (whether to approve the OON request) is made (network adequacy, clinical specialty/ need, cultural and linguistic needs), the clinician assesses for medical necessity.<br><br>Step 4: BH and PH follow an integrated policy as well as an Integrated Utilization Management Program Description that addresses when a member can access OON -IP benefits. The PH team considers the same factors (clinical specialty and cultural and linguistic needs) for OON non acute IP services as BH. Before a medical necessity decision is rendered, both BH and PH clinicians assess these needs and consult with the Manager if needed. The clinical associates in both PH and BH are Nurses or other Licensed Clinicians.<br><br>Step 5/Ongoing Monitoring: Complaints are reviewed, analyzed and reported by BH and Med/Surg to the BH QMC. There is a focus on any complaints related to OON IP denials. Non UR denials (administrative denials for OON) are also reviewed, analyzed and reported by both BH and Med/Surg to the BH QMC. Data indicates that BH has not issued any denials for IP – OON requests. In addition, the Non UR denials for both PH and BH will be reported to the BH QMC starting August 31, 2021. Particular attention is paid if there are complaints related to OON IP denials. Non-UR denials (administrative denials for OON) are also reviewed and BH Non-UR denials for OON coverage and PH denials for OON coverage are compared to ensure parity. In addition workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity (at least annually or quarterly based on BHQMC discussion/monitoring and feedback).<br><br>Note: 2021 data indicates that BH has not issued any denials for IP –OON requests. |



| MCO Representative's Signature | Date<br>June 29, 2021 |
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| [redacted] | Step 6: Both PH and BH use the same standards for IP acute and non-acute care services.<br><br>Staff Training (Steps 2-6): In addition to the training outlined above, as part of the plan's Mental Healht and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. This is our plan to educate/train staff of any necessary changes to address potential noncompliance. All associates will have 60 days to complete this mandatory, which will be required annually and as part of new associate orientation. The exact date for the implementation of the formal POC is June 29, 2021. In addition to the training outline within the SOD/SOF, additional training will be provided annually within the IP and OP Team Meetings and each time processes are updated (at least annually or quarterly based on BHQMC feedback).<br><br>The workbook was updated to include these changes. This was completed on April 19, 2021<br><br>Responsible Parties: UM IP Manager - [redacted] - primary, BH Program Manager- [redacted]<br><br>Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.<br><br>Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.<br><br>The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH. The status of the parity findings will include the results of the ongoing analysis and if the BH |

processes are more stringent then a plan of action to ensure parity compliance will be developed.

Plan of Action will include the following:

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

Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.

Milestones for Implementation and Responsible Parties: [redacted] Director, GBD Quality Management; BH Program Manager - [redacted] - secondary

The next BH QMC meeting is scheduled for August 31, 2021.

Plan Response:

**Medicaid Managed Care Model Contract 35.1 Contractor and SDOH Compliance with Applicable Laws – The POC is unacceptable. The MCO provided workbook responses for out-of-network coverage standards. The MCO failed to provide methods to revise and remediate (operational activities) the identified deficiencies and a plan, with milestones, to monitor the implementation of the POC and for ongoing monitoring that ensures corrections are adequately executed and maintained for out-of-network coverage standards**

**Outpatient Out of Network Coverage Standards**

Method to Revise and Remediate: Outpatient Out of Network Coverage Standards – Revise/Re-Mediate and Monitoring steps below are inclusive Steps 3 through 6

Step 3: Plan has multiple integrated policies and procedures that addresses out of network services, Continuity of Care, Core process, Practitioner appointment and access standards. OON Outpatient services are approved by both BH and PH for Continuity of care when a member enrolls with our plan or when an INN provider leaves our network.
In addition, both teams approve OON OP care if:
• A member is unable to locate an INN provider-lack of appointment availability that meets member's needs.
When an appointment with the appropriate

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specialist/service is not available within the appointment availability standards or the member requires the visit sooner than is available within network

• A member's clinical needs cannot be met by INN providers and needs a specialist who is not in network-member may need CBT, or TMS and plan does not have an adequate number of these specialists in network; or member needs to be seen by a Child and Adolescent psychiatrist and plan does not have a specialist available close to where the member lives and is able see the member at a time when member is available ( specialist – time and distance)

• A member has cultural, language/linguistic needs that cannot be met by an INN provider- a member may need a therapist who speaks Mandarin and plan does not have a provider available to see the member (time and distance); member may need services by a provider who has a same religious belief as the member or same ethnic background as the member or be part of the same cultural group as the member but plan does not have any INN providers to meet member's needs.

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

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

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

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ep 4: BH and PH follow an Integrated policy and Integrated tilization Management Program Description that addresses hen a member can access OON -OP benefits The Physical Health team considers the same factors (clinical specialty and

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| | cultural and linguistic needs) for OON OP services as does BH. Before a medical necessity decision is rendered, both BH and PH clinicians assess these needs and consult with the Manager if needed. The clinical associates in both PH and BH are Nurses or other Licensed Clinicians |

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| Title Health Plan President | |

Step 5 (Ongoing Monitoring): Complaints are reviewed, analyzed and reported by BH and Med/Surg to the BH QMC. There is a focus on any complaints related to OON IP denials. Non-UR denials (administrative denials for OON) are also reviewed, analyzed andreported by both BH and Med/Surg to the BH QMC. Data indicates that BH has not issued any denials for IP –OON requests. In addition, the Non UR denials for both PH and BH will be reported to the BH QMC starting August 31, 2021. Particular attention is paid if there are complaints related to OON OP denials. Non-UR denials (administrative denials for OON) are also reviewed and BH Non UR denials for OON coverage and PH denials for OON coverage are compared to ensure parity. In addition workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity. Data indicates that BH has not issued any denials for IP –OON requests. In addition, the Non UR denials for both PH and BH willbe reported to the BH QMC starting August 31, 2021.

Step 6: Both PH and BH use the same standards for OP OON services.

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

Responsible Parties: BH Program Manager [redacted] primary; [redacted] –Director HCMS secondary

Staff Training (Steps 2-6 and as outlined above): As part of the plan's Mental Health and SubstanceUse Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. Allassociates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. The exact date for the implementation of the form POC is June 29, 2021. In addition to the training outlined withing the SOD/SOF, additional training will be provided annually within the IP and OP Team Meetings and each time processes are updated (at least annually or quarterly if changes are noted in the BHQMC).

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

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit awritten certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or theCompliance Director. A

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copy will be provided to the Board of Managers.

Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.

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

Plan of Action will include the following:

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

Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.

Milestones for Implementation and Responsible Parties: [redacted] Director, GBD Quality Management; BH Program Manager - [redacted] - secondary

The next BH QMC meeting is scheduled for August 31, 2021.

Phase II - Deficiency: Coding Edits - Failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits.



For outpatient, emergency care, and prescription drug coding edits, failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency

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| | (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency. |

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

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| | As a part of the overall analysis we will:<br><br>1. Describe the code editing protocols for both MH/SUD benefits and medical/surgical benefits.<br><br>2. Identify factors<br><br>3. Identify and describe evidentiary standards and other evidence relied upon<br><br>4. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits.<br><br>5. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits.<br><br>6. Updates on the above steps will be shared at the first BH QMC meeting with Parity included.<br><br>Monitoring the Implementation:<br><br>• Identify and evaluate correct coding claim edits that create a pend by May 1, 2021.<br>• Review the edits that are pended to assess the process for adjudicating the pend by June 30, 2021.<br>• Create a process annually to reassess new edits July 19, 2021.<br>• Educate Claims Editing Services team on new process July 31, 2021.<br>Responsible Parties: Reimbursement Policy Management- [redacted] |

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| MCO Representative's Signat [redacted] ate | June 29, 2021 |
| Title Health Plan President | |

Date of Implementation: May 1, 2021

Staff Training: As part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. The exact date for the implementation of the formal POC is June 29, 2021. In addition to the training outlined within the SOD/SOF, additional training will be provided annually within Team Meetings and each time processes are updated (at least annually or quarterly if changes are noted in the BHQMC).

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

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.

Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.

The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH.

Plan of Action will include the following:

- Identify any processes that appear to be more stringent
- Identify changes that need to be implemented to ensure parity
- Identify specific due dates and business owners for tracking
- Identify the methodology to complete a parity analysis once the changes are implemented to ensure parity compliance

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| | • Staff training and dates of training will be included within the action plan.<br><br>Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.<br><br>Milestones for Implementation and Responsible Parties: [redacted], Director, GBD Quality Management; BH Program Manager - [redacted] secondary<br><br>The next BH QMC meeting is scheduled for August 31, 2021. |

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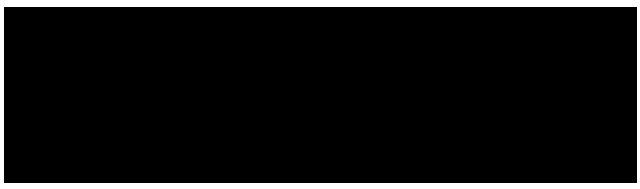
| MCO Representative's Signature [redacted] | Date August 25, 2021 |
| Title Health Plan President | |



**Statement of Findings**
**HealthNow of New York, Inc.**
**MHPAEA Testing Phase I and Phase II Workbooks**
**August 22, 2018- September 8, 2020**

**Parity Compliance**

**35.1 Contractor and SDOH Compliance With Applicable Laws**
**Notwithstanding any inconsistent provisions in this Agreement, the Contractor and SDOH shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; the State Finance Law; the State Mental Hygiene Law; the State Insurance Law; Title XIX of the Social Security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 84, as amended; the Age Discrimination Act of 1975 and 45 CFR Part 91, as amended; the ADA; Title XIII of the Federal Public Health Services Act, 42 U.S.C § 300e et seq., regulations promulgated thereunder; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and related regulations; the Federal False Claims Act, 31 U.S.C. § 3729 et seq.; Mental Health Parity and Addiction Equity Act of 2008, (P.L. 110-345); for Contractors operating in New York City, the New York City Health Code; and all other applicable legal and regulatory requirements in effect at the time that this Agreement is signed and as adopted or amended during the term of this Agreement. The parties agree that this Agreement shall be interpreted according to the laws of the State of New York.**

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

**Finding:**

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

- Specifically, in Phase I, HealthNow failed to provide substantive comparative analyses for (Step3)evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug prior authorization. For concurrent review, HealthNow failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent stringency for outpatient. Additionally, HealthNow failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review.

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

equivalent stringency and (Step 5) in operation comparability and equivalent stringency for prescription drug formulary design.

**Plan Response**

HealthNow of New York, Inc., now "Highmark Blue Cross Blue Shield of Western New York" (Highmark BCBS WNY) is not required to respond to deficiencies related to the Prescription Drug Classification or formulary design NQTL.

Phase I -Deficiency: For concurrent review, Highmark BCBS WNY -Amerigroup failed to provide substantive comparative analyses for (Step 2) factors triggering the NQTL for inpatient and (Step 3) evidentiary standards comparability and equivalent stringency for outpatient.

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

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

Our process for identifying members to review for IP concurrent review has changed since our initial submission. We do not conduct reviews for any IP Substance Use admissions unless someone remains IP after 28 days. Members less than 18 who are inpatient for psychiatric services are not reviewed unless their length of stay exceeds 14 days. Based on the Guiding Principles for IP psychiatric reviews shared by OMH, we submitted revised workflows for adults who are IP psych to the state for review on January 8, 2021. When we receive feedback from OMH on our proposed workflows related to the IP Concurrent review process we will make the needed changes and update our processes within 45 days.

Associates will be trained on the revised processes no later than 30 days of finalization. This training will be completed at weekly staff meetings held every Wednesday. Additionally, all teams within BH will again review their focused process at smaller team meetings.

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

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

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

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

Responsible Parties: UM IP Manager – [redacted]o - primary, BH Program Manager - [redacted] - secondary

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

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

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.

Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.

The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH.

Plan of Action will include the following:

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

Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.

Milestones for Implementation and Responsible Parties: [redacted], Director, GBD Quality Management; BH Program Manager - [redacted] - secondary

The next BH QMC meeting is scheduled for August 31, 2021.

Phase I - Deficiency: Additionally, HealthNow failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency for outpatient and provide all required information and substantive comparative analyses for Steps 2 through 5 for prescription drug concurrent review.

Plan Response: Method to Revise and Remediate: Evidentiary Standards for the Comparative Analysis

Triggers for review were included in step 2 within the workbook. The workbook was updated to include these on April 19, 2021.

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

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

Responsible Parties: BH Program Manager- [redacted] (primary); Director I HCMS – [redacted] (secondary)

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

**Finding**

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

**Plan Response**

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

**Finding**

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

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

Feedback on Finding from 8/19/2021 (see below sections for OP and IP OON steps 2-6): Medicaid Managed Care Model Contract 35.1 Contractor and SDOH Compliance with Applicable Laws – The POC is unacceptable. The MCO provided workbook responses for out-of-network coverage standards. The MCO

failed to provide methods to revise and remediate (operational activities) the identified deficiencies and a plan, with milestones, to monitor the implementation of the POC and for ongoing monitoring that ensures corrections are adequately executed and maintained for out-of-network coverage standards.

**Plan Response**

**Inpatient Out of Network Standards**

Method to Revise and Re-mediate: Inpatient Out of Network Coverage– Revise/Re-Mediate and Monitoring steps below are inclusive of Steps 2 through 6

Step 2: OON Post stabilization services resulting from an emergency are covered by both PH and BH for all products-Medicaid, CHP. OON services for acute inpatient care are covered for both PH and BH services. Neither the PH nor the BH team redirect members to an In-Network provider when a member accesses IP services as a result of an emergency.

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

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

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

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

Step 3: The PH team considers the same factors (clinical specialty and cultural and linguistic needs) for OON non acute IP services as BH. Plan has an integrated policy that includes OON services. The PH team considers the same factors (clinical specialty and cultural and linguistic needs) for OON non acute IP services as does BH. Before a medical necessity decision is rendered, both BH and PH clinicians assess these needs and consult with the Manager if needed. Once a benefit decision (whether to approve the OON request) is made (network adequacy, clinical specialty/need, cultural and linguistic needs), the clinician assesses for medical necessity.

Step 4: BH and PH follow an integrated policy as well as an Integrated Utilization Management Program Description that addresses when a member can access OON -IP benefits. The PH team considers the same factors (clinical specialty and cultural and linguistic needs) for OON non acute IP services as BH. Before a medical necessity decision is rendered, both BH and PH clinicians assess these needs and consult with the Manager if needed. The clinical associates in both PH and BH are Nurses or other Licensed Clinicians.

Step 5/Ongoing Monitoring: Complaints are reviewed, analyzed and reported by BH and Med/Surg to the BH QMC. There is afocus on any complaints related to OON IP denials. Non UR denials (administrative denials for OON) are also reviewed, analyzed and reported by both BH and Med/Surg to the BH QMC. Data indicates that BH has not issued any denials for IP –OON requests. In addition, the Non UR denials for both PH and BH willbe reported to the BH QMC starting August 31, 2021.

Particular attention is paid if there are complaints related to OON IP denials. Non-UR denials (administrative denials for OON) are also reviewed and BH Non-UR denials for OON coverage and PH denials for OON coverage are compared to ensure parity. In addition workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity (at least annually or quarterly based on BHQMC discussion/monitoring and feedback).

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

Step 6: Both PH and BH use the same standards for IP acute and non acute care services.

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

Responsible Parties: UM IP Manager - [redacted] - primary, BH Program Manager- [redacted]

Staff Training (Steps 2-6): In addition to the training outlined above, as part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. This is our plan to educate/train staff of any necessary changes to address potential noncompliance. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. The exact date for the implementation of the formal POC is June 29, 2021.
In addition to the training outlined within the SOD/SOF, additional training will be provided annually within the IP and OP Team meetings and each time processes are updated.

Ongoing Monitoring (Steps 2-6): Compliance with state and federal requirements for provision of comparable coverage for benefits to treat mental health and substance use disorder is monitored via the MentalHealth and Substance Use Disorder Parity Compliance Program. Status of parity findings will be reported in quarterly Behavioral Health Quality Management Committee beginning August 31, 2021.

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.

Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.

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

Plan of Action will include the following:

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

Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.

Milestones for Implementation and Responsible Parties: [redacted] Director, GBD Quality Management; BH Program Manager - [redacted] - secondary

The next BH QMC meeting is scheduled for August 31, 2021.

**Plan Response**

**Medicaid Managed Care Model Contract 35.1 Contractor and SDOH Compliance with Applicable Laws – The POC is unacceptable. The MCO provided workbook responses for out-of-network coverage standards. The MCO failed to provide methods to revise and remediate (operational activities) the identified deficiencies and a plan, with milestones, to monitor the implementation of the POC and for ongoing monitoring that ensures corrections are adequately executed and maintained for out-of-network coverage standards**

**Outpatient Out of Network Coverage Standards**

Method to Revise and Remediate: Outpatient Out of Network Coverage Standards – Revise/Re-Mediate and Monitoring steps below are inclusive Steps 3 through 6.

Step 3: Plan has multiple integrated policy & procedures that addresses out of network services, Continuity of Care, Core process, Practitioner appointment and access standards. OON Outpatient services are approved by both BH and PH for Continuity of care when a member enrolls with our plan or when an INN provider leaves our network.

In addition, both teams approve OON OP care if:

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

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

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

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

Step 4: BH and PH follow an Integrated policy and Integrated Utilization Management Program Description that addresses when a member can access OON -OP benefits The Physical Health team considers the same factors (clinical specialty and cultural and linguistic needs) for OON OP services as does BH. Before a medical necessity decision is rendered, both BH and PH clinicians assess these needs and consult with the Manager if needed. The clinical associates in both PH and BH are Nurses or other Licensed Clinicians

Step 5 (Ongoing Monitoring): Complaints are reviewed, analyzed and reported by BH and Med/Surg to the BH QMC. There is afocus on any complaints related to OON IP denials. Non UR denials (administrative denials for OON) are also reviewed, analyzed and reported by both BH and Med/Surg to the BH QMC. Particular attention is paid if there are complaints related to OON OP denials. Non-UR denials (administrative denials for OON) are also reviewed and BH Non UR denials for OON coverage and PH

denials for OON coverage are compared to ensure parity. In addition workflows are reviewed, any changes in P&P are reviewed and workflows that may need to be changed are identified and implemented to ensure compliance with parity. Data indicates that BH has not issued any denials for IP –OON requests. In addition, the Non UR denials for both PH and BH will be reported to the BH QMC starting August 31, 2021.

Step 6: Both PH and BH use the same standards for OP OON services.

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

Responsible Parties: BH Program Manager [redacted] primary; [redacted] –Director HCMS secondary

Staff Training (Steps 2-6): In addition to the training outlined above, as part of the plan's Mental Health and Substance Use Disorder Parity Compliance Program, a training module of overall parity requirements will be launched on June 30, 2021. This is our plan to educate/train staff of any necessary changes to address potential noncompliance. All associates will have 60 days to complete this mandatory training, which will be required annually and as part of new associate orientation. The exact date for the implementation of the formal POC is June 29, 2021.
In addition to the training outlined within the SOD/SOF, additional training will be provided annually within the IP and OP Team meetings and each time processes are updated (at least annually or quarterly if changes are noted in the BHQMC).

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

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.

Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.

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

Plan of Action will include the following:

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

Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.

Milestones for Implementation and Responsible Parties: [redacted], Director, GBD Quality Management; BH Program Manager - [redacted] secondary

The next BH QMC meeting is scheduled for August 31, 2021.

**Finding**

Phase II Coding Edits - Failed to provide all information and substantive comparative analyses for (Step 2) factors triggering the NQTL, (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency, and (Step 5) in operation comparability and equivalent stringency for inpatient coding edits.

For outpatient, emergency care, and prescription drug coding edits, failed to provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency (outpatient and emergency care only), and (Step 5) in operation comparability and equivalent stringency.

**Plan Response**

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

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

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

Prepayment claim edits administered through ClaimsXten and Cotiviti for outpatient facility and professional claims (we do not have any edits for inpatient claims) utilize industry standard coding principles to establish edits. These edits can come from multiple sources including CMS, AMA, Specialty societies and the FDA to name a few. Also, we use these editing tools to implement edits supported by the New York state guidelines. Edits are not distinguished by their categorizations (i.e. MH/SUD vs. medical/surgical). It is based on how the service should correctly be coded. We do have edits that require claims to pend for review. We will evaluate those claim pends to determine whether they are being treated differently for MH/SUD vs. Medical/surgical. For program integrity purposes all claims are subject to pre-pay and post-pay review and recoupment in accordance to established billing, utilization and/or reimbursement policies. The Plan's Special Investigation's Unit (SIU) processes apply equally to providers paid under fee-for-service arrangements as well as providers paid under a shared savings or risks bearing agreement or through any government programs. When appropriate, we will include an analysis of our pre/post pay review processes.

As a part of the overall analysis we will:

1. Describe the code editing protocols for both MH/SUD benefits and medical/surgical benefits.
2. Identify factors
3. Identify and describe evidentiary standards and other evidence relied upon
4. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits.
5. Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes

and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits.

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

Monitoring the Implementation:

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

Responsible Parties: Reimbursement Policy Management-[redacted].

Date of Implementation: May 1, 2021

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

Written policies and procedures that describe how parity compliance is assessed, monitored, and managed were established effective on December 28, 2020, including the system for the ongoing assessment of parity compliance. By December 31, 2021 and annually thereafter, the plan will submit a written certification to the Commissioner that these requirements have been satisfactorily met. This certification will be in the form prescribed by the Commissioner and signed by the plan president or the Compliance Director. A copy will be provided to the Board of Managers.

Status of parity findings will be reported quarterly in Behavioral Health Quality Management Committee (BH QMC) beginning August 31, 2021. The Committee will review the Phase I and II parity workbooks on a quarterly basis monitoring to ensure workbooks are updated and maintained with the required information and substantive comparative analyses demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008.

The Committee will also review any plan of action that needs to be submitted to ensure parity compliance, if the comparative analysis reveals that a BH process is more stringent than PH.

Plan of Action will include the following:

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

Updates and findings from the BH QMC will be reported at the Plan QAC which meets quarterly and to executive leadership at Plan Compliance Committee which meets quarterly.

Milestones for Implementation and Responsible Parties: [redacted], Director, GBD Quality Management; BH Program Manager -[redacted]- secondary

The next BH QMC meeting is scheduled for August 31, 2021.

[redacted]

8/25/2021

[redacted], Health Plan President Date