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 Visiting Nurses Service of New York Choice (VNSNY)	**TYPE OF SURVEY:** Focus Survey: MHPAEA Testing Phase I and Phase II Workbooks
STREET ADDRESS, CITY, STATE, ZIP CODE 1250 Broadway, 26th Floor New York, NY 10001	**SURVEY DATES:** August 22, 2018 – September 8, 2020

NOTE: The following list of deficiencies was identified by Health Department representatives during an Article 44 and/or Article 49 operational or focused survey of your Managed Care Organization (MCO). Correction of these deficiencies is required in order to bring your MCO into compliance with Article 44 and/or 49 of the New York State Public Health Law and the New York State Official Compilation of Codes, Rules, and Regulations (10NYCRR). In the column headed Provider Plan of Correction, describe the Plan of Corrective Action and anticipated date of corrections. The Plan of Correction should be returned within 15 business days.

Deficiencies	Plan of Correction with Timetable
10 CRR-NY 98-1.16 Disclosure and filing. **(h) In the event an MCO does not provide substantially complete reports or other information required under this Subpart by the due date, or provide requested information within 30 days of any written request for a specific analysis or report by the superintendent or commissioner, the superintendent or commissioner is authorized to levy a civil penalty, after notice and hearing, pursuant to section 12 of the Public Health Law or sections 307 and 308 of the Insurance Law.** **Deficiency:** Based on the review of Visiting Nurses Service of New York Choice (VNSNY) 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 4 of 9 NQTLS examined; concurrent review, medical necessity criteria, out of network coverage standards and reimbursement. • Specifically, in Phase I, VNSNY failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency and provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient concurrent review. For prescription drug concurrent review, VNSNY failed to provide complete responses, inclusive of all required information and substantive comparative analyses for	VNSNY CHOICE SelectHealth (the "Plan") has reviewed your letter dated March 3, 2020 regarding the Focus Survey referenced above and is submitting our Revised Plan of Correction. The Plan is committed to complying with the parity requirements related to the Focused Survey. In preparation for our Revised Plan of Correction, the Plan attended a conference call on March 11, 2021 with the Department and Milliman during which clarification was provided for certain requirements for our response. We thank the Department and Milliman for this technical assistance. Also, as confirmed in our call with the Department, the Plan will not address any pharmacy related findings due to the impending pharmacy benefit carve- out from Medicaid Managed Care. The Plan acknowledges receipt of the following specific areas of non-compliance: Phase I: 1. Inpatient and Outpatient Concurrent Review Steps 3,5 and 6 2. Medical Necessity Steps 3,4,5 and 6 Phase II: 1. Out-of-Network Coverage Steps 2 through 6 2. Reimbursement Steps 2 through 6

Steps 1 through 5. Additionally, the MCO failed to provide substantive comparative analyses for (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient medical necessity criteria. For prescription drug medical necessity criteria, VNSNY failed to provide all required information and substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency. • Specifically, in Phase II, VNSNY failed to provide all information and substantive comparative analyses that were responsive to the NQTL and each step 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 and outpatient out of network coverage standards. Additionally, the MCO failed to provide all information and complete substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency due to an added factor that was not previously identified for inpatient and outpatient reimbursement.	**Corrective Actions:** Phase I and Phase II workbooks will be updated and maintained with the required information and substantive analysis demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Specifically, the plan will conduct reviews of the following data elements from the State tools: For Step 2, Phase I Out-of-Network Coverage, the Plan will define factors by reviewing plan specific data from the following examples listed on page 14 of the Compliance Assistance Guide MHPAEA which were determined to be applicable to the plan such as: 1. Excessive utilization; 2. Recent medical cost escalation; 3. High variability in cost per episode of care; 4. High levels of variation in length of stay; 5. Lack of adherence to quality standards; 6. Claim types with high percentage of fraud; 7. Current and projected demand for services. For Step 3, Phase I Inpatient and Outpatient Concurrent Review, Medical Necessity and Phase II Out-of-Network Coverage, evidentiary standards will be developed using plan specific data from the factors listed on page 14 of the compliance assistance guide MHPAEA including but not limited to: 1. Internal claims analysis; 2. Medical expert reviews; 3. State and Federal requirements; 4. Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits. For Step 4, Phase I Medical Necessity and Phase II Out-of-Network Coverage, the plan will conduct analyses substantiating that factors, evidentiary standards and processes are comparable by reviewing plan specific data such as the following that were found to be applicable to the plan listed on page 17 of the Compliance Assistance Guide MPHAEA:

1. Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
2. Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
3. A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had "high cost variability" and were therefore subject to the NQTL.

Should the steps defined above indicate the plan is applying MH/SUD benefits more stringently than the medical/surgical benefits, the plan will make corrections to correct the issues identified.

The responsible parties will conduct quarterly monitoring of data elements listed above to ensure continued compliance. Reeducation and training will be provided as needed.

Responsible Parties: [redacted], Director, Care and Utilization Management and [redacted] Director, Behavioral Health

Date Certain: June 30, 2021

For Step 5 of each area of non-compliance described above, the Plan will conduct audits such as the following that were listed on page 71-72 of the NQTL Spreadsheet Guidance:

1. Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
2. Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
3. Audit results that demonstrate the process of consulting with expert reviewers for MH/ SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of

	consultation with expert reviewers and qualifications of staff involved. Audit results that produce a non-compliant finding will be documented and addressed as part of a corrective action plan. Ongoing compliance auditing will occur on a quarterly basis. **Responsible Party:** [redacted], Compliance Manager **Date Certain:** June 30, 2021 For Phase II Reimbursement Steps 3,4, and 5, the Plan will use the prompts provided on the workbooks as follows to correct the deficiencies: For Step 3, the Plan will review and confirm: a. If the payment methodology factor included fee schedules, specify which ones. b. If benchmarking was a factor, explain which unit or units were selected for benchmarking and describe how the benchmarking was determined, e. g., 100% of Medicare or Medicaid rates. c. If market dynamics or market studies were factors used, identify which ones and how the results of those dynamics, studies, data, etc. informed rate setting. d. If practice size or type was a factor relied upon, how did it inform rate setting. e. If provider training, experience, licensure, etc. was a factor relied upon, how did it inform rate setting. f. Define how various contract factors relied upon or what their parameters were (e.g., frequency of rate review, value of rate escalators, variability in negotiating rates). For Step 4, the Plan will review the following items indicated in the workbook including but not limited to:

	1. The written materials delivered, provided, or exchanged with potential network providers, 2. any internal written documents developed and circulated to staff regarding rate setting and negotiating with providers, 3. minutes from staff meetings regarding rate setting, etc. The responsible party will conduct monitoring of these processes quarterly to ensure continued compliance. Reeducation and training will be provided as needed. **Responsible Party:** [redacted], Director, Network Contracting and Provider Relations **Date certain:** June 30, 2021 For Step 5, Phase II Reimbursement, the Plan will conduct the following as indicated in the Phase II workbook including but not limited to: A comparison of the negotiation processes between the Plan and providers as well as any processes in place for adjusting rates for MH/SUD providers and the negotiation processes between the Plan and providers as well as any processes in place for adjusting rates for medical/surgical providers. Comparison results that indicate the reimbursement process is more stringent for MH/SUD than medical/surgical will be documented and address as part of a corrective action plan. Ongoing compliance auditing will occur on a quarterly basis to ensure complaint workbook updates are maintained. **Responsible party:** [redacted], Compliance Manager **Date Certain:** June 30, 2021 For Step 6, upon successful completion of the steps outlined above for Phase I and Phase II, the Plan will develop a written summary for the Department's review confirming the plan is in compliance with MHPAEP.

	Responsible party: [redacted], Senior Vice President, VNSNY CHOICE SelectHealth **Date Certain:** September 30, 2021

[redacted]	Date 3/17/21
Title **President, VNSNY CHOICE SelectHealth**	

Statement of Findings
Visiting Nurses Service of New York Choice
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 Visiting Nurses Service of New York Choice (VNSNY) 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 4 of 9 NQTLS examined; concurrent review, medical necessity criteria, out of network coverage standards and reimbursement.

- Specifically, in Phase I, VNSNY failed to define factors in (Step 3) evidentiary standards comparability and equivalent stringency and provide substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient concurrent review. For prescription drug concurrent review, VNSNY failed to provide complete responses, inclusive of all required information and substantive comparative analyses for Steps 1 through 5.

  Additionally, the MCO failed to provide substantive comparative analyses for (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency for inpatient and outpatient medical necessity criteria. For prescription drug medical necessity criteria, VNSNY failed to provide all required information and substantive comparative

analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency.

- Specifically, in Phase II, VNSNY failed to provide all information and substantive comparative analyses that were responsive to the NQTL and each step 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 and outpatient out of network coverage standards.

  Additionally, the MCO failed to provide all information and complete substantive comparative analyses for (Step 3) evidentiary standards comparability and equivalent stringency, (Step 4) as written comparability and equivalent stringency and (Step 5) in operation comparability and equivalent stringency due to an added factor that was not previously identified for inpatient and outpatient reimbursement.

Plan of Correction

VNSNY CHOICE SelectHealth (the "Plan") has reviewed your letter dated March 3, 2020 regarding the Focus Survey referenced above and is submitting our Revised Plan of Correction. The Plan is committed to complying with the parity requirements related to the Focused Survey.

In preparation for our Revised Plan of Correction, the Plan attended a conference call on March 11, 2021 with the Department and Milliman during which clarification was provided for certain requirements for our response. We thank the Department and Milliman for this technical assistance. Also, as confirmed in our call with the Department, the Plan will not address any pharmacy related findings due to the impending pharmacy benefit carve- out from Medicaid Managed Care.

The Plan acknowledges receipt of the following specific areas of non-compliance:

Phase I:

1. Inpatient and Outpatient Concurrent Review Steps 3,5 and 6
2. Medical Necessity Steps 3,4,5 and 6

Phase II:

1. Out-of-Network Coverage Steps 2 through 6
2. Reimbursement Steps 2 through 6

Corrective Actions:

Phase I and Phase II workbooks will be updated and maintained with the required information and substantive analysis demonstrating compliance with Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Specifically, the plan will conduct reviews of the following data elements from the State tools:

For Step 2, Phase I Out-of-Network Coverage, the Plan will define factors by reviewing plan specific data from the following examples listed on page 14 of the Compliance Assistance Guide MHPAEA which were determined to be applicable to the plan such as:

1. Excessive utilization;
2. Recent medical cost escalation;
3. High variability in cost per episode of care;
4. High levels of variation in length of stay;
5. Lack of adherence to quality standards;
6. Claim types with high percentage of fraud;
7. Current and projected demand for services.

For Step 3, Phase I Inpatient and Outpatient Concurrent Review, Medical Necessity and Phase II Out-of-Network Coverage, evidentiary standards will be developed using plan specific data from the factors listed on page 14 of the compliance assistance guide MHPAEA including but not limited to:

1. Internal claims analysis;
2. Medical expert reviews;
3. State and Federal requirements;
4. Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

For Step 4, Phase I Medical Necessity and Phase II Out-of-Network Coverage, the plan will conduct analyses substantiating that factors, evidentiary standards and processes are comparable by reviewing plan specific data such as the following that were found to be applicable to the plan listed on page 17 of the Compliance Assistance Guide MPHAEA:

1. Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
2. Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
3. A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had "high cost variability" and were therefore subject to the NQTL.

Should the steps defined above indicate the plan is applying MH/SUD benefits more stringently than the medical/surgical benefits, the plan will make corrections to correct the issues identified.

The responsible parties will conduct quarterly monitoring of data elements listed above to ensure continued compliance. Reeducation and training will be provided as needed.

Responsible Parties: [redacted] Director, Care and Utilization Management and [redacted], Director, Behavioral Health

Date Certain: June 30, 2021

For Step 5 of each area of non-compliance described above, the Plan will conduct audits such as the following that were listed on page 71-72 of the NQTL Spreadsheet Guidance:

1. Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
2. Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.

Audit results that demonstrate the process of consulting with expert reviewers for MH/ SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.

Audit results that produce a non-compliant finding will be documented and addressed as part of a corrective action plan.

Ongoing compliance auditing will occur on a quarterly basis.

Responsible Party: [redacted], Compliance Manager
Date Certain: June 30, 2021

For Phase II Reimbursement Steps 3,4, and 5, the Plan will use the prompts provided on the workbooks as follows to correct the deficiencies:

For Step 3, the Plan will review and confirm:

a. If the payment methodology factor included fee schedules, specify which ones.

b. If benchmarking was a factor, explain which unit or units were selected for benchmarking and describe how the benchmarking was determined, e. g., 100% of Medicare or Medicaid rates.

c. If market dynamics or market studies were factors used, identify which ones and how the results of those dynamics, studies, data, etc. informed rate setting.

d. If practice size or type was a factor relied upon, how did it inform rate setting.

e. If provider training, experience, licensure, etc. was a factor relied upon, how did it inform rate setting.

f. Define how various contract factors relied upon or what their parameters were (e.g., frequency of rate review, value of rate escalators, variability in negotiating rates).

For Step 4, the Plan will review the following items indicated in the workbook including but not limited to:

1. The written materials delivered, provided, or exchanged with potential network providers,
2. any internal written documents developed and circulated to staff regarding rate setting and negotiating with providers,
3. minutes from staff meetings regarding rate setting, etc.

The responsible party will conduct monitoring of these processes quarterly to ensure continued compliance. Reeducation and training will be provided as needed.

Responsible Party: [redacted], Director, Network Contracting and Provider Relations
Date certain: June 30, 2021

For Step 5, Phase II Reimbursement, the Plan will conduct the following as indicated in the Phase II workbook including but not limited to:

A comparison of the negotiation processes between the Plan and providers as well as any processes in place for adjusting rates for MH/SUD providers and the negotiation processes between the Plan and providers as well as any processes in place for adjusting rates for medical/surgical providers.

Comparison results that indicate the reimbursement process is more stringent for MH/SUD than medical/surgical will be documented and address as part of a corrective action plan.

Ongoing compliance auditing will occur on a quarterly basis to ensure complaint workbook updates are maintained.

Responsible party: [redacted], Compliance Manager
Date Certain: June 30, 2021

For Step 6, upon successful completion of the steps outlined above for Phase I and Phase II, the Plan will develop a written summary for the Department's review confirming the plan is in compliance with MHPAEP.

Responsible party: [redacted], Senior Vice President, VNSNY CHOICE SelectHealth
Date Certain: September 30, 2021