

ATTORNEY GENERAL OF THE STATE OF NEW YORK

In the Matter of

MVP Health Care, Inc.

Assurance No.: 14-006

**ASSURANCE OF DISCONTINUANCE
UNDER EXECUTIVE LAW
SECTION 63, SUBDIVISION 15**

Pursuant to the provisions of Section 63(12) of the Executive Law and Article 22-A of the General Business Law, Eric T. Schneiderman, Attorney General of the State of New York, caused an inquiry to be made into certain business practices of MVP Health Care, Inc. relating to its administration of behavioral health benefits. Based upon that inquiry, the Office of the Attorney General (“the OAG”) has made the following findings, and MVP Health Care, Inc. has agreed to modify its practices and assure compliance with the following provisions of this Assurance of Discontinuance (“Assurance”).

I. BACKGROUND

1. MVP Health Care, Inc., a not-for-profit corporation, has three subsidiaries that offer health plans to New York consumers: (i) MVP Health Plan, Inc. a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law; (ii) MVP Health Insurance Company, a for-profit accident and health stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law; and (iii) MVP Health Services Corp., a not-for-profit health service

corporation licensed pursuant to Article 43 of the New York Insurance Law. In this Assurance, “MVP” will refer to the aforementioned entities.

2. MVP’s principal offices are located at 625 State Street, Schenectady, New York 12305.

3. In the regular course of business, MVP enrolls consumers in health plans and contracts with health care providers for the delivery of health care services to those consumers. Offering about 300 different health plans in New York State, MVP provides health care coverage for approximately 500,000 New York consumers. In 2012, MVP had revenues of \$2.7 billion.

II. THE OAG’S INVESTIGATION AND FINDINGS

4. The Health Care Bureau of the OAG conducted an investigation into MVP’s administration of behavioral health benefits following the receipt of consumer complaints alleging that MVP had improperly denied coverage for behavioral health services. In this Assurance, “behavioral health services” will refer to both mental health and substance use disorder services.

The Need for Adequate Coverage of Behavioral Health Treatment

5. Mental and emotional well-being is essential to overall health. Every year, almost one in four New Yorkers has symptoms of a mental disorder. Moreover, in any year, one in ten adults and children experience mental health challenges serious enough to affect functioning in work, family and school life. Lack of access to treatment, which can be caused by health plans’ coverage denials, can have serious consequences for consumers, resulting in interrupted treatment, more serious illness, and even death.

6. Mental illness is the leading illness-related cause of disability, a major cause of death (via suicide), and a driver of school failure, poor overall health, incarceration and homelessness.

7. For example, in any given year, one in ten individuals has a diagnosable mood disorder, such as major depression. Three to four percent of women will have an eating disorder, such as anorexia nervosa or bulimia nervosa, at some point in their lives. Individuals with anorexia have mortality rates up to 18 times greater than the average population without anorexia, the highest mortality rate of any mental illness.

MVP's Behavioral Health Benefits

8. MVP offers health plans that provide inpatient and outpatient benefits for medical/surgical and behavioral health conditions. Since 2009, MVP has subcontracted its administration of behavioral health benefits to ValueOptions, Inc. ("ValueOptions"), a managed behavioral health organization. MVP delegates its administration of benefits in only three other limited areas: chiropractory, radiology, and dental services for children. MVP's subcontracting of its members' behavioral health benefits has resulted in MVP's placing all behavioral health claim coverage determinations with ValueOptions. Neither MVP nor ValueOptions, its contractor, has been comparing behavioral health claims approvals and denials with those in the medical/surgical realm.

MVP's Utilization Review of Behavioral Health Benefits

9. Utilization review is the process by which a health plan examines plan members' claims for health care services to determine whether the services are medically necessary, and thus eligible for coverage. When an MVP member (or her provider) submits a claim for coverage for health services to MVP, the plan will either pay the

claim automatically or conduct utilization review for the claim.¹ In the latter situation, an MVP reviewer will determine whether the services are medically necessary under MVP's criteria.

10. Medically necessary services are those that are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of an individual. If MVP deems the services to satisfy its criteria, MVP will pay the claim. If MVP does not deem the services to satisfy its criteria, MVP will send the member an adverse determination letter, which, under New York law, must contain a detailed explanation of the clinical rationale for the denial and information about the member's appeals rights.

11. A member whose claim has been denied due to lack of medical necessity has the right, under New York law, to file an internal appeal, which is decided by ValueOptions without any involvement or oversight by MVP, an optional second-level, internal appeal, which is decided by ValueOptions without any involvement or oversight by MVP, and then an external appeal, which is reviewed by an independent clinician who has no relationship with MVP or ValueOptions. ValueOptions, on behalf of MVP, typically performs utilization review for all inpatient, partial hospitalization and intensive outpatient behavioral health claims, and certain outpatient visits.

12. The OAG's review of consumer complaints, as well as MVP's utilization review data, indicates that MVP applies more rigorous – and frequent – utilization review for behavioral health benefits than for medical/surgical benefits. From 2011 through

¹ Where this Assurance describes the administration of MVP's behavioral health benefits, it refers to actions taken by ValueOptions pursuant to contracts in which MVP has delegated responsibility to ValueOptions to administer the behavioral health benefits of MVP members.

2013, although behavioral health benefits comprised less than 3% of overall benefits paid by MVP, claims for behavioral health benefits comprised 14% of all reviews for claims for health care services. MVP made adverse determinations in 21% of the behavioral health reviews it performed, while making adverse determinations in only 15% of the medical/surgical reviews it performed.

13. Over the last three years, MVP has denied almost 40,000 of its members' claims for mental health treatment and an additional 11,000 of its members' claims for substance use disorder treatment. These numbers include medical necessity denials (which include denials for lack of clinical information and lack of preauthorization) and administrative denials. In particular, over the last three years, MVP has denied 39% of its members' claims for inpatient psychiatric treatment, totaling more than 1,200 denied claims. Over the same period, MVP denied 47% of its members' claims for inpatient substance use disorder treatment, totaling almost 900 denied claims. In contrast, MVP denied less than 18% of its members' inpatient medical/surgical claims during the same period. Moreover, when it does approve more intensive levels of care, such as inpatient or partial hospitalization treatment, MVP will often approve just a few days or visits at a time.

14. MVP's adverse determination letters denying behavioral health claims are generic and lack specific detail about why coverage was denied for particular members. The letters also fail to explain adequately the medical necessity criteria used in making the determinations and why members failed to meet such criteria. For example, each of the denial letters contain boilerplate language such as:

- “[T]he information indicates the patient has made progress toward treatment goals and no longer requires the same frequency of treatment.”

- “[O]ur review indicates continuing treatment does not meet the clinical criteria of the plan of benefits because the treatment planning does not include specific goals and objectives within a reasonable timeframe.”
- “[T]he review does not indicate the presence of biomedical or psychological impairment, or the likelihood of relapse requiring treatment at the acute inpatient hospitalization with 24 hour medical supervision level of care. An appropriate level of care to the current needs of the patient is intensive outpatient services. The patient’s addiction can be effectively treated in a lower level of care such as intensive outpatient services.”

Without details of the denial or the criteria used in making the determination, members are without the means to lodge a meaningful appeal of MVP’s denials.

15. Although substance abuse programs in New York State are required to use criteria for level of care determinations approved by the New York Office of Alcoholism and Substance Abuse Services (“OASAS”), MVP uses different criteria, created by ValueOptions, for determining medical necessity for substance abuse treatment.

16. MVP does not classify denials of coverage for behavioral health services due to lack of preauthorization or lack of clinical information as medical necessity denials, thereby depriving members of their appeal rights in some instances.

17. In 2011 and 2012, more than 2,300 MVP members were eligible to file external appeals of MVP’s denials of coverage for behavioral health benefits. That is more than twice the number of MVP members eligible to file appeals of medical/surgical denials (1,112). Fewer than 80 of the members eligible for appeals of behavioral health denials – less than 3% of those eligible – have actually filed external appeals. MVP’s decisions have been overturned in 40% of those cases.

18. Persons with mental health and substance use disorders comprise a vulnerable population, and may be reluctant to seek care. Frequent and time-consuming

utilization review may pose obstacles preventing them from accessing or completing treatment.

19. Additionally, MVP applies a utilization review tool for outpatient behavioral health benefits known as the Outpatient Outlier Model, under which a certain number of member outpatient psychotherapy visits triggers a special form of intensive utilization review, whereby additional treatments are more deeply scrutinized, and are often denied. The thresholds are based on MVP's past claims paid data, which may result in the thresholds being lowered. For example, after a member with major depression – a chronic, often life-long, biologically based illness – submits claims for 25 psychotherapy visits, the member is subject to review under the Outpatient Outlier Model, with the expectation that such review will result in the reduction or termination of treatment.

20. Once MVP places a member in the Outpatient Outlier Model, it may request extensive records from the provider, including progress notes, a treatment plan, a discharge plan, and other information, before it will authorize further coverage. MVP will also recommend a lower frequency of visits as a strategy of working towards treatment termination.

21. MVP conducted almost 4,500 reviews under the Outpatient Outlier Model from 2011 through 2013, contributing to the denial of coverage of more than 2,100 sessions of outpatient behavioral health care. MVP employs population health analytics programs in the administration of its medical/surgical benefits, but these programs are not equivalent to the Outpatient Outlier Model.

MVP's Coverage of Residential Treatment for Behavioral Health Conditions

22. Until 2014, most MVP benefit plans did not cover residential treatment for behavioral health conditions. Residential treatment is a standard, recommended, evidence-based, form of behavioral health treatment. Offering medication, counseling and structure, residential treatment facilities for behavioral health disorders provide a critical intermediate level of care between acute inpatient and outpatient treatment, enabling patients to transition back to living with their families. Residential treatment programs provide an intermediate level of care as compared to inpatient services, similar to skilled nursing treatment for medical/surgical conditions.

23. For example, residential treatment is deemed to be a potentially medically necessary option for treating persons with severe eating disorders, which can require round-the-clock supervision, and is a standard form of treatment for mental health disorders. According to Section 3.301 of the medical necessity criteria of ValueOptions, MVP's contractor:

Residential Treatment Services are provided to children/adolescents who require 24-hour treatment and supervision in a safe therapeutic environment. RTS is a 24 hour a day/7 day a week facility-based level of care. RTS provides individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. RTS address the identified problems through a wide range of diagnostic and treatment services, as well as through training in basic skills such as social skills and activities of daily living that cannot be provided in a community setting.

24. Residential treatment is also a standard form of treatment for substance abuse disorders. According to Section 4.301 of the medical necessity criteria of ValueOptions, MVP's contractor:

Residential treatment is a 24 hour a day/7 day a week facility-based level of care which provides individuals with significant and persistent substance abuse disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. Residential rehabilitation addresses the identified problems through a wide range of diagnostic and treatment services by reliance on the treatment community setting.

MVP's Cost-Sharing for Behavioral Health Services

25. Until 2014, approximately 40% of MVP plans charged a higher co-payment for outpatient mental health visits than for outpatient primary care visits. In some MVP plans, the mental health co-payment was twice as high as the primary care co-payment.

III. RELEVANT LAWS

26. Timothy's Law, enacted in 2006, mandates that New York group health plans that provide coverage for inpatient hospital care or physician services must also provide "broad-based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, . . . at least equal to the coverage provided for other health conditions." N.Y. Ins. Law §§ 3221(l)(5)(A); 4303(g)(1). Further, all group plans must cover, annually, a minimum of 30 days of inpatient care, 20 visits of outpatient care, and up to 60 visits of partial hospitalization treatment for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. N.Y. Ins. Law §§ 3221(l)(5)(A)(i)&(ii); 4303(g)(1)(A)&(B).

27. Timothy's Law also requires that deductibles, co-payments and co-insurance for mental health treatment be consistent with those imposed on other benefits, N.Y. Ins. Law §§ 3221(l)(5)(A)(iii); 4303(g)(1)(C), and that utilization review for mental health benefits be applied "in a consistent fashion to all services covered by [health

insurance and health maintenance organization] contracts.” 2006 N.Y. Laws ch. 748, § 1. From 2007 through 2010, MVP received \$7.4 million in New York State funds to subsidize its compliance with Timothy’s Law.

28. The New York Insurance Law requires every group plan that provides coverage for inpatient hospital care to cover at least 60 outpatient visits in any calendar year for the diagnosis and treatment of chemical dependence, of which up to 20 may be for family members. N.Y. Ins. Law §§ 3221(1)(7); 4303(1).

29. In 2004, New York enacted legislation creating Comprehensive Care Centers for Eating Disorders (the “CCCED Law”). New York L. 2004, ch.114. Pursuant to the CCCED Law, the New York State Department of Health designated three Centers, each of which must provide or arrange for a continuum of care tailored to the specialized needs of individuals with eating disorders, including residential treatment. N.Y. Public Health Law § 2799-g. The CCCED Law prohibits plans from excluding coverage provided by a Comprehensive Care Center for Eating Disorders. N.Y. Ins. Law §§ 3221(k)(14); 4303(dd).

30. The federal Mental Health Parity and Addiction Equity Act (“The Federal Parity Act”), enacted in 2008, prohibits large group, individual, and Medicaid health plans that provide both medical/surgical benefits, and mental health or substance use disorder benefits, from: (i) imposing financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket expenses) on mental health or substance use disorder benefits that are more restrictive than the predominant level of financial requirements applied to substantially all medical/surgical benefits; (ii) imposing treatment limitations (such as limits on the frequency of treatment, number of visits, and

other limits on the scope or duration of treatment) on mental health or substance use disorder treatment that are more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits, or applicable only with respect to mental health or substance use disorder benefits; and (iii) conducting medical necessity review for mental health or substance use disorder benefits using processes, strategies or standards that are not comparable to, or are applied more stringently than, those applied to medical necessity review for medical surgical/benefits. 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i). The essential health benefit regulations under the Affordable Care Act extend the federal parity requirements to small and individual plans. 45 C.F.R. § 156.115(a)(3).

31. The New York State Executive Law authorizes the Attorney General, where there are “repeated . . . illegal acts” or “persistent . . . illegality in the carrying on, conducting or transaction of business,” to seek relief, including enjoining the continuance of such business activity or of any illegal acts, as well as restitution and damages. N.Y. Exec. Law § 63(12).

32. Based on the findings of the Attorney General’s investigation, the Attorney General has determined that MVP’s conduct has resulted in violations of N.Y. Executive Law Section 63(12), Timothy’s Law and the Federal Parity Act. MVP’s practices have had the effect of unlawfully limiting MVP members’ access to behavioral health services.

NOW, WHEREAS, MVP neither admits nor denies the Attorney General's findings in Paragraphs 5 through 25 above; and

WHEREAS, access to adequate behavioral health treatment is essential for individual and public health; and

WHEREAS, MVP has cooperated with the OAG's investigation; and

WHEREAS, the Attorney General is willing to accept the terms of this Assurance under Executive Law Section 63(15) and to discontinue his investigation; and

WHEREAS, the parties each believe that the obligations imposed by this Assurance are prudent and appropriate; and

WHEREAS, the Attorney General has determined that this Assurance is in the public interest.

IT IS HEREBY UNDERSTOOD AND AGREED, by and between the parties that:

IV. PROSPECTIVE RELIEF

33. By July 1, 2014, MVP will implement the following reforms:

34. Cost-Sharing Requirements: For MVP members' outpatient behavioral health visits to psychologists, social workers, nurse practitioners, and other practitioners other than providers with medical degrees, MVP will apply the particular member's primary care cost-sharing schedule. If the member has elected to designate a psychiatrist as his or her primary care provider, MVP shall review such election according to the primary care designation requirements set forth in New York Insurance Law § 4804(c) and New York Public Health Law § 4403(6)(c), and will provide notice of such process to members.

35. Comparability of Utilization Review Processes: MVP and/or any entity that administers benefits on behalf of MVP will not use the Outpatient Outlier Model for utilization review purposes. If MVP and/or any entity that administers benefits on behalf of MVP uses a utilization review tool for behavioral health services that is based on quantity or frequency of outpatient visits, such tool will be developed and updated annually based on clinical evidence and will be approved by a physician who is board-certified in general psychiatry, or, in the case of substance abuse services, a physician who is certified in addiction medicine. Any utilization review performed by MVP and/or any entity that administers benefits on behalf of MVP under such tool will be conducted only to the extent that the quantity or frequency of visits is inconsistent with clinical evidence. Where, after applying such tool to the requests or claims of a member, MVP denies coverage for services, the member shall be afforded all internal and external appeal rights.

36. No visit limits: there will not be any day or visit limits for behavioral health services in any MVP plan, except for family counseling services, which may be capped at 20 visits per year.

37. Utilization Review Process Reforms:

- a. Co-Location of Utilization Review Staff: a significant number of MVP's utilization review staff, and staff of any entity that administers behavioral health benefits on behalf of MVP, will be located at the same physical site. For purposes of this Paragraph, "a significant number" means any amount between 40% and 60% of utilization review staff subject to this Paragraph. In the event that a significant number of utilization review staff is not located at the same physical site for any reason, including, but not limited to, change of vendor or loss of staff members due to resignations/terminations/reductions, MVP shall have 180 days within which period to meet the requirements of this Paragraph. MVP supervisors at the site will have access to employees of any entity that administers behavioral health benefits on behalf of MVP.
- b. Collection of Information During Utilization Review: MVP and any entity that administers behavioral health benefits on behalf of MVP will follow a protocol for the collection of information during Utilization Review, which will include the elements set forth in Exhibit A.

- c. Substance Abuse Treatment: The utilization review process for determining medical necessity for inpatient substance abuse rehabilitation treatment should reflect that there are individuals for whom it may be medically necessary to begin inpatient substance abuse rehabilitation treatment without first undergoing outpatient treatment.
- d. Substance Abuse Treatment Criteria: For determining medical necessity for substance abuse treatment for Medicaid patients, MVP will adopt criteria that comport with or otherwise follow guidelines set by the New York State Department of Health and/or the New York State Office of Alcoholism and Substance Abuse Services.
- e. Continued Treatment: When an MVP member transitions from one level of behavioral health treatment to another, for example from inpatient to outpatient care, the review for the second level will be conducted as a concurrent review, because it concerns continued treatment.
- f. Classification of Denials: Any denials by MVP of coverage for behavioral health services due to lack of clinical information, and/or preauthorization, where the request for preauthorization was submitted by a credentialed provider for the actual date and services provided, will be processed as medical necessity denials.
- g. Duration of Approvals: The number of days or visits approved for behavioral health treatment will not be limited to one day or one visit

per approval and will be based on the treatment needs of the member, unless clinically appropriate.

38. Compliance Administrator: Within 30 days of the Effective Date, MVP will designate an MVP employee or consultant, subject to OAG approval, to serve as a compliance administrator (the “Compliance Administrator”) to: (i) evaluate MVP’s compliance with the terms of this Assurance; (ii) assess MVP’s utilization review system for behavioral health benefits; (iii) provide guidance to MVP and entities administering behavioral health benefits on behalf of MVP; and (iv) provide quarterly reports concerning items (i) through (iii) to the OAG.

- a. The Compliance Administrator will have appropriate qualifications and shall serve for a minimum of three (3) years from the date such Administrator commences service, subject to the provisions of subparagraph (h) below.
- b. The Compliance Administrator will be paid by MVP.
- c. On a quarterly basis, the Compliance Administrator will gather, review, and provide the OAG with data sufficient for the Compliance Administrator and OAG to evaluate MVP’s administration of behavioral health benefits, including: (i) claims review data; (ii) metrics demonstrating adequate access to effective behavioral health services, including, at a minimum: penetration rate; dollar spend on behavioral health services; utilization review results (including medical necessity denials); internal appeals and results thereof; external appeals and results thereof; and member satisfaction with

behavioral health coverage; and (iii) the content of adverse determination letters. The data described in this subparagraph (c) may be provided in the form of utilization analyses, key indicator reports, population analyses, and/or other reports generated in the normal course of business by MVP.

- d. The Compliance Administrator will analyze metrics for each level of behavioral health care: inpatient psychiatric, substance use disorder detoxification, substance use disorder rehabilitation, residential, partial hospitalization, intensive outpatient, and outpatient. The Compliance Administrator will also review a statistically significant sample of MVP's behavioral health medical necessity adverse determinations, and determine whether the determinations are correct.
- e. Based on the analyses described in (c) and (d) above, on a quarterly basis, the Compliance Administrator will provide a report to MVP's Chief Medical Officer and to the OAG, which report will address MVP's compliance with the terms of this Assurance and include data in support of the report's conclusions.
- f. In the quarterly reports described above, the Compliance Administrator will evaluate MVP's compliance with the terms of this Assurance, and will evaluate the performance of the Behavioral Health Advocates (who are described below), reviewing, in particular, metrics regarding call volume and case load.

- g. If, in the quarterly reports described above, the Compliance Administrator or OAG concludes that MVP is not compliant with the terms of this Assurance, MVP will create a written plan of corrective action, which it will provide within 30 days to the OAG. If, after reviewing the quarterly reports, OAG determines that MVP is not compliant with the terms of this Assurance, upon written notice from the OAG, MVP will create a written plan of corrective action, which it will provide within 30 days to the OAG.
- h. If, after the Compliance Administrator has functioned in the position for two years, MVP makes a showing to the OAG that it is compliant with the terms of this Assurance, and the OAG agrees that MVP is compliant with the terms of this Assurance, the Compliance Administrator shall cease to function.
- i. If, after the expiration of a three (3)-year period after the Effective Date, the OAG determines that MVP is not compliant with the terms of this Assurance, the Compliance Administrator will continue to function, pursuant to the provisions of this Paragraph 38, and the OAG shall produce a report setting forth MVP's alleged non-compliance with the terms of this Assurance and proposed steps for MVP to come into compliance. Following such OAG report, MVP, in consultation with OAG, shall develop a plan of corrective action to achieve compliance with the terms of this Assurance. In the event the Compliance Administrator continues to serve pursuant to the

provisions of this Paragraph following the conclusion of the three-year period after the Effective date, the Compliance Administrator's role shall terminate upon the conclusion of two consecutive quarters in which OAG deems that MVP is in compliance with the terms of this Assurance.

39. Adverse Determination Notification:

- a. When making adverse benefits determinations, MVP, and entities administering behavioral health benefits on behalf of MVP, must notify the member and provider in accordance with New York Public Health Law § 4903 and New York Insurance Law § 4903. Where practicable, such written notification shall be transmitted electronically, in a manner and in a form agreed upon by MVP and the provider(s). In addition, MVP shall provide: (i) contact information for the Behavioral Health Advocates (who are described below in Paragraph 40), with a notation that the Advocates can provide information about facilities and/or providers able to provide alternative services to the member; and (ii) the address of an online portal containing the medical necessity criteria used, if any, in making the adverse determination, and notice of the availability of a copy of such criteria, free of charge, upon request.
- b. Adverse determination letters will: (i) reflect the application of medical necessity criteria applicable to the requested level of care; (ii) provide the reason(s) for the adverse determination, including the

clinical rationale; (iii) contain member-specific facts linked to the reason(s) for denial and an explanation as to why the criteria are not met; (iv) contain clear, specific information about how to initiate standard and expedited appeals and a description of what, if any, additional necessary information must be provided to, or obtained by, MVP to render a decision on the appeal; and (v) be reviewed for accuracy by the individual who authorized the adverse determination prior to distribution to members and providers.

40. Behavioral Health Advocates: MVP will designate a minimum of three (3) full-time employees to serve as Behavioral Health Advocates, each of whom will spend all necessary time on services related to behavioral health advocacy, as set forth below:

- a. The Advocates, who may be employees of MVP or an entity that administers behavioral health benefits on behalf of MVP, will provide information and assistance to members with behavioral health complaints and appeals. Each member whose claim or request for coverage for behavioral health services is denied will be assigned an Advocate. Upon any denial of coverage for behavioral health services, upon request, MVP will provide to the member and provider the name of the assigned Advocate, who will be accessible to both the member and the provider and will supply them with assistance and detailed, accurate and current information regarding Utilization Review determinations and processes, medical necessity criteria, and appeals, as well as alternative treatment options for the member in the

member's area. MVP will also provide the OAG with the names of all Advocates and the members for whom each is responsible, upon request.

- b. As set forth above in Paragraph 38(f), on a quarterly basis, MVP will provide the OAG with data regarding the utilization of Behavioral Health Advocates, in particular, daily/weekly call volume and case load (for each Advocate). If, based on its review of such data, the OAG determines that the number of Advocates or the time spent by Advocates on services related to behavioral health advocacy is insufficient, MVP shall increase the time spent by Advocates on services related to behavioral health advocacy or designate additional Advocates.
- c. Nothing in this Assurance shall be interpreted to prevent any Behavioral Health Advocate from engaging in other work activities so long as all members who have requested assistance from a Behavioral Health Advocate have been provided assistance within the scope of this Paragraph.

41. Internal Appeals: MVP will offer members the assistance of Behavioral Health Advocates (described above) in internal appeals. MVP will review all behavioral health cases that have exhausted internal appeals and retain the ability to overrule internal appeal decisions of any entity that administers behavioral health benefits on behalf of MVP. MVP will continue coverage of treatment pending the completion of internal appeals.

42. External Appeals: To facilitate MVP members' timely submission of external appeals, in particular expedited appeals:
- a. When MVP or any entity acting on its behalf renders an adverse determination of a request for coverage of behavioral health services, such determination will be eligible for expedited external review, if it meets the criteria under New York Insurance Law Section 4914(b)(3) or New York Public Health Law Section 4914(2)(c), *i.e.*, if the member's provider states that a delay in providing the services would pose an imminent or serious threat to the health of the member.
 - b. When a member is eligible for expedited external appeal, as set forth in subpart (a) of this Paragraph, MVP will provide clear and conspicuous instructions, to the member and provider, orally and in writing, regarding external appeal options, including expedited appeals.
 - c. A provider may file an external appeal (whether standard or expedited) on behalf of a member for a prospective, concurrent, or retrospective denial of coverage for behavioral health services.

43. Residential Treatment: MVP will cover medically necessary residential treatment for behavioral health conditions in commercial health insurance products. As described in MVP's medical necessity criteria, residential treatment facilities provide 24-hour per day/7-day per week treatment and supervision to individuals with severe and persistent psychiatric disorders. Such facilities typically provide therapeutic intervention and specialized programming in a controlled environment with a high degree of

supervision and structure, in the context of a comprehensive, multidisciplinary and individualized treatment plan, with regular physician visits.

44. Training: MVP will provide training to all Utilization Review and customer relations staff regarding the requirements of Timothy's Law, New York Insurance Law provisions regarding substance use and eating disorder treatment, the Federal Parity Act, proper application of medical necessity criteria, and appeals processes. MVP will provide a copy of such training materials to the Compliance Administrator and the OAG for approval before dissemination.

45. Complaints: For a three (3)-year period, MVP will provide the OAG with a quarterly summary of member and provider complaints regarding behavioral health coverage. Upon OAG request, MVP will provide copies of individual complaints. If, pursuant to the provisions of Paragraph 38(h) above, the Compliance Administrator ceases to function prior to the expiration of a three (3)-year period after the Effective Date, MVP's obligation to provide complaint summaries to the OAG will cease at the same time.

46. Disclosures: MVP will provide to members, in clear and conspicuous language, in member handbooks, certificates of coverage, subscriber contracts, and/or where otherwise appropriate, disclosures regarding behavioral health coverage, as set forth in Exhibit B.

47. Annual Compliance Report: For each of the three (3) years following the Effective Date, MVP will file an annual report with the Compliance Administrator and the OAG, certifying compliance with the terms of this Assurance and outlining how its plans comply with Timothy's Law, New York Insurance Law provisions regarding

substance use and eating disorder treatment, and the Federal Parity Act. Such reports shall include the information set forth in Exhibit C. If, pursuant to the provisions of Paragraph 38(h) above, the Compliance Administrator ceases to function prior to the expiration of a three (3)-year period after the Effective Date, MVP's obligation to provide Annual Compliance Reports to the OAG will cease at the same time.

V. RETROSPECTIVE RELIEF

48. Within ninety (90) days of the Effective Date, MVP will implement the following remedial measures:

49. Independent Review of Medical Necessity Denials: For the period from January 1, 2011, through the Effective Date, where MVP denied a member or provider's request or claim for behavioral health treatment on the grounds of lack of medical necessity (other than denials covered under Paragraph 50 below), and the member subsequently incurred out-of-pocket costs for such treatment, but the member did not file an external appeal with respect to such request or claim:

- a. MVP will offer such members the opportunity to appeal the denial to an independent entity, designated by MVP and approved by the OAG, which will decide whether the treatment was medically necessary.
- b. MVP will provide a notice letter to such members informing them of their right to an independent appeal, in the form attached as Exhibit D. The OAG and MVP will agree on the form of the appeal application, which will be provided to such members along with the notice letter. These members will have four (4) months from the date of receipt of the notice letter and application to complete and return the application.
- c. If such member files an appeal under this Paragraph, and the independent entity determines that the treatment was medically necessary, MVP will reimburse that member the amount payable by MVP for such services, subject to applicable cost-sharing.

- d. “Lack of medical necessity,” as used in this Paragraph, shall mean a request or claim for treatment denied due to lack of medical necessity, lack of clinical information, or lack of preauthorization, where the request for preauthorization was submitted by a credentialed provider for the actual date and services provided.
- e. MVP Behavioral Health Advocates, described above in Paragraph 40, will be available to assist members with the appeal process described in this Paragraph, in addition to the Advocates’ other duties.
- f. MVP will bear the costs of the notice and appeals process.

50. Residential Treatment Reimbursement: For the period from January 1, 2011, through the Effective Date, where MVP denied a member or provider’s request or claim for residential treatment for behavioral health services on the grounds that residential treatment was not a covered service, and the member subsequently incurred out-of-pocket costs for such treatment, or where an MVP member obtained residential treatment services for behavioral health treatment purposes, and the member incurred out-of-pocket costs for such treatment but did not submit a claim to MVP for coverage of such services (“Residential Treatment Recipients”), MVP will reimburse such members as follows:

- a. MVP will provide a notice letter to certain members, including Residential Treatment Recipients, giving them the opportunity to submit information regarding any behavioral health treatment that resulted in out-of-pocket costs for residential treatment services during the period specified in this Paragraph, including those requests or

claims that were subsequently denied. The OAG and MVP will agree on the types of members who will receive such notice, to include, at a minimum, members who filed requests or claims for residential treatment and/or partial hospitalization services. Residential Treatment Recipients will have four (4) months from the date of receipt of this letter to submit all relevant information.

- b. MVP Behavioral Health Advocates, described above in Paragraph 40, will be available to assist Residential Treatment Recipients with the appeal process described in this Paragraph, in addition to the Advocates' other duties.
- c. MVP will reimburse Residential Treatment Recipients the amount payable by comparable third-party payers for such services, subject to applicable cost sharing, for residential treatment incurred during the period of time contemplated in this Paragraph, subject to the Residential Treatment Reimbursement Cap as defined in section (e).
- d. MVP will bear the costs of the notice and appeals process.
- e. The total funds available to MVP members under this Paragraph shall be \$1,500,000 (the "Residential Treatment Reimbursement Cap") and shall be distributed to Residential Treatment Recipients as follows:
 - i. If the total amount of money to be paid according to section (c) of this Paragraph is equal to, or less than, the Residential Treatment Reimbursement Cap, then each Residential Treatment Recipient shall receive reimbursement in the amount paid by comparable

third-party payers for such services, subject to applicable cost sharing; and

- ii. If, however, the total amount of money to be paid according to section (c) of this Paragraph exceeds the Residential Treatment Reimbursement Cap, then each Residential Treatment Recipient shall receive a *pro rata* reimbursement based on the amount paid by comparable third-party payers for such services, subject to applicable cost sharing.

VI. PENALTIES

51. Within sixty (60) days of the Effective Date, MVP shall pay \$300,000 to the OAG as a civil penalty, in lieu of any other action which could be taken by the OAG in consequence of the foregoing.

VII. MISCELLANEOUS

Compliance

52. MVP shall submit to the OAG, within ninety (90) days of the completion of the activities and restitution set forth in Paragraphs 33 through 50 above, a letter certifying and setting forth its compliance with this Assurance.

MVP's Representations

53. The OAG has agreed to the terms of this Assurance based on, among other things, the representations made to the OAG by MVP and its counsel and the OAG's own factual investigation as set forth in the above Findings. To the extent that any material representations are later found to be inaccurate or misleading, this Assurance is voidable

by the OAG in its sole discretion.

Communications

54. All communications, reports, correspondence, and payments that MVP submits to the OAG concerning this Assurance or any related issues is to be sent to the attention of the person identified below:

Michael D. Reisman, Esq.
Assistant Attorney General
Health Care Bureau
Office of the New York Attorney General
120 Broadway
New York, New York 10271
Michael.reisman@ag.ny.gov

55. Receipt by the OAG of materials referenced in this Assurance, with or without comment, shall not be deemed or construed as approval by the OAG of any of the materials, and MVP shall not make any representations to the contrary.

56. All notices, correspondence, and requests to MVP shall be directed as follows:

Justin B. Carangelo, Esq.
Acting Deputy General Counsel
MVP Health Care
625 State Street
Schenectady, New York 12305
JCarangelo@mvphealthcare.com

Valid Grounds and Waiver

57. MVP hereby accepts the terms and conditions of this Assurance and waives any rights to challenge it in a proceeding under Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

No Deprivation of the Public's Rights

58. Nothing herein shall be construed to deprive any member or other person

or entity of any private right under law or equity.

No Blanket Approval by the Attorney General of MVP's Practices

59. Acceptance of this Assurance by the OAG shall not be deemed or construed as approval by the OAG of any of MVP's acts or practices, or those of its agents or assigns, and none of them shall make any representation to the contrary.

Monitoring by the OAG

60. To the extent not already provided under this Assurance, MVP shall, upon request by the OAG, provide all documentation and information necessary for the OAG to verify compliance with this Assurance. This Assurance does not in any way limit the OAG's right to obtain, by subpoena or by any other means permitted by law, documents, testimony, or other information.

No Limitation on the Attorney General's Authority

61. Nothing in this Assurance in any way limits the OAG's ability to investigate or take other action with respect to any non-compliance at any time by MVP with respect to this Assurance, or MVP's noncompliance with any applicable law with respect to any matters.

No Undercutting of Assurance

62. MVP shall not take any action or make any statement denying, directly or indirectly, the propriety of this Assurance or expressing the view that this Assurance is without factual basis. Nothing in this paragraph affects MVP's (a) testimonial obligations or (b) right to take legal or factual positions in defense of litigation or other legal proceedings to which the OAG is not a party.

Governing Law; Effect of Violation of Assurance of Discontinuance

63. Under Executive Law Section 63(15), evidence of a violation of this Assurance shall constitute prima facie proof of a violation of the applicable law in any action or proceeding thereafter commenced by the OAG.

64. This Assurance shall be governed by the laws of the State of New York without regard to any conflict of laws principles.

65. If a court of competent jurisdiction determines that MVP has breached this Assurance, MVP shall pay to the OAG the cost, if any, of such determination and of enforcing this Assurance, including, without limitation, legal fees, expenses, and court costs.

No Presumption Against Drafter; Effect of any Invalid Provision

66. None of the parties shall be considered to be the drafter of this Assurance or any provision for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Assurance was drafted with substantial input by all parties and their counsel, and no reliance was placed on any representation other than those contained in this Assurance.

67. In the event that any one or more of the provisions contained in this Assurance shall for any reason be held to be invalid, illegal, or unenforceable in any respect, in the sole discretion of the OAG such invalidity, illegality, or unenforceability shall not affect any other provision of this Assurance.

Entire Agreement; Amendment

68. No representation, inducement, promise, understanding, condition, or

warranty not set forth in this Assurance has been made to or relied upon by MVP in agreeing to this Assurance.

69. This Assurance contains an entire, complete, and integrated statement of each and every term and provision agreed to by and among the parties, and the Assurance is not subject to any condition not provided for herein. This Assurance supersedes any prior agreements or understandings, whether written or oral, between and among the OAG and MVP regarding the subject matter of this Assurance.

70. This Assurance may not be amended or modified except in an instrument in writing signed on behalf of all the parties to this Assurance.

71. The division of this Assurance into sections and subsections and the use of captions and headings in connection herewith are solely for convenience and shall have no legal effect in construing the provisions of this Assurance.

Binding Effect

72. This Assurance is binding on and inures to the benefit of the parties to this Assurance and their respective successors and assigns, provided that no party, other than the OAG, may assign, delegate, or otherwise transfer any of its rights or obligations under this Assurance without prior written consent of the OAG.

Effective Date

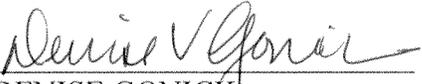
73. This Assurance is effective on the date that it is signed by the Attorney General or his authorized representative (the "Effective Date"), and the document may be executed in counterparts, which shall all be deemed an original for all purposes.

AGREED TO BY THE PARTIES:

Dated: Schenectady, New York

March ____, 2014

MVP Health Care, Inc.

By: 
DENISE GONICK
President and Chief Executive Officer

Dated: New York, New York

March 19, 2014

ERIC T. SCHNEIDERMAN
Attorney General of the State of New York

LISA LANDAU
Health Care Bureau Chief

By: 
MICHAEL D. REISMAN
Assistant Attorney General
Health Care Bureau

Exhibit A

Protocol for Collecting Information for Medical Necessity Determinations

In making medical necessity determinations regarding requests for coverage of behavioral health treatment, MVP will:

1. Attempt to obtain from members and providers all information necessary for determining whether a request for coverage of treatment meets the medical necessity for the particular level of care at issue. Such information will, at a minimum, and where appropriate, include: diagnosis; symptoms; treatment goals; and risks to the member from not continuing treatment.
2. Inform the member and provider, in writing, and where practicable, orally, of the specific information needed for making the medical necessity determination, the time frame to provide the information, and acceptable methods of submission.
3. Make available to the member and provider, upon request, a copy of MVP's medical necessity criteria for the level of care at issue.
4. In a case in which MVP determines that it lacks sufficient information to make a medical necessity determination, MVP will make reasonable efforts to obtain such information from the member and/or provider within the applicable statutory time frames for rendering decisions, including at least one attempt in writing and at least one attempt telephonically.

Exhibit B

Disclosures

MVP will make the following disclosures in member handbooks, certificates of coverage, subscriber contracts, and/or where otherwise appropriate:

1. MVP provides broad-based coverage for the diagnosis and treatment of behavioral health conditions, equal to the coverage provided for other health conditions. Behavioral health conditions include mental health and substance abuse disorders.

2. MVP provides, subject to medical necessity, unlimited benefits for inpatient and outpatient behavioral health care, as well as for residential treatment for behavioral health conditions, except for family counseling services, which may be capped at 20 visits per year.

3. For MVP members' outpatient behavioral health visits to psychologists, social workers, and nurse practitioners, MVP applies the member's primary care cost-sharing schedule. For outpatient behavioral health visits to psychiatrists, MVP applies the member's primary care cost-sharing schedule if the member has elected to designate his or her psychiatrist as his or her primary care provider, and MVP has approved that designation according to plan documents and procedures.

4. The utilization review conducted by MVP for each request or claim for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by MVP for each request or claim for similar medical/surgical benefits.

5. Any annual or lifetime limits on behavioral health benefits for MVP benefit plans are no stricter than such limits on medical/surgical benefits.

6. MVP does not apply any cost-sharing requirements that are applicable only to behavioral health benefits.

7. MVP does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at 20 visits per year.

8. The criteria for medical necessity determinations made by MVP regarding behavioral health benefits are made available: (i) on a website accessible by MVP members and providers; and (ii) upon request, to any current or potential participant, beneficiary, or contracting provider.

9. Where an MVP benefit plan covers medical/surgical benefits provided by out-of-network providers, the benefit plan covers behavioral health benefits provided by out-of-network providers.

10. Where an MVP member's benefit plan has a deductible, MVP charges a single deductible for all benefits, whether services rendered are for medical/surgical or behavioral health conditions, with the exception that MVP charges a separate deductible for prescription drugs.

11. MVP offers its members the services of Behavioral Health Advocates, who are trained to assist MVP members in accessing their behavioral health benefits, by supplying them detailed, accurate, and current information regarding: treatment options in the member's area; utilization review determinations and processes; medical necessity criteria; and appeals.

Exhibit C

Compliance Report

MVP will include in its annual Compliance Report evidence of the following:

1. MVP provides broad-based coverage for the diagnosis and treatment of behavioral health conditions, equal to the coverage provided for other health conditions. Behavioral health conditions include mental health and substance abuse disorders.
2. MVP provides, subject to medical necessity, unlimited benefits for inpatient and outpatient behavioral health care, as well as for residential treatment for behavioral health conditions, except for family counseling services, which may be capped at 20 visits per year.
3. For MVP members' outpatient behavioral health visits to psychologists, social workers, and nurse practitioners, MVP applies the member's primary care cost-sharing schedule. For outpatient behavioral health visits to psychiatrists, MVP applies the member's primary care cost-sharing schedule if the member has elected to designate his or her psychiatrist as his or her primary care provider, and MVP has approved that designation according to plan documents and procedures.
4. The utilization review conducted by MVP for each request or claim for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by MVP for each request or claim for similar medical/surgical benefits.
5. Any annual or lifetime limits on behavioral health benefits for MVP benefit plans are no stricter than such limits on medical/surgical benefits.

6. MVP does not apply any cost-sharing requirements that are applicable only to behavioral health benefits.

7. MVP does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at 20 visits per year.

8. The criteria for medical necessity determinations made by MVP regarding behavioral health benefits are made available: (i) on a website accessible by MVP members and providers; and (ii) upon request, to any current or potential participant, beneficiary, or contracting provider.

9. Where an MVP benefit plan covers medical/surgical benefits provided by out-of-network providers, the benefit plan covers behavioral health benefits provided by out-of-network providers.

10. Where an MVP member's benefit plan has a deductible, MVP charges a single deductible for all benefits, whether services rendered are for medical/surgical or behavioral health conditions, with the exception that MVP charges a separate deductible for prescription drugs.

Exhibit D

[Residential Treatment Denial Letter]

[MVP Letterhead]

[date]

Dear Member:

As the result of an investigation by the Health Care Bureau of the New York State Office of the Attorney General (OAG), it has come to our attention that (1) MVP has denied your request(s) or claim(s) for behavioral health treatment on the grounds that residential treatment was not a covered benefit, or (2) MVP has determined that you are a member who may have opted not to submit a claim for coverage of residential treatment services because such treatment was not a covered benefit.

As a result of a settlement with the OAG, this letter is to inform you that MVP has agreed to retroactively cover medically necessary residential treatment services provided for behavioral health purposes between January 1, 2011 through the date of this letter. The retroactive coverage will address two groups of claims, as follows:

First, MVP will be submitting all previously submitted, but denied, claims to a third-party, independent reviewer. If you possess any documentation to support your initial claim(s), please submit such documents to MVP, along with the enclosed claim appeal form, so that such information may be considered by the third-party, independent reviewer.

Second, for members who opted not to submit a claim for residential treatment services provided during the above time period, you may submit such claims at this time by following the instructions in the enclosed claim appeal application.

Both groups of claims will be reviewed by the third-party, independent reviewer for a medical necessity determination. Where the third-party, independent reviewer determines that the resident treatment was medically necessary, MVP will reimburse you in accordance with the terms of your policy's certificate of coverage in place at the time of service, subject to a total cap of claim payments for all retroactive coverage by MVP of \$1,500,000. Please note that the determination of the independent entity shall be final and no appeal rights will be provided to either the member or MVP following the independent entity's determination.

Enclosed please find [an explanation of benefits form, along with] an appeal application. If you wish to pursue the appeal, please complete and return the application, with all necessary documentation, within four (4) months from the date you received this

letter.

If you have any concerns regarding the appeal process, you may also contact the OAG's Health Care Bureau for assistance by phone at (800) 428-9071 or by writing to:

NYS Office of the Attorney General
Health Care Bureau
The Capital, Albany, N.Y. 12224-0341

Very Truly,

[MVP Letterhead]
[Medical Necessity Denial Letter]

[date]

Dear Member:

As the result of an investigation by the Health Care Bureau of the New York State Office of the Attorney General (OAG), it has come to our attention that MVP has denied your request(s) or claim(s) for behavioral health treatment for services provided between January 1, 2011 through the date of this letter on the grounds that the treatment was not medically necessary, and that MVP's denial letters may have insufficiently notified you of the reasons for MVP's denial.

As a result of a settlement with the OAG, this letter is to inform you that MVP has agreed to allow members an independent appeal of denials of certain requests and claims. If, for behavioral health services provided between January 1, 2011 through the date of this letter, you have not already filed an external appeal of a request or claim that was denied on the grounds that treatment was not medically necessary, you may appeal, at this time, that denial to a third-party, independent reviewer, which will decide whether the treatment was medically necessary.

If the independent entity determines that the treatment was medically necessary, MVP will reimburse you in accordance with the terms of your policy's certificate of coverage in place at the time of service. The determination of the independent entity shall be final and no appeal rights shall be provided to either the member or MVP following the independent entity's determination.

Enclosed please find an explanation of benefits form, along with an appeal application. If you wish to pursue the appeal, please complete and return the application within four (4) months from the date you received this letter. If you need assistance in this process, you may contact an MVP Behavioral Health Advocate at_____.

If you have any concerns regarding the appeal process, you may also contact the OAG's Health Care Bureau for assistance by phone at (800) 428-9071 or by writing to:

NYS Office of the Attorney General
Health Care Bureau
The Capital, Albany, N.Y. 12224-0341

Very Truly,