ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU

In the Matter of

Assurance No. 24-011

Investigation by LETITIA JAMES,
Attorney General of the State of New York, of

MVP Health Plan, Inc. and
MVP Health Services Corp.,

Respondents.

ASSURANCE OF DISCONTINUANCE

The Office of the Attorney General of the State of New York ("OAG") commenced an investigation pursuant to New York Executive Law § 63(12) into the business practices of MVP Health Plan, Inc. and MVP Health Services Corp. (collectively, "Respondents") relating to the accuracy of their mental health participating provider directories and the adequacy of their networks of mental health providers. This Assurance of Discontinuance ("Assurance") contains the findings of OAG's investigation ("Findings") and the relief agreed to by the OAG and Respondents, whether acting through its respective directors, officers, employees, representatives, agents, affiliates, or subsidiaries (collectively, the "Parties").

OAG's INVESTIGATION AND FINDINGS

1. MVP Health Plan, Inc. is a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law and MVP Health Services Corp. is a not-for-profit health service corporation licensed pursuant to Article 43 of the New York Insurance Law.

2. Respondents' principal offices are located at 625 State Street, Schenectady, New York 12305.

3. In the regular course of business, Respondents enroll consumers in health plans and contracts with mental health care providers for the delivery of health care services to those consumers within 55 New York counties.

The Mental Health Crisis in New York State

4. Three million adult New Yorkers — one in five — live with mental illness.[1] In February 2023, 31% of New Yorkers reported symptoms of anxiety or depression. [2] The COVID-19 pandemic dramatically increased the need for mental health services.[3]

5. Access to treatment remains out of reach for many. More than half of insured adults surveyed in a national survey[4] who do not get needed mental health treatment cite lack of coverage by their health plans as the reason.[5] In 2022, almost 500,000 New York children aged 3 through 17 had a diagnosed behavioral health condition (depression, anxiety problems, or behavioral or conduct problems).[6] Of those children, 196,000 (40%) did not receive treatment or counseling.[7]

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[1] Kaiser Family Found. (KFF), *New York: Mental Health & Substance Abuse*, https://www.kff.org/state-category/mental-health/?state=NY (2,972,000 (19.5%) adults in New York reported mental illness from 2018-19).
[2] Kaiser Family Found. (KFF), *Mental Health in New York*, https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/new-york.
[3] *See* N.Y. State Health Found., *Mental Health Impact of the Coronavirus Pandemic in New York State* (2021), https://nyshealthfoundation.org/wp-content/uploads/2021/02/mental-health-impact-coronavirus-pandemic-new-york-state.pdf; NYC Dep't of Health and Mental Hygiene, *Impacts of COVID-19 on Mental Health in New York City*, 2021 (2021), https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf.
[4] Kaiser Family Foundation. (KFF), *KFF Survey of Consumer Experiences with Health Insurance* (Jun. 15, 2023). https://www.kff.org/private-insurance/poll-findings/kff-survey-of-consumer-experiences-with-health-insurance/. Survey of Consumer Experiences with Health Insurance | KFF
[5] Kaiser Family Found. (KFF), *Proposed Mental Health Parity Rule Signals New Focus on Outcome Data as Tool to Assess Compliance* (Sept. 29, 2023), https://www.kff.org/mental-health/issue-brief/proposed-mental-health-parity-rule-signals-new-focus-on-outcome-data-as-tool-to-assess-compliance/.
[6] Child and Adolescent Health Measurement Initiative, *2022 National Survey of Children's Health*, https://www.childhealthdata.org/browse/survey/results?q=10029&r=34.
[7] *Id*.

6. Consumers depend on their health insurance to access and afford mental health treatment for themselves and their family members. One important way to find in-network treatment providers and to shop for insurance is for consumers to look to provider directories published by health plans. But consumers – in particular those with mental health conditions – experience many challenges when using these directories, including providers not accepting new patients, long wait times to see providers, and inaccurate or out-of-date provider information.

7. Secret shopper surveys, in which callers simulate the experience of consumers calling providers in a plan's network directory, is one way to test directory accuracy and identify gaps in access to network providers. Numerous secret shopper studies conducted during the past eight years have pointed to serious inaccuracies in health plans' provider directory listings for mental health providers, including incorrect and/or out-of-date information about network status, location, and availability to accept new patients.[8] In July 2024, a study published in the Journal of the American Medical Association showed that only 17.8% of mental health clinicians listed as in-network for Medicaid plans were reachable, accepted Medicaid, and could provide a new patient appointment.[9] These are referred to as "ghost networks" — providers who are listed in a provider directory as being in-network but may not be taking new patients as of that date or may not actually

[8] In 2017, a survey of BlueCross BlueShield plans in five cities found that mental health appointments for children were obtained with only 40% of the pediatricians and 17% of the child psychiatrists. Shireen Cama et al., Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities, 47 Int'l J. Health Servs. 621, 630 (2017), https://pubmed.ncbi.nlm.nih.gov/28474997/. A different study of BlueCross BlueShield plans in three cities found that mental health appointments with psychiatrists were obtained with only 26% of psychiatrists. Monica Malowney et al., Availability of Outpatient Care from Psychiatrists: A Simulated-Patient Study in Three U.S. Cities, 66 Psychiatr. Serv. 94, 95 (2015), https://pubmed.ncbi.nlm.nih.gov/25322445/. And a study of three health plans' directories in the Washington, D.C. area found that only seven percent of psychiatrists offered an appointment within two weeks. Benzion Blech et al., Availability of Network Psychiatrists Among the Largest Health Insurance Carriers in Washington, D.C., 68 Psychiatr. Serv. 962, 964 (2017), https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201600454.

[9] Cantor J, Schuler MS, Matthews S, Kofner A, Breslau J, McBain RK. Availability of Mental Telehealth Services in the US. *JAMA Health Forum.* 2024;5(2):e235142, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2814605.

be in a health plan's network as of that date based upon the results of a secret shopper survey phone call.

OAG's Investigation of Respondents

8. Respondents issue and administer various types of health plans in New York, including, without limitation, preferred provider organization plans, health maintenance organization plans, Medicaid Managed Care Plans, and Child Health Plus plans.

9. Respondents contract with various types of mental health providers and facilities in New York to participate in their networks ("Participating Providers") and accept negotiated rates plus the applicable member co-payment, coinsurance, and/or deductible as payment in full for covered services rendered to the members of their plans ("Members").

10. Currently, Respondents have approximately 328,175 Members in their commercial insurance and Medicaid plans, most of whom reside in New York's Capital District, Hudson Valley, and counties in Western New York.

11. Respondents maintain a website that through an online search engine allows users to search for information about credentialed mental health Participating Providers ("Online Provider Directory"). Respondents also publish a printed directory of Participating Providers ("Print Directory").

12. Respondents' Online Provider Directory includes listings, by specialty, for mental health Participating Providers (including facilities) that include name, addressees, telephone number(s), and in the case of psychiatrists, specialty area, any hospital affiliations, any applicable board certification, and whether they are accepting new patients.

13. Respondents' Online Provider Directory is not only available to Members but is also accessible to those consumers who seek information about Respondents' Participating Provider network before becoming a Member.

14. Using a methodology commonly used in academic studies published in peer reviewed journals, OAG conducted a "simulated patient" secret shopper study of mental health Participating Providers listed in Respondents' Online Provider Directory. In 2023, OAG's Health Care Bureau investigated the accuracy of mental health provider listings in Respondents' Online Provider Directory by calling 24 listed mental health Participating Providers who have offices in three New York counties: Albany, Schenectady, Columbia; with satellite offices also in Dutchess, Orange, Saratoga, Ulster, Warren, and Westchester. All telephonic secret survey calls were made to mental health providers specifically listed in Respondents' Online Provider Directory as accepting new patients, and included psychiatrists, nurse practitioners, doctoral-level psychologists, and social workers.

15. The OAG called providers posing as a family member of a person with a mental health condition, with the goal of securing an appointment for them using Respondents' health plans. For two-thirds of the calls, staff used Scenario A (a fictional prospective adult patient), stating the family member is depressed and their primary care physician suggested they see a mental health provider. For one-third of the calls, staff used Scenario B (a fictional prospective child patient), stating they are the parent of a 14-year-old who has who has begun having problems in school. When callers reached a voicemail they left a message with a request for a call back. When the listed phone number was incorrect but callers reached a person who could direct them to another number, the caller followed those instructions and attempted to reach the listed provider.

16. Of the 24 Participating Providers listed in Respondents' Online Provider Directory whom the OAG contacted, as of the survey date seven (29%) did not work at the listed location, seven (29%) were not accepting new patients, and six (25%) were non-working numbers, incorrect numbers, or unreturned calls. During the survey period, OAG staff were unable to make appointments with any of the listings. Based on its secret shopper survey, the OAG concluded that all of the listed providers staff attempted to contact were therefore "ghosts," as they were either unreachable, not accepting new patients, or not in-network — despite being listed in Respondents' directory as in-network and accepting new patients. The following chart shows detailed results of the OAG's survey:

Plan: MVP | Location: Albany

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	14	4	0	0	0%	100%
Scenario B (child)	10	5	0	0	0%	100%
MVP totals	**24**	**9**	**0**	**0**	**0%**	**100%**

The OAG's investigation has uncovered systemic problems with MVP's mental health provider directory accuracy and MVP members' ability to access mental health care.

The Harms Caused by Inaccurate Provider Directories

17. Inaccurate provider directories cause consumers seeking health care to expend time and resources combing through website listings and calling providers' officers to secure an appointment with an in-network provider. Ghost networks can exacerbate mental health conditions, creating additional anxiety and feelings of hopelessness for patients, who may delay or forego care altogether due to the difficulty of accessing services, the cost, or both.

18. Surveys consistently show that lack of adequate insurance coverage is a major reason why consumers with mental health conditions go without treatment. According to a 2022

survey conducted by The Harris Poll, 43% of Americans who needed mental health or substance use-related care in the past year did not receive it, compared to only 21% of those who needed primary care.[10] Notably, 43% of those who did not receive necessary mental health care in the past year cited insurance-related issues as the barrier and 37% reported that cost-related issues prevented them from accessing care.[11]

19. Inaccurate provider directories — and the resultant inability to find in-network providers — lead many consumers to seek out-of-network care. A study analyzing health insurance claims data showed large disparities in out-of-network provider use between behavioral health and physical health services. In New York in 2017, outpatient behavioral health office visits were 10 times more likely than medical/surgical inpatient stays and primary care visits to be out-of-network.

20. Many consumers who use out-of-network providers are confronted with surprise bills. In other words, they did not initially know that a provider was out-of-network. In a national survey conducted in 2018, the majority of respondents who had used a mental health provider directory encountered inaccuracies, and as a result of those inaccuracies, were twice as likely as recipients of general medical services to be treated by an out-of-network provider and four times more likely to receive a surprise outpatient out-of-network bill.[12]

21. Higher out-of-network utilization results in higher costs for consumers. A study of psychotherapy costs between 2007 and 2017 found that out-of-network prices dramatically

[10] Nat'l Council for Mental Wellbeing, 2022 Access to Care Survey Results, at 4 (May 11, 2022), https://www.thenationalcouncil.org/resources/2022-access-to-care-survey-results/.
[11] *Id.* at 9, 20.
[12] Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39 Health Affs. 975, 978-80 (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

increased for both adults (from $123.30 to $148.64) and children (from $119.83 to $139.18), even as in-network prices and cost sharing declined.[13] Consumers who lack out-of-network benefits must pay the entire cost of treatment, which is a strong deterrent to seeking care.

22. The harms related to the lack of adequate behavioral health service providers in New York State fall disproportionately on populations that are already marginalized in the health care system.

Directory Accuracy Requirements for Health Plans

23. New York law requires health plans to include in their provider directories a listing, by specialty, of the name, address, and telephone number of all participating providers, noting whether each provider is accepting new patients. N.Y. Ins. L. §§ 3217-a(a)(17) and 4324(a)(17); N.Y. Pub. Health L. § 4408(1)(r). For mental health and substance use disorder treatment providers, the directories must include any affiliations with participating facilities certified or authorized by the Office of Mental Health ("OMH") or the Office of Addiction Services and Supports ("OASAS"), and any restrictions regarding the availability of the individual provider's services. Insurers must maintain the provider directory on their website and revise it annually, updating the website within 15 days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliations.

24. New York law dictates that if a health plan member receives a bill for out-of-network services resulting from inaccurate network status information provided by their health plan, the plan must pay for the services and can charge the member only their in-network cost

[13] Nicole M. Benson & Zirui Song, *Prices and Cost Sharing for Psychotherapy In Network Versus Out Of Network In The United States*, 39 Health Affs. 1210, 1212-1213 (July 2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01468. The prices are adjusted to 2016 US dollars.

sharing, regardless of whether the member's coverage includes out-of-network services. N.Y. Ins. L. §§ 3217-b(n) and 4325(o); N.Y. Pub. Health L. § 4406-c(12); 11 N.Y.C.R.R. § 52.77(a).

25. New York 10 N.Y.C.R.R. 98-1.16(i) requires that "every MCO shall maintain and update, on a quarterly basis, a listing by specialty of the names, addresses and telephone numbers of all participating providers, including facilities, and in the case of physicians, board certification. Where the MCO contracts with behavioral health facilities rather than directly with behavioral health providers, the provider types available at the facilities must be included in the listing."

26. The federal No Surprises Act requires all private health plans to verify their online provider directories at least every 90 days. 42 U.S.C. § 300gg-115(a).

Mental Health Network Adequacy Requirements for Health Plans

27. New York requires each commercial health insurance plan to "ensure that the[ir] network is adequate to meet the health and mental health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract." N.Y. Ins. L. § 3241(a)(1).

28. New York health plans must provide referrals to non-participating providers at in-network cost sharing for members who are unable to access an appropriate participating provider. N.Y. Ins L. §§ 4804(a), 4910(b)(4).

29. Pursuant to the Affordable Care Act, CMS has issued network adequacy regulations for qualified health plans ("QHPs") including those sold on the New York State of Health Marketplace. Each QHP must maintain a network "that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay." 45 C.F.R. § 156.230(a)(1)(ii).

Health Plans' Obligations to Provide Accurate Information

30. New York General Business Law § 349(a) prohibits "deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service" in New York State.

31. New York General Business Law § 350 prohibits false advertising "in the conduct of any business, trade or commerce or in the furnishing of any service" in New York.

32. New York Public Health Law § 4405(10) permits health maintenance organizations to advertise their health care services provided that "all information disseminated to the public shall be strictly factual in nature and accurate in all respects and shall not in any way be misleading to the public."

33. OAG finds that Respondents' actions and omissions are in violation of: N.Y. Exec. L. § 63(12); N.Y. Ins. L. §§ 3217-a(a)(17), 4324(a)(17), and 3241(a)(1)); N.Y. Pub. Health L. §§ 4408(1)(r) and 4405(10); 10 N.Y.C.R.R. § 98-1.16(i); General Business Law §§ 349(a) and 350; 42 U.S.C. § 300gg-115(a); and 45 C.F.R. § 156.230(a)(1)(ii).

34. Respondents neither admit nor deny the OAG's Findings set forth above, in Paragraphs 1 through 33, but have been responsive and fully cooperative with the OAG's investigation.

35. The OAG finds the relief and agreements contained in this Assurance appropriate and in the public interest. THEREFORE, the OAG is willing to accept this Assurance pursuant to Executive Law § 63(15), in lieu of commencing a statutory proceeding for violations of Executive Law § 63(12) based on the conduct described above during the period of January 1, 2022 through present.

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

RELIEF

Entities Bound By Assurance

36. This Assurance binds Respondents as well as their principals, officers, successors, and assigns.

Compliance with the Law

37. Respondents shall not engage, or attempt to engage, in conduct in violation of any applicable laws and regulations, including but not limited to N.Y. Exec. L. § 63(12); N.Y. Ins. L. §§ 3217-a(a)(17), 4324(a)(17), and 3241(a)(1)); N.Y. Pub. Health L. §§ 4408(1)(r) and 4405(10); 10 N.Y.C.R.R. § 98-1.16(i); N.Y. Gen. Bus. L. §§ 349(a) and 350; 42 U.S.C. § 300gg-115(a); and 45 C.F.R. § 156.230(a)(1)(ii).

Programmatic Relief

38. Respondents will begin to implement the relief described in Paragraphs 40 through 57 below immediately upon the full execution of this Assurance.

39. For avoidance of any doubt, the relief described in Paragraphs 40 through 57 below apply to mental health Participating Providers contracted with Respondents' fully insured commercial health plans, Medicaid managed care plans, and Child Health Plus plans.

40. Respondents shall maintain an Online Provider Directory that includes an accurate listing for each Participating Provider ("Participating Provider Information") that shall include, as reported by such Participating Provider and verified by Respondents:

a. name, address, telephone number, licensure, and digital contact information;

b. whether the provider or facility is accepting new patients;

c. for mental health and substance use disorder providers, any affiliations with participating facilities certified or authorized by the Office of Mental Health or the Office of Addiction Services and Supports;

d. any restrictions regarding the availability of the individual provider or facility's services;

e. languages other than English spoken by the Participating Provider; and

f. for physicians, board certification and any affiliations with participating hospitals.

g. The above-noted information shall also be published in a Print Directory made available to current and new enrollees, upon request, which shall contain a clear and conspicuous disclaimer that the information contained therein was accurate as of the date of publication and that Members should consult the Online Provider Directory to obtain the most current provider directory information.

41. Respondents shall, as of the Effective Date of this Assurance:

a. update their Online Provider Directory within fifteen (15) days of Respondents learning of, or receiving from a Participating Provider, information regarding the beginning or termination of network agreements, or material changes to the content of the Participating Provider Information of the provider.

b. document providers who are removed from and added to the Online Provider Directory by name, office address, date of removal or addition, reason for removal or addition, and if applicable, date on which their participation in Respondents' networks ended.

c. create and maintain the "Mental Health Provider Directory Deletion/Addition Report," which shall include, for mental health providers who are removed from or added to their Online Provider Directory, name, office address, date of removal or addition, reason for removal or addition, and if applicable, date on which their participation in Respondents' networks ended. As used in this Assurance, a "Mental Health Provider" is a New York-licensed psychiatrist, psychiatric nurse practitioner, master social worker, clinical social worker, psychologist, mental health counselor, creative arts therapist, marriage and family therapist, or psychoanalyst.

42. ***Verification Process***. Within ninety (90) days after the Effective Date, Respondents shall establish an Online Provider Directory verification process ("Verification Process"). Respondents shall follow a written procedure, a copy of which written procedure Respondents shall provide to the OAG within thirty (30) days after the Effective Date.

a. Every ninety (90) days (a "Verification Cycle"), Respondents shall:

i. Outreach each credentialed mental health Participating Provider by electronic means, fax, or through U.S. mail (for those that opt out of electronic communications) to request they verify the accuracy of information included in their directory listing. Electronic means shall include, but not be limited to, a pop-up message triggered upon login to provider websites maintained by Respondents, which is linked to a directory information accuracy verification form.

ii. Stratify Participating Providers into three groups:

(a) Providers who remain in the directory. These include providers who verified the accuracy of their directory information.

(b) Providers who remain in the directory but require further investigation. This includes Providers who attest to the accuracy of their directory information but require further investigation by Respondents to determine accuracy based on the following criteria, including at least two follow-up contacts or action steps to confirm the following:

(1) Providers who have not submitted a claim within the last 90 days. Respondents shall attempt at least two contacts with such providers to confirm their continued participation, including one by certified mail, return receipt requested.

(2) Providers with deactivated, invalid, missing or HHS OIG Exclusion-listed NPIs.

(3) Providers listed as practicing at five or more unaffiliated locations.

(c) Providers who must be removed from the directory. Within thirty (30) days after the Effective Date, Respondents shall complete a review of their most recent provider verification information and, within fifteen (15) days after such review, remove Participating Providers who have: (i) not responded to MVP's most recent verification request; or (ii) indicated in response to a verification request or other communication to MVP that they are no longer providing services, no longer participating with MVP or not accepting new patients. Thereafter, Respondents shall remove Participating Providers who do

not verify their directory information within fifteen (15) days after a verification cycle, or within fifteen (15) days from when Respondents learn, through a response to a verification request or other communication to MVP, that a Participating Provider is no longer providing services, no longer participating with MVP or not accepting new patients, regardless of a Verification Cycle. Respondents may use a third party to verify directory information on Respondents' behalf.

(1) Notwithstanding Paragraph 42(a)(ii)(c) above, if a Provider does not verify their directory information within fifteen (15) days after a Verification Cycle, but in the past ninety (90) days has submitted to Respondents claims, request for authorization, and/or medical records, such Provider may remain in the directory but without a notation that they are accepting new patients, and Respondents shall perform diligence to ensure the directory information for the provider is accurate and take all reasonable steps to secure a verification as soon as possible. If Respondents cannot verify such Providers' directory information, they shall remove such providers from its directory.

iii. Conduct rolling outreach such that each Participating Provider verifies the accuracy of their information every 90 days. In other words, the provider's verification resets the 90-day cycle.

iv. Maintain documentation of all efforts undertaken in the Verification Process for each Participating Provider listed in their Online Provider

Directory, which shall accurately reflect the dates on which each provider's Participating Provider status and Participating Provider Information were verified. If Respondents use telephone communications to verify Participating Provider status and Participating Provider Information as part of their Verification Process, it shall record any and all telephone calls.

v. Conduct educational outreach to professional associations to emphasize the importance of provider cooperation in Respondents' verification process.

43. ***Response Protocol***. Within 90 days after the Effective Date, Respondents shall establish a protocol for processing requests for information regarding Participating Providers ("Response Protocol") that shall follow a written policy and procedure, a copy of which written policy and procedure Respondents shall provide to the OAG within 30 days of the Effective Date.

a. For Members who request information on whether a provider is in-network through a letter, telephone call or electronic, web-based, or Internet-based means, Respondents shall reply to the Member as soon as practicable and in no case later than three business days after such communication is received, through a written electronic, print, or telephonic (as requested by such individual) communication.

b. Respondents shall retain such communication in such Member's file for at least two years following such response.

44. ***Incorrect Directory Information Protocol.*** Within 90 days of the Effective Date, Respondents shall modify its procedures to establish an incorrect Directory Information Protocol. This Incorrect Directory Information Protocol shall follow a written policy and procedure, a copy of which Respondents shall provide to the OAG within 60 days of the Effective Date.

a. If Respondents provide "inaccurate network status" information to a Member, Respondents shall not impose on the Member a cost-sharing amount greater than that which would apply if the service had been provided by a Participating Provider.

b. Respondents shall be deemed to provide inaccurate network status information: (i) if Respondents indicate in their Online Provider Directory that a non-participating provider is participating in Respondents' networks; (ii) if Respondents provide, through their Response Protocol, that a non-participating provider is participating in Respondents' networks; (iii) if Respondents fail to provide information regarding a specific provider's participating status within three business days of a request from a member; (iv) if Respondents indicate in a print provider directory that a provider is participating in Respondents' networks and the provider is non-participating as of the date of publication.

45. ***Complaint Monitoring System***. Within 90 days of the Effective Date, Respondents shall modify its procedures related to a Provider Directory Network Access Complaint Monitoring System ("Complaint Monitoring System"). Respondents shall:

a. log and track by date all disputes and complaints relating to the subject matter of this Assurance, including but not limited to inaccurate Online Provider Directory listings, network access issues, and requests for referrals to non-participating providers made to or through Respondents' regulatory affairs group, customer service lines, and appeals processes.

b. document how each dispute or complaint was handled and resolved.

c. create and maintain a report ("Complaint Report") listing the information contained in (a) and (b).

46. ***Mental Health Participating Provider Recruitment and Retention Plan***. Within 90 days of the Effective Date Respondents shall create and submit to OAG a mental health provider recruitment and retention plan ("Mental Health Provider Recruitment and Retention Plan"), which shall include details regarding mechanisms through which Respondents can expand their network of mental health providers, including new and existing providers that offer in-person and telehealth services, so long as Respondents have enough providers in their networks to meet the needs of Members who request in-person services. The Mental Health Provider Recruitment and Retention Plan shall include, at a minimum, specific proposals for: (a) outreach to New York-licensed mental health providers who are not currently Participating Providers; and (b) periodically reviewing existing provider fee schedules and network needs for Mental Health Participating Providers

47. ***Training***. Respondents shall develop a written training protocol regarding the provisions in Paragraphs 40 through 46 above for all personnel involved in administering the Online Provider Directory and/or in provider relations ("Relevant Personnel"). Respondents shall submit such training materials to the OAG within 30 days of the Effective Date.

a. Respondents shall train staff based on the written materials. All Relevant Personnel shall be trained on the materials within three months of OAG approval of such materials. Thereafter, new Relevant Personnel will be trained within thirty days of commencing their duties. Training will continue on an annual basis and must be provided to all Relevant Personnel no less than one time per year until three years after the Effective Date.

b. Respondents shall create and maintain records regarding all training conducted pursuant to this Paragraph, including records of attendance. Such records shall be reviewed by the Compliance Administrator as part of its audits, and provided to OAG no more than 14 days after a demand for such records is made.

48. Respondents shall make new and meaningful investments in implementing one or more of the following initiatives and, during the period in which the Compliance Administrator functions (see Paragraphs 49 through 51 below), shall report annually to OAG a summary of the investments made:

a. Recruiting additional psychiatrists and psychiatric nurse practitioners who treat children and adolescents into Respondents' provider networks, though outreach efforts to: hospitals; clinics; professional associations; medical fellowship, residency and internship programs; medical schools; universities and colleges; behavioral health advocacy organizations; and other community resources.

b. Providing assistance to providers in navigating Respondents' directory information verification process.

c. Conducting outreach to members regarding mental health services spanning the continuum of care that are available in their communities and covered by Respondents.

Monitoring and Oversight by Compliance Administrator

49. Within 90 days of the Effective Date, Respondents will designate an MVP employee(s) or consultant(s), approved by the OAG, with experience in reviewing online provider directories, provider networks, and health insurance claims processes, to serve as compliance administrator ("Compliance Administrator"), to submit to OAG bi-annual reports detailing

Respondents' compliance with the requirements set forth in Paragraphs 40 through 47 of this Assurance (each, a "Compliance Report"). The first such Compliance Report shall be submitted to the OAG nine months after the Effective Date (the "First Compliance Report"). Subsequently, Respondents shall submit Compliance Reports every six months, continuing until Respondents have submitted four such Compliance Reports, subject to the provisions of Paragraph 49 below. Within 60 days after the Effective Date, Respondents shall make all necessary information available to the Compliance Administrator, including, but not limited, to provider network and health claims data systems. The Compliance Reports shall: (a) assess Respondents' compliance with the programmatic relief set forth above in Paragraphs 40 through 47; (b) summarize the Compliance Administrator's collection and review of the information set forth below in Paragraphs 52 through 58; and (c) report on administration of the restitution process set forth below in Paragraph 59. Each Compliance report shall also include: detailed results of the Compliance Administrator's reviews, including relevant statistics; the Complaint Report (described above in Paragraph 45(c)) and Mental Health Provider Directory Deletion/Addition Report (described above in Paragraph 41(c)); and a description and schedule of any corrective measures taken by Respondents or planned to be taken by Respondents, if necessary.

50. If, after the Compliance Administrator has submitted to the OAG reports every six months for two years from the date of implementation of all protocols listed above, Respondents demonstrate compliance with the terms of this Assurance, and the OAG agrees that Respondents are compliant with the terms of this Assurance, the Compliance Administrator shall cease to function. For the avoidance of doubt, notwithstanding this paragraph, the OAG retains its right to begin a new investigation.

51. If, after the Respondents have submitted four compliance reports, the OAG determines that Respondents are not compliant with the terms of this Assurance, the Compliance Administrator will continue to function and the OAG shall produce a report setting forth Respondents' alleged non-compliance with the terms of this Assurance and proposed steps for Respondents to come into compliance. Following such OAG report, Respondents, in consultation with OAG, shall develop a plan of corrective action to achieve compliance with the terms of this Assurance. Thereafter, the Compliance Administrator's role shall terminate upon the conclusion of a reporting cycle after which OAG deems that Respondents are in compliance with the terms of this Assurance.

52. ***Verification process review.*** The Compliance Administrator shall:

a. take a statistically valid random sampling of mental health Participating Providers who were subject to Respondents' Verification Process (the "Verified Providers");

b. compare the Participating Provider Information of the Verified Providers that is contained in Respondents' Online Provider Directory with current source documentation obtained through their Verification Processes and other quality control processes. The Compliance Administrator may consult Respondents' documentation, including claims data, applicable scripts, email notices, other correspondences and telephonic recordings, as well as independent data sources;

c. determine the percentage of those Verified Providers whose Participating Provider Information is accurately listed in Respondents' Online Provider Directory (the "Accuracy Percentage"); and

d. if Respondents' Accuracy Percentage falls below the regulatory requirements, the Compliance Administrator and Respondents shall develop and present to the OAG an appropriate remedial action plan, which may include additional protocols, monitoring and/or retraining.

53. ***Access review***. The Compliance Administrator shall:

a. survey a statistically significant sample of mental health Participating Providers (the "Access Sample") to determine their next available appointment;

b. determine the percentage of mental health Participating Providers in the Access Sample who have an appointment available within the following time frames ("Access Time Frames"):

i. Ten business days for an initial appointment with an outpatient facility or clinic, or a health care professional not employed or contracted with an outpatient facility or clinic; and

ii. Seven calendar days for an appointment following a hospital discharge or an emergency room visit;

c. determine the percentage of the Access Sample who have an available appointment within the Access Time Frames (the "Access Percentage");

d. if Respondents' Access Percentage falls below the regulatory requirements, the Compliance Administrator shall develop and present to Respondents and the OAG an appropriate remedial action plan, including additional monitoring, recruiting, and/or retraining; and

e. assess whether Respondents have approved referrals to non-participating providers at in-network cost sharing for members who were unable to access an appropriate Participating provider within the wait times set forth above.

54. ***Out-of-network utilization review***. The Compliance Administrator shall analyze Respondents' claims data to calculate:

a. by CPT code and provider type, the percentage of Members submitting claims for outpatient mental health treatment with out-of-network providers vs. in-network providers;

b. by CPT code and provider type, the percentage of Members submitting claims for outpatient medical/surgical treatment with out-of-network providers vs. in-network providers; and

c. The discrepancies, if any, between (a) and (b).

55. ***Provider reimbursement review***. The Compliance Administrator shall analyze a statistically valid random sampling of Respondents' claims data to calculate (for informational purposes only):

a. by CPT code and provider type, reimbursement rates for mental health Participating Providers;

b. by CPT code and provider type, reimbursement rates for medical/surgical Participating Providers; and

c. The discrepancies, if any, between (a) and (b).

56. ***Network breadth review***. The Compliance Administrator shall calculate:

a. the percentage of all mental health providers in Respondents' service area who are Participating Providers;

b. the percentage of all medical/surgical providers in Respondents' service area who are Participating Providers; and

c. The discrepancies, if any, between (a) and (b).

57. ***Consumer complaint review***. The Compliance Administrator shall analyze Respondents' Complaint Reports and related data to:

a. determine patterns of consumer complaints regarding directory inaccuracy and network inadequacy;

b. determine opportunities for improvement, if any, in Respondents' responses to consumer complaints; and

c. evaluate the sufficiency of the Respondents' consumer complaint mechanism.

58. ***Corrective action plan.*** For deficiencies and disparities within the scope of this Assurance, the Compliance Administrator shall propose remedial strategies, including but not limited to: improved recruitment of mental health providers of all licensures, improving outreach to and problem resolution for providers, reducing barriers to provider credentialing and contracting, providing for improved or expanded use of telehealth, and improving the timeliness and accuracy of processes such as claim payment and prior authorization.

Restitution

59. Respondents shall implement a restitution process, to be overseen by the Compliance Administrator or its agent, as follows:

a. For the period beginning January 1, 2020 through the Effective Date (the "Restitution Period"), Respondents shall provide restitution to all Members who fall into one or more of these following categories:

i. Members who paid amounts in excess of any applicable in-network co-payment, coinsurance, or deductible for mental health services rendered by non-participating providers who were incorrectly listed as participating providers in Respondents' Online Provider Directory at the time they received services ("Listed Non-Par Providers"). Listed Non-Par Providers shall include, but not be limited to, those providers who had terminated or disputed their participation status, or had not verified their participation status, but continued to be listed as participating providers. Such claims shall be referred to as "Directory Claims."

ii. Members who paid amounts in excess of any applicable in-network co-payment, coinsurance, or deductible for mental health services rendered by non-participating providers after being unable to secure an appointment with an appropriate in-network mental health provider. Such claims shall be referred to as "Network Claims."

iii. Respondents shall provide notice on their member website regarding Members' ability to submit Directory Claims and Network Claims.

b. Directory Claims.

i. Respondents shall make available to the Compliance Administrator records sufficient to enable it to identify and review Directory Claims received during the Restitution Period.

ii. Within 60 days from the date that all Directory Claims are identified by the Respondents, Respondents shall issue restitution to each Member with a Directory Claim for amounts paid in excess of any applicable in-network

co-payment, coinsurance, or deductible from the date of payment until the date restitution is issued.

iii. Members shall be entitled to submit additional Directory Claims to the Compliance Administrator for services rendered during the Restitution Period by the Listed Non-Par Providers, which the Compliance Administrator shall review to determine if such claims are valid Directory Claims.

c. Network Claims.

i. Within 30 days of the Effective Date, Respondents shall submit to OAG for approval a form of notice ("Notice") to all Members that they may be eligible to submit a Network Claim. The Notice shall include:

(a) a statement that all Members are entitled to submit during the Restitution Period restitution claims for services rendered by non-participating providers after being unable to secure an appointment with an appropriate in-network mental health provider.

(b) the procedures and timeframes for submitting a claim for restitution.

(c) A statement that Members may also submit Directory Claims for services rendered during the Restitution Period by the Listed Non-Par Providers. Such claims shall be handled by the Compliance Administrator in accordance with Paragraph 58(b) above.

ii. The Compliance Administrator shall send the Notice to all Members within 45 days of the OAG's approval of the Notice. Respondents shall also post the Notice in a clear and conspicuous location on their websites.

iii. The Compliance Administrator shall evaluate each Network Claim to determine if the Member received services by a non-participating provider after being unable to secure an appointment with an appropriate in-network mental health provider (a "Valid Network Claim").

iv. Within 30 days of the date of the Compliance Administrator's determination of a Valid Network Claim, Respondents shall issue restitution to the Members for amounts paid in excess of any applicable in-network co-payment, coinsurance, or deductible plus interest in the amount of 12% from the date of payment until the date restitution is issued.

d. Within three (3) months of completion of restitution payments, the Compliance Administrator shall submit to the OAG a report documenting all Members who submitted claims for restitution, those to whom restitution was paid, those whose claims were denied, the provider's name and office address, dates services rendered, restitution amount and date paid, and reason for denial.

General Provisions

60. Acceptance of this Assurance by the OAG is not an approval or endorsement by OAG of any of Respondents' policies practices or procedures, and Respondents shall make no representation to the contrary.

61. Compliance with Other Obligations. In the event that Respondents reasonably believe that the performance of their obligations under any provision of this Assurance would

conflict with any federal or state law or regulation that may be enacted or adopted after the effective date of this Assurance such that compliance with both this Assurance and such provision of law or regulation is not possible, Respondents shall notify the OAG promptly and the Parties shall meet and confer at their earliest convenience to attempt to resolve such alleged conflict.

62. Respondents expressly agree and acknowledge that a default in the performance of any obligation under this Assurance is a violation of the Assurance against the defaulting Respondents, and that the OAG thereafter may commence the civil action or proceeding contemplated in Paragraph 35, in addition to any other appropriate investigation, action, or proceeding, and that evidence that the Assurance has been violated shall constitute prima facie proof of the statutory violations described in Paragraph 33, pursuant to Executive Law § 63(15).

Ongoing Cooperation

63. Respondents agree to cooperate with all ongoing requests by the OAG for information related to this investigation and to ensure compliance with this Assurance.

Penalties, Fees, and/or Costs

64. Respondents shall pay to the State of New York $250,000 in penalties, fees, and/or costs. Payment shall be made in full by wire transfer within thirty (30) business days of the effective date of this Assurance. The OAG shall provide transfer information to Respondents.

MISCELLANEOUS

Subsequent Proceedings

65. Respondents expressly agree and acknowledge that the OAG may initiate a subsequent investigation, civil action, or proceeding to enforce this Assurance, for violations of the Assurance, or if the Assurance is voided pursuant to Paragraph 71, and agree and acknowledge that in such event:

a. any statute of limitations or other time-related defenses are tolled from and after the Effective Date of this Assurance;

b. the OAG may use statements, documents or other materials produced or provided by Respondents prior to or after the Effective Date of this Assurance; any civil action or proceeding must be adjudicated by the courts of the State of New York, and that Respondents irrevocably and unconditionally waive any objection based upon personal jurisdiction, inconvenient forum, or venue; and

c. evidence of a violation of this Assurance shall constitute prima facie proof of a violation of the applicable law pursuant to N.Y. Exec. L. § 63(15).

66. If a court of competent jurisdiction determines that the Respondents have violated the Assurance, Respondents shall pay to the OAG the reasonable cost, if any, of obtaining such determination and of enforcing this Assurance, including without limitation legal fees, expenses, and court costs.

Effects of Assurance

67. All terms and conditions of this Assurance shall continue in full force and effect on any successor, assignee, or transferee of Respondents. Respondents shall include any such successor, assignment or transfer agreement a provision that binds the successor, assignee or transferee to the terms of the Assurance. No party may assign, delegate, or otherwise transfer any of its rights or obligations under this Assurance without the prior written consent of the OAG.

68. Nothing contained herein shall be construed as to deprive any person of any private right under the law.

69. This Assurance is not intended for use by any third party in any other proceeding and is not intended, and should not be construed, as an admission of liability by MVP Health Plan, Inc. and MVP Health Services Corp.

70. Any failure by the OAG to insist upon the strict performance by Respondents of any of the provisions of this Assurance shall not be deemed a waiver of any of the provisions hereof, and the OAG, notwithstanding that failure, shall have the right thereafter to insist upon the strict performance of any and all of the provisions of this Assurance to be performed by Respondents.

Communications

71. All notices, reports, requests, and other communications pursuant to this Assurance shall be in writing and shall, unless expressly provided otherwise herein, be given by express courier; or electronic mail at an address designated in writing by the recipient, followed by postage prepaid mail, and shall be addressed as follows:

If to Respondents, to: Jennifer Clarke, jclarke@mvphealthcare.com, or in their absence, to the person holding the title of Deputy General Counsel.

If to the OAG, to: Michael Reisman, Michael.Reisman@ag.ny.gov, or in his absence, to the person holding the title of Bureau Chief, Health Care Bureau.

Any changes in the person to whom communications should be specifically directed shall be made in writing in advance of the change. Respondents may share any communication of or concerning this Assurance with its retained external law firm attorneys and/or regulators or policymakers.

Representations and Warranties

72. The OAG has agreed to the terms of this Assurance based on, among other things, the representations made to the OAG by Respondents and their counsel and the OAG's own factual

investigation and Findings, as set forth above in Paragraphs 1 through 33. Respondents represent and warrant that neither they nor their counsel have made any material representations to the OAG that are inaccurate or misleading. If any material representations by Respondents or their counsel are later found to be inaccurate or misleading, this Assurance is voidable by the OAG in its sole discretion.

73. No representation, inducement, promise, understanding, condition, or warranty not set forth in this Assurance has been made to or relied upon by Respondents in executing this Assurance.

74. Respondents represent and warrant, through the signatures below, that the terms and conditions of this Assurance are duly approved. Respondents further represent and warrant that MVP Health Plan, Inc. and MVP Health Services Corp., by Karla Austen, Chief Financial Officer, as the signatory to this Assurance, is a duly authorized officer acting at the direction of the Boards of Directors of MVP Health Plan, Inc. and MVP Health Services Corp.

General Principles

75. Unless a term limit for compliance is otherwise specified within this Assurance, Respondents' obligations under this Assurance are enduring. Nothing in this Assurance shall relieve Respondents of other obligations imposed by any applicable state or federal law or regulation or other applicable law.

76. Respondents shall not in any manner discriminate or retaliate against any health care providers who cooperated or are perceived to have cooperated with the investigation of this matter or any future investigation related to enforcing this agreement.

77. Respondents agree not to take any action or to make or permit to be made any public statement denying, directly or indirectly, the propriety of the Assurance. This paragraph shall not

(a) preclude Respondents from acknowledging that, by entering the Assurance, it did not admit to the OAG's Findings and entered the Assurance to avoid the time and expense of litigation, (b) affect Respondents' testimonial obligations, or (c) affect Respondents' right to take legal or factual positions in response to, or defense of, any inquiry, audit, litigation or other proceedings, including, without limitation, any inquiry or action brought by an individual, entity, or governmental authority other than the OAG.

78. Nothing contained in this Assurance shall be construed to limit the remedies available to the OAG in the event that Respondents violate the Assurance after its Effective Date.

79. Any failure by the OAG to insist upon the strict performance by Respondents of any of the provisions of this Assurance shall not be deemed a waiver of any of the provisions hereof, and the OAG, notwithstanding that failure, shall have the right thereafter to insist upon the strict performance of any and all the provisions of this Assurance to be performed by Respondents.

80. This Assurance may not be amended except by an instrument in writing signed on behalf of the Parties to this Assurance.

81. In the event that any one or more of the provisions contained in this Assurance shall for any reason be held by a court of competent jurisdiction 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.

82. Respondents acknowledge that they have entered this Assurance freely and voluntarily and upon due deliberation with the advice of counsel.

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

84. The Assurance and all its terms shall be construed as if mutually drafted with no presumption of any type against any party that may be found to have been the drafter.

85. This Assurance may be executed in multiple counterparts by the parties hereto. All counterparts so executed shall constitute one agreement binding upon all parties, notwithstanding that all parties are not signatories to the original or the same counterpart. Each counterpart shall be deemed an original to this Assurance, all of which shall constitute one agreement to be valid as of the Effective Date of this Assurance. For purposes of this Assurance, copies of signatures shall be treated the same as originals. Documents executed, scanned and transmitted electronically and electronic signatures shall be deemed original signatures for purposes of this Assurance and all matters related thereto, with such scanned and electronic signatures having the same legal effect as original signatures.

86. The Effective Date of this Assurance shall be _____, 2025 (the "Effective Date").

LETITIA JAMES
Attorney General of the State of New York
28 Liberty Street
New York, NY 10005

By: _____

Michael Reisman
Assistant Attorney General

MVP Health Plan, Inc.,
MVP Health Services Corp.

By: _____

Karla Austen
Chief Financial Officer