

ATTORNEY GENERAL OF THE STATE OF NEW YORK

In the Matter of

ValueOptions, Inc.

Assurance No.: 14-176

**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 ValueOptions, Inc. (“ValueOptions”), 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 ValueOptions has agreed to modify its practices and comply with the following provisions of this Assurance of Discontinuance (“Assurance”).

I. BACKGROUND

1. ValueOptions, a for-profit corporation, administers behavioral health benefits for health benefit plans and insurance companies. ValueOptions’ principal offices are located at 240 Corporate Boulevard, Norfolk, Virginia 23502. ValueOptions merged with Beacon Health Strategies on December 23, 2014, and is now Beacon Health Options. ValueOptions agrees that its merger does not alter its obligations under this Assurance and any respective successors and assigns are bound herein as set forth in Paragraph 99 below.

2. In the regular course of business, ValueOptions, a managed behavioral health care organization (“MBHO”), administers behavioral health benefits for approximately 2.7 million New Yorkers in fully funded or state and local governmental health plans, who include members of the following health plans: MVP Health Care, Inc. (“MVP”), EmblemHealth, Inc. (“Emblem,” which includes Group Health Incorporated (“GHI”) and Health Insurance Plan of Greater New York (“HIP”)), Oscar Insurance Corporation (“Oscar”) (as of January 1, 2014), and the Empire Plan (as of January 1, 2014), the health benefit plan for New York State and certain local governmental employees. In 2013, ValueOptions had revenues of approximately \$1.3 billion nationally, and \$95 million for its fully insured Emblem and MVP business.

3. MVP and Emblem entered into separate Assurance of Discontinuance agreements with the OAG, effective March 19, 2014, Assurance No. 14-006 (“MVP AOD”), and July 3, 2014, Assurance No. 14-031 (“Emblem AOD”), respectively.

II. THE OAG’S INVESTIGATION AND FINDINGS

4. The Health Care Bureau of the OAG conducted an investigation into ValueOptions’ administration of behavioral health benefits following the receipt of dozens of consumer complaints alleging that ValueOptions 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 a level of mortality up to 18 times greater than the average population without anorexia, the highest mortality rate of any mental illness.

8. The failure of health plans and MBHOs to reimburse members adequately for behavioral health costs, including those for substance abuse treatment, means that plan members who need treatment may not be getting the treatment recommended by their providers. In any given year, 11% of New Yorkers (1.8 million people) have a substance use disorder, but only 11% of these individuals receive any treatment for their condition. In contrast, more than 70% of individuals with hypertension and diabetes receive treatment for those conditions.

ValueOptions' Administration of Behavioral Health Benefits

9. Health plans provide inpatient and outpatient benefits for medical/surgical and behavioral health conditions. Several New York health plans – including MVP, Emblem, Oscar and Empire Plan – subcontract administration of their members'

behavioral health benefits to ValueOptions. These health plans typically pay ValueOptions a fixed fee per member, per month, for ValueOptions to administer behavioral health benefits for their members. Despite the passage of both federal and state laws requiring that plans provide behavioral health coverage “on par” with medical/surgical coverage, most of these health plans – in particular, MVP and Emblem – have not been comparing behavioral health claims approvals and denials with those in the medical/surgical realm.

10. Access to adequate behavioral health care appears to be an issue for health plan members whose benefits are administered by ValueOptions. ValueOptions does not regularly report penetration rate, an important metric that shows the percentage of members accessing behavioral health benefits, to its health plan clients. For some of ValueOptions’ contracting health plans, spending on behavioral health benefits has decreased since they outsourced administration of behavioral health benefits to ValueOptions. In particular, Emblem’s overall spending on behavioral health care (not including prescription drugs) has declined precipitously from 2011 to 2013, from 3.6% of spending on health care claims to 2.6%. Similarly, of MVP’s overall spending on all health claims, approximately 2.6% is directed to behavioral health care, and its payments to ValueOptions for behavioral health benefits management declined more than 20% from 2011 to 2012. In contrast, behavioral health care, including prescription drugs, accounts for approximately 7.3% of all health spending in the U.S. These data suggest that ValueOptions may not be sufficiently covering behavioral health treatment.

ValueOptions' Utilization Review of Behavioral Health Benefits

11. Utilization review is the process by which a health plan (or the MBHO with which it subcontracts) examines plan members' requests or claims for health care services to determine whether the services are medically necessary, and thus eligible for coverage. For services for which preauthorization is required, such as inpatient services, typically a provider will file a request for authorization with the plan (or MBHO) on behalf of the member, and the plan (or MBHO) will review the request to determine whether the services are medically necessary under its medical necessity criteria. If the plan (or MBHO) denies the request, in many cases, the member will not receive the requested service, and will not file a claim for benefits. On the other hand, where services have already been provided, a member or provider will typically submit a claim for benefits, and the plan (or MBHO) will either pay the claim automatically or conduct utilization review for the claim. In the latter situation, the plan (or MBHO) will determine whether the services are medically necessary under its medical necessity criteria.

12. Medically necessary services are those that are reasonable and necessary for the diagnosis or treatment of illness or injury, or to maintain or improve the functioning of an individual. If ValueOptions deems the services to satisfy its criteria, the health plan (or ValueOptions) will pay the claim. If ValueOptions does not deem the services to satisfy its criteria, it 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.

13. A member whose request or claim for behavioral health services ValueOptions denies due to lack of medical necessity (and for certain other reasons) has the right, under New York law, to file: (i) an internal appeal, which ValueOptions decides without any involvement or oversight by the contracting health plan; (ii) in some cases, a second-level, internal appeal, which ValueOptions also decides without any involvement or oversight by the contracting health plan; and (iii) an external appeal, which is reviewed by an independent clinician who has no relationship with ValueOptions or the health plan. ValueOptions, on behalf of the contracting health plan, typically performs utilization review for all inpatient, partial hospitalization and intensive outpatient behavioral health claims, and certain outpatient visits.

14. The OAG's review of consumer complaints, as well as health plans' utilization review data, indicates that ValueOptions applies more rigorous – and frequent – utilization review for behavioral health benefits than the contracting plans apply to medical/surgical benefits. Emblem's Senior Director of Behavioral Health described ValueOptions' approach to utilization review for behavioral health benefits as “aggressive.”

15. From January 2011 through mid-2013, 18% of the reviews ValueOptions conducted for requests for behavioral health treatment coverage for Emblem members (for example, requests for preauthorization) resulted in denials, encompassing more than 7,500 denied requests. After many of these denials, the member did not receive the requested care, and did not file a claim for benefits. In contrast, Emblem's medical/surgical reviews resulted in denials only 11% of the time.

16. Additionally, during the same period, ValueOptions denied 22% of behavioral health claims submitted by Emblem members (where services were already provided), whereas Emblem denied only 13% of medical/surgical claims submitted during that period. ValueOptions also denied 38% of all substance abuse treatment claims by Emblem members during that time. From January 2011 through March 2014, ValueOptions denied at least 15,000 requests or claims of Emblem members for behavioral health treatment due to its determination that the treatment was not medically necessary, with billed charges of more than \$31,000,000.

17. ValueOptions' denial rates for more intensive levels of behavioral health care – such as inpatient treatment – are especially high. From January 2011 through mid-2013, 26% of ValueOptions' reviews of Emblem members' requests for inpatient psychiatric treatment resulted in adverse decisions, totaling approximately 4,000 denied requests. After many of these denials, the member did not receive the requested care, and did not file a claim for benefits. Additionally, ValueOptions denied 36% of Emblem members' claims for inpatient psychiatric treatment, totaling more than 2,500 denied claims. In the same period, 39% of ValueOptions' reviews of Emblem members' requests for inpatient substance abuse rehabilitation coverage (*e.g.*, preauthorization requests) resulted in adverse decisions, totaling more than 2,300 denied requests, and ValueOptions denied 41% of Emblem members' claims for already-received services for that level of care, totaling almost 2,000 denied claims.

18. In contrast, ValueOptions' contracting health plans conduct utilization review for medical/surgical benefits in a more lenient manner. For example, from 2011 through 2013, only 20% of Emblem's reviews for inpatient medical/surgical treatment

resulted in denials, and only 29% of inpatient medical/surgical claims were denied by Emblem.

19. Similarly, ValueOptions' review of MVP members' behavioral health benefits has been more stringent than MVP's review of its members' medical/surgical claims. From 2011 through 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. ValueOptions made adverse determinations in 21% of the behavioral health reviews it performed for MVP members, while MVP made adverse determinations in only 15% of the medical/surgical reviews it performed.

20. Over the last three years, ValueOptions has denied almost 40,000 of MVP members' claims for mental health treatment and an additional 11,000 of MVP 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. (An administrative denial is a denial based on a defect in the request or claim, *e.g.*, incomplete claim form, lack of member or provider eligibility, provider contract limitation, or lack of out-of-network benefit, etc.) In particular, over the last three years, ValueOptions has denied 39% of MVP members' claims for inpatient psychiatric treatment, totaling more than 1,200 denied claims. Over the same period, ValueOptions denied 47% of MVP 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.

21. Not only does ValueOptions apply more stringent utilization review to behavioral health benefits than the contracting health plans do to medical/surgical benefits, it appears on some occasions to apply medical necessity criteria incorrectly when it reviews behavioral health-related requests and claims. For example, even though substance abuse rehabilitation is not an acute level of care, in denying requests for coverage of rehabilitation, ValueOptions classifies it as acute care, and in certain cases, ValueOptions has denied requests for coverage of substance abuse rehabilitation on the grounds that the member was not experiencing “life-threatening withdrawal,” which is not a requirement for such treatment. In fact, individuals who are suffering from life-threatening withdrawal require a more intensive level of care than rehabilitation, such as medically managed inpatient detoxification. For example, in a case in which an MVP member, who was addicted to heroin and prescription painkillers, requested coverage for inpatient substance use disorder rehabilitation treatment, ValueOptions rejected the claim, stating that the member did not have withdrawal symptoms, which is not a criterion for the level of care requested.

22. Although ValueOptions’ medical necessity criteria do not contain any “fail first” requirements, in some cases, it has denied requests for coverage of substance abuse rehabilitation treatment through application of “fail first” requirements. For example, ValueOptions denied a request for coverage of substance abuse rehabilitation because the member had not recently failed an outpatient program. This requirement places yet another obstacle in front of members who, suffering from addiction, may have a small window of opportunity to access treatment and embark on the path to recovery. Emblem’s own doctors, however, have stated that a member’s lack of an attempt at an

outpatient mode of care is not a reason to deny an inpatient stay. Emblem does not apply such a “fail first” requirement to medical/surgical benefits.

23. 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. Moreover, when ValueOptions approves more intensive levels of care, such as inpatient or partial hospitalization treatment, it will often approve just a few days or visits at a time, requiring members and providers to focus on health coverage rather than treatment. Additionally, in some cases in which ValueOptions has approved a certain number of inpatient days or outpatient visits, it has denied requests for authorization of additional days or visits until claims for all previously authorized days or visits have been exhausted – which may take days or weeks. This also has the effect of interrupting treatment, because the member must wait for ValueOptions to authorize additional care.

24. The utilization review that ValueOptions conducts for behavioral health claims is often intensive and frequent, and providers and members must spend a great deal of time justifying each day or visit. For example, a 14-year old MVP member with an eating disorder was receiving partial hospitalization treatment for her illness, until ValueOptions denied additional days of treatment. As a result, the member had to interrupt treatment while an appeal was lodged on her behalf, exacerbating the symptoms of her illness, and causing her and her family extreme emotional stress. Additionally, although it is not possible to complete substance abuse rehabilitation treatment in one day, in some cases, ValueOptions authorizes one day of inpatient substance abuse rehabilitation treatment at a time.

25. Until recently, ValueOptions, at Empire Plan's direction, required providers of outpatient behavioral health treatment to Empire Plan members to submit "outpatient treatment reports" after ten sessions, before it would authorize further care. Further, ValueOptions required behavioral health providers – even at the outpatient level – to submit treatment and discharge plans, denying coverage if providers failed to do so. For example, ValueOptions required the providers of outpatient behavioral health services to Empire Plan members to submit treatment plans to ValueOptions after ten outpatient visits before it would authorize further care. In contrast, health plans such as Emblem do not typically require medical/surgical providers to develop treatment plans or to demonstrate discharge planning.

26. From 2011 through 2013, in 42% of behavioral health cases of Emblem members that went to external appeal, ValueOptions' denials were reversed, compared with only a 30% reversal rate in medical/surgical cases. After Emblem directed its staff to review behavioral health cases before they went to external appeal, to determine whether the denials were correct, Emblem subsequently reversed the denials in almost 20% of the cases it reviewed. 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 MVP members eligible for appeals of behavioral health denials – less than 3% of those eligible – actually filed external appeals. MVP's decisions have been overturned in 40% of those cases.

The Outpatient Outlier Model

27. ValueOptions applied 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 may be denied. For example, after a member with major depression – a chronic, often life-long, biologically based illness – submitted claims for a certain number of psychotherapy visits, ValueOptions placed that member in the Outpatient Outlier Model, with the expectation that the member will soon terminate treatment. The thresholds are based only on ValueOptions' past claims paid data, not on clinical evidence or research regarding length of treatment for particular mental health conditions.

28. Once ValueOptions places a member in the Outpatient Outlier Model, it requested further information from the member's provider before it would authorize further coverage. ValueOptions has in some cases also recommended a lower frequency of visits as a strategy of working towards treatment termination, even though it cannot point to any literature or evidence supportive of session frequency as a treatment variable.

29. The thresholds in ValueOptions' Outpatient Outlier Model are inconsistent across different members' health plans, depending on the plan design. For example, for GHI members, ValueOptions requires prior approval for the first session of outpatient substance abuse treatment, and another approval prior to the eleventh session of such treatment, whereas other plans have varying thresholds. Additionally, ValueOptions has failed to perform analyses supporting the Outpatient Outlier Model that are required by its own policies, which calls into question the integrity of the model. For example, the

Outpatient Outlier Model policy requires ValueOptions to, on an annual basis: perform an evaluation of population-based utilization and clinical data to determine a set of specific types of potential outlier cases; provide the rationale for inclusion in the outlier program, reporting micromanagement strategies and specific interventions to be followed; and reevaluate the designated national outlier types and the results of the specialized interventions and clinical care management process to assure that the interventions initiated continue to be clinically appropriate. ValueOptions has never taken any of these actions.

30. ValueOptions conducted almost 4,500 reviews of MVP members' treatment 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.

31. MVP and Emblem do not implement a utilization review tool equivalent to the Outpatient Outlier Model in administering medical/surgical benefits.

Inadequate Denial Letters

32. ValueOptions' adverse determination letters denying behavioral health claims are generic and lack specific detail explaining 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.”
- “[T]he review indicates that the treatment plan goals and objectives have been attained and that the signs and symptoms that brought the patient into the treatment have been stabilized.”

- “[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.”

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

33. Emblem has admitted that, in ValueOptions’ denial letters, “[c]linical rationales primarily state in general rather than specific terms why the member’s condition does not meet medical necessity criteria.” Emblem has also admitted that ValueOptions’ boilerplate denial reasons in the letters are not sufficient and that denial letters often mischaracterize the level of treatment requested. Such flawed letters call into question the accuracy of ValueOptions’ adverse decisions. In contrast, letters issued by MVP and Emblem denying coverage for medical/surgical conditions, are more detailed.

34. Until at least 2012, ValueOptions did not provide sufficiently detailed language regarding the reason for its denial of substance abuse treatment requests and claims. ValueOptions neither cited the medical necessity criteria it used in its denial letters, nor provided the criteria upon request to members, as it is legally required to do.

35. In its denial letters, ValueOptions recommends a less intensive level of care for the member. However, in some cases, after the member has subsequently requested approval for that recommended level of care, ValueOptions has denied the request as well. ValueOptions reported that in one such case, its reviewers failed to take note of the company’s own recommendations.

36. Although substance abuse programs in New York State are required to use Guidelines for Level of Care Determinations approved by the New York Office of

Alcoholism and Substance Abuse Services (“OASAS”), ValueOptions uses different criteria, created by ValueOptions, for determining medical necessity for substance abuse treatment, which may result in denial of care, since providers are required to use OASAS-approved criteria.

Lack of Coverage for Residential Treatment for Behavioral Health Conditions

37. Until 2014, MVP and the HIP division of Emblem did not cover residential treatment for behavioral health conditions, and ValueOptions would therefore deny requests by these health plans’ members for coverage of such treatment.

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.

38. Residential treatment is deemed to be a medically necessary option for treating persons with severe eating disorders, which can require round-the-clock supervision. According to ValueOptions’ own treatment guidelines, residential treatment is the standard form of treatment for eating disorders for persons who do not meet the criteria for inpatient hospitalization, but nevertheless are ill enough that they require 24-hour structure and supervision of all meals in order to achieve a healthier weight level, to decrease suicidality, and to develop sufficient motivation to successfully undertake

outpatient treatment. Given the potentially lethal nature of eating disorders, denial of coverage for residential treatment can place members' lives in jeopardy.

39. According to Section 3.301 of ValueOptions' medical necessity criteria:

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.

40. Residential treatment is also a standard form of treatment for substance abuse disorders. According to Section 4.301 of ValueOptions' medical necessity criteria:

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.

41. ValueOptions' medical director stated that there is evidence to support residential treatment for eating disorders. Moreover, ValueOptions has designated certain residential treatment facilities as diagnostic specialty units, because such units have demonstrated areas of clinical expertise and provide effective treatment. The categorical denial of coverage applied by ValueOptions had a deleterious impact on New Yorkers. In one case, ValueOptions denied residential treatment for a 14-year old Emblem member suffering from anorexia nervosa, even though her doctors in an inpatient facility (where she had been hospitalized with an irregular heartbeat) believed that she needed such care. After a short period of day treatment, the girl relapsed,

necessitating further hospitalization. In another case, ValueOptions denied coverage of residential treatment for a young woman with a severe case of anorexia, even though she was at 72% of ideal body weight – a dangerous condition. As a result, her family paid thousands of dollars out of pocket for room and board so she could be monitored on a 24/7 basis in a residential treatment facility. Even then, ValueOptions denied coverage of therapy services as not medically necessary, until an external reviewer reversed ValueOptions’ decision, concluding that ValueOptions had “not acted reasonably, nor with sound medical judgment, and not in the best interest of the patient.”

Cost-Sharing for Behavioral Health Services

42. ValueOptions has assessed higher copayments for behavioral health outpatient treatment than health plan members were charged for outpatient medical/surgical treatment. Until 2014, approximately 40% of MVP plans charged a higher copayment for outpatient mental health visits than for outpatient primary care visits. In some MVP plans, the mental health copayment was twice as high as the primary care copayment. Until 2014, approximately 23% of HIP large-group plans charged a higher copayment for outpatient mental health visits than for outpatient primary care visits, in some cases, double the primary care copayment.

Other Problems With ValueOptions’ Administration of Behavioral Health Benefits

43. The OAG’s investigation has revealed numerous other deficiencies in ValueOptions’ administration of behavioral health benefits. The OAG has received numerous complaints with regard to the Empire Plan that ValueOptions’ provider network is inadequate, and does not include certain types of providers, such as licensed

mental health counselors, as set forth in the Empire Plan benefits design. Providers and consumers have also complained that ValueOptions has failed to assist providers and members in transitioning between providers, and that ValueOptions' network provider listings are inaccurate and contain the names of providers who are not accepting new patients, calling into question the adequacy of ValueOptions' provider network.

44. In some instances, ValueOptions did not cover treatment for Emblem members, pending completion of internal appeals. Due to numerous deficiencies with ValueOptions' administration of Emblem members' behavioral health benefits, including the issues described above, ValueOptions terminated the director of the office where those benefits are administered. ValueOptions has reduced reimbursement to members for out-of-network behavioral health visits to non-M.D.'s for procedure codes that are typically not billed by M.D.'s. For example, the procedure code for 45 minute psychotherapy (90834) is not intended for use by M.D.'s, thus usual, customary and reasonable ("UCR") rates contained in the FAIR Health database reflect billed charges by social workers and psychologists, not M.D.'s. However, ValueOptions pays only 65% of the UCR rate for procedure code 90834 for visits to social workers, and 75% of that rate to psychologists. As a result, consumers are forced to pay more out-of-pocket for behavioral health care. ValueOptions has also failed to reimburse certain procedure codes that are standard in the mental health field (such as initial evaluation codes), has reimbursed psychiatrists for evaluation and management codes at lower rates than other medical/surgical providers receive, and generally has provided lower reimbursement for in-network psychiatric services in 2014 than in past years.

45. A 2012 Department of Financial Services audit concluded that ValueOptions failed to meet the notification requirements of the New York Utilization Review Law for prospective and concurrent review in almost all cases sampled. Section 4903(b) of the New York Insurance Law states that a utilization review agent must make a utilization review determination involving health care services which require pre-authorization, and provide notice to the insured and their provider thereof, within three business days. In all 15 sampled cases, ValueOptions failed to provide verbal notification to the insured and their provider within the statutorily required timeframe. Section 4903(c) of the New York Insurance Law states that a utilization review agent must make a determination involving continued or extended health care services, and provide notice to the insured and their provider thereof, within one business day. In 11 of 15 sampled cases, ValueOptions failed to provide verbal notification to the insured and their provider within the statutorily required timeframe.

III. RELEVANT LAWS

46. 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).

47. Timothy's Law also requires that deductibles, copayments 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.

48. 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 twenty may be for family members. N.Y. Ins. Law §§ 3221(l)(7); 4303(l).

49. In 2004, New York enacted legislation creating Comprehensive Care Centers for Eating Disorders (the "CCCED Law"). New York L. 2004, c.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).

50. 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, copayments, 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 Act’s requirements to small and individual plans. 45 C.F.R. § 156.115(a)(3).

51. Timothy’s Law and the Federal Parity Act work together, in that Timothy’s Law mandates coverage of mental health treatment which is at least equal to coverage for other health conditions, and the Federal Parity Law requires that behavioral health coverage be no more restrictive than coverage of medical/surgical treatment. For example, Timothy’s Law requires coverage of at least 20 sessions of outpatient mental health treatment per year. If a health plan does not place visit limits on substantially all outpatient medical/surgical treatment, it may not place visit limits on outpatient mental health treatment.

52. ValueOptions is obligated to comply with the mental health parity laws. ValueOptions has stated that it has “supported over 50 customers in becoming parity

compliant.” In administering behavioral health benefits, ValueOptions has prepared mental health parity compliance checklists for its health plan clients. ValueOptions was a member of The Coalition for Parity, Inc., which brought an unsuccessful 2010 lawsuit to block implementation of the Interim Final Rules under the federal Mental Health Parity and Addiction Equity Act (“The Federal Parity Act”), contending that complying with the rules would have a substantial impact on it. Further, the Chief Medical Officer of ValueOptions’ Commercial Division testified that ValueOptions must comply with the mental health parity laws.

53. The Affordable Care Act requires health plans to allow enrollees to receive continued coverage pending the outcome of internal appeals. 42 U.S.C. § 300gg-19(a)(1)(C); 29 C.F.R. 2590.715-2719(b)(2)(iii) (group plans); 45 C.F.R. 147.136(b)(3)(iii) (individual plans).

54. The New York General Business Law prohibits “[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state.” N.Y. G.B.L. § 349(a).

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

56. Based on the findings of the Attorney General’s investigation, the Attorney General has determined that ValueOptions’ conduct has resulted in violations of N.Y. Executive Law Section 63(12), Timothy’s Law, the Federal Parity Act, and the

Affordable Care Act. ValueOptions' practices have had the effect of unlawfully limiting members' access to behavioral health services.

NOW, WHEREAS, ValueOptions neither admits nor denies the Attorney General's findings in Paragraphs 4 through 45 above; and

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

WHEREAS, ValueOptions 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 recently entered into Assurances of Discontinuance with MVP Health Care, Inc. (Assurance No. 14-006) and EmblemHealth, Inc. (Assurance No. 14-031), each of which relates to ValueOptions' administration of New Yorkers' behavioral health benefits; 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

57. Within ninety (90) days of the Effective Date, ValueOptions will implement the reforms set forth below in Paragraphs 58 through 72, for fully funded and state and local governmental health plans in New York.

58. Cost-Sharing Requirements: For outpatient behavioral health visits by members of Emblem and MVP plans, ValueOptions will apply the member's primary care cost-sharing schedule in accordance with the AODs with those entities. For all other plans, ValueOptions will work with and make recommendations to its clients to support their compliance with relevant mental health parity laws, which include applying the member's primary care cost-sharing schedule for outpatient behavioral health visits. If ValueOptions has a good faith belief that applying the specialist cost-sharing schedule for outpatient behavioral health visits is legally permissible for a health plan, it will provide written notice to the OAG regarding its basis for same and will not implement same until thirty (30) days after parties have met and conferred.

59. No visit limits:

- a. For members of Emblem and MVP plans, ValueOptions will not apply any day or visit limits for behavioral health services, except for family counseling services, coverage for which may be capped at 20 visits per year, in accordance with the AODs for those entities. For all other plans, ValueOptions will work with and make recommendations to its clients to support their compliance with relevant mental health parity laws, including that they will not apply any day or visit limits for behavioral health services in any health plan it administers, except for

family counseling services, coverage for which may be capped at 20 visits per year, or any other limitations required by law. If

ValueOptions has a good faith belief that such limitations are required by law, it will provide written notice to the OAG regarding its basis for same and will not implement same until thirty (30) days after parties have met and conferred.

- b. For members of Emblem and MVP plans, ValueOptions will provide coverage for services provided by mental health practitioners licensed under Article 163 of the New York Education Law, in accordance with the AODs for those entities. ValueOptions will work with and make recommendations to its clients to support their compliance with relevant mental health parity laws and the provider non-discrimination provision of the Affordable Care Act, 42 U.S.C. 300gg-5(a), including that they provide coverage for services provided by mental health practitioners licensed under Article 163 of the New York Education Law. If ValueOptions has a good faith belief that excluding coverage for services provided by certain licensures of behavioral health providers is justified, it will provide written notice to the OAG regarding its basis for same and will not implement same until thirty (30) days after parties have met and conferred.

60. Network Adequacy and Transitions:

- a. ValueOptions will ensure that its provider network contains an adequate number of behavioral health providers of different types

(including psychiatrists, psychologists, social workers, nurse practitioners, and mental health counselors), within a reasonable distance from members' residences, to meet the treatment needs of such members.

- b. ValueOptions will maintain a listing on its website (the "online provider directory"), and make same available to members in hard copy upon request, of the name, address and telephone number of all participating providers, including facilities, and in the case of physicians, board certification. ValueOptions will update the online provider directory within fifteen days of the addition or termination of a provider from ValueOptions' network or a change in a physician's hospital affiliation.
- c. When a provider leaves ValueOptions' network, ValueOptions will assist members receiving services from that provider in locating and transitioning to a new network provider, if requested.
- d. Before ValueOptions adopts a new fee schedule, it will give providers 30 days written notice, along with a copy of the applicable fee schedule showing the effective date, procedure codes and rates, and indicating the clients/products to which it is applicable.

61. Reimbursement:

- a. ValueOptions will reimburse members for out-of-network services at the usual, customary and reasonable rate ("UCR") for the relevant behavioral health service, without applying lowered rates for non-

M.D. providers, unless any such lowered rates are already factored into the UCR data source that ValueOptions employs.

- b. ValueOptions will provide reimbursement for standard evaluation and management codes (*e.g.*, 99201, 99202, 99203, 99204, and 99205), and will not require preauthorization of crisis codes.
- c. ValueOptions will provide reimbursement for covered behavioral health services by a licensed behavioral health provider for behavioral health treatment of any diagnosis listed in the Diagnostic and Statistical Manual of the American Psychiatric Association (the “DSM”) that is covered by the client. ValueOptions will work with and make recommendations to its clients to support their compliance with relevant mental health parity laws, including providing reimbursement for those DSM diagnoses covered under the Empire Plan (the plan provided to public officers and employees pursuant to Article 11 of the Civil Service Law), which currently includes the vast majority of DSM diagnoses.

62. Utilization Review Process Reforms:

- a. Preauthorization: ValueOptions will not impose any preauthorization requirements for outpatient behavioral health services, and will discontinue its practice of requiring submission by providers of outpatient treatment reports after a set number of outpatient behavioral health visits, unless comparable requirements are imposed for substantially all outpatient medical/surgical benefits. If ValueOptions

has a good faith belief that it may impose preauthorization requirements for outpatient behavioral health benefits, pursuant to this Paragraph, it will provide written notice to the OAG regarding its basis for same and will not implement same until 30 days after parties have met and conferred.

- b. Comparability of Utilization Review Processes: ValueOptions will not use the Outpatient Outlier Model for utilization review purposes. If ValueOptions uses a utilization review tool for behavioral health services that is based on quantity or frequency of outpatient visits, it will develop such tool and update it annually based on clinical evidence, and such tool 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 board-certified in addiction medicine. ValueOptions will conduct utilization review under such tool 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, ValueOptions denies coverage for services, the member shall be afforded all internal and external appeal rights.
- c. Thoroughness of Reviews: Each ValueOptions staff member conducting utilization review will consult the member's entire case file before rendering any utilization review decision, in particular to determine whether ValueOptions has previously recommended a particular level of care.

- d. Integration of Utilization Review for Medical/Surgical and Behavioral Health Benefits: ValueOptions will cooperate with measures implemented by its contracting health plans, in particular MVP and Emblem, to promote the integration of administration of medical/surgical and behavioral health benefits.
- e. Collection of Information During Utilization Review: ValueOptions will follow a protocol for the collection of information during utilization review, which will include the elements set forth in Exhibit A.
- f. Substance Abuse Treatment: ValueOptions will not apply any “fail first” requirement for substance abuse rehabilitation treatment. ValueOptions will administer coverage of outpatient substance abuse treatment received in office settings, including, but not limited to, medication-assisted treatment for opioid addiction.
- g. Medical Necessity Criteria: ValueOptions has applied to OASAS for approval of its criteria for determining medical necessity for substance abuse treatment, and will continue to exercise best efforts to secure such approval. ValueOptions will not require that members pose a potential risk of serious harm to self or others in order to satisfy the medical necessity criteria for behavioral health residential treatment or inpatient substance abuse rehabilitation treatment.
- h. Continued Treatment: When a member transitions from one level of behavioral health treatment to another, for example from inpatient to

outpatient care, ValueOptions will conduct the review for the second level as a concurrent review, because it concerns continued treatment.

- i. Classification of Denials: ValueOptions will process as medical necessity denials any denials of coverage for behavioral health services due to lack of clinical information and/or preauthorization.
- j. Duration of Approvals: ValueOptions will not limit the number of days or visits it approves for behavioral health treatment to one day or one visit per approval, and will base such approvals on the treatment needs of the member, unless clinically appropriate.
- k. Concurrent Reviews: ValueOptions will conduct clinically appropriate concurrent reviews in accordance with the following, unless a shorter period of time is requested by the provider: (a) with regard to residential treatment care, at least three days in advance of exhaustion of previously approved days or visits, so as not to interfere with treatment; (b) with regard to substance abuse rehabilitation, at least two days in advance of exhaustion of previously approved days or visits, so as not to interfere with treatment; and (c) with regard to outpatient care, at least seven days in advance of exhaustion of previously approved days or visits, so as not to interfere with treatment. Providers may also request authorization of additional days or visits in advance of exhaustion of previously approved days or visits, consistent with the foregoing.

1. Retrospective Reviews: ValueOptions will not conduct retrospective reviews based upon predetermined billing codes or combination codes (e.g., evaluation and management plus psychotherapy, which is a standard combination), unless the coding pattern is unusual or indicates fraud and abuse.

63. Adverse Determination Notification: When making adverse benefit determinations, ValueOptions will provide to the member and provider:
 - a. Telephonically, with respect to prospective and concurrent determinations and, in writing, with respect to all adverse determinations, the adverse determination.
 - b. In writing, a detailed explanation of the clinical reason for the denial, citing to specific medical necessity criteria (explaining why they are not met), member-specific facts, and treatment records.
 - c. In writing, what, if any, additional necessary information must be provided to, or obtained by, ValueOptions to render a decision on the appeal.
 - d. In writing, a prominent statement regarding the availability, to members and providers, of Behavioral Health Advocates (who are described below in Paragraph 64), with a notation that the provider and member can contact an Advocate to obtain information about facilities and providers able to provide alternative services to the member.

- e. In writing, clear, specific information about internal and external appeals (including information as described below in Paragraphs 65 and 66);
- f. In writing, the address of a website containing the medical necessity criteria used in making the adverse determination, and notice of the availability, free of charge upon request, of a copy of such criteria.

For all adverse determinations, ValueOptions will also provide the information described above telephonically in a general manner (*e.g.*, ValueOptions will advise that appeal rights are available, but will not describe such rights in detail, unless asked to do so).

With respect to Emblem and MVP, adverse determination letters will be reviewed for accuracy by the individual who authorized the adverse determination prior to distribution to members and providers. With respect to all other clients, adverse determination letters will be reviewed for accuracy by a clinical peer reviewer who has the authority to modify or reverse the contents of the letter prior to distribution to members and providers. When ValueOptions recommends or states in an adverse determination letter that a member can be safely treated in a less intensive or restrictive level of care, it will then approve a request for authorization for that level of care, as long as such request is made within ten (10) days of receipt of the adverse determination letter, and will confirm that treatment services are available to the member at such level of care within a reasonable distance from the member's home. ValueOptions will also include in adverse determination letters a short list of alternative providers in the member's area.

64. Behavioral Health Advocates: ValueOptions will cooperate with Behavioral Health Advocates, individuals who are employed to aid MVP and Emblem

members, in particular those whose requests or claims have been denied, by providing accurate and current information regarding utilization review determinations and processes, medical necessity criteria, complaint processes, and appeals, as well as alternative treatment options for the member in the member's area. Behavioral Health Advocates employed by ValueOptions will return member calls within one (1) business day.

65. Internal Appeals: ValueOptions will continue coverage of treatment pending the completion of internal appeals.

66. External Appeals: To facilitate members' timely submission of external appeals, in particular expedited appeals, ValueOptions will cooperate with MVP and Emblem as follows:

- a. When ValueOptions renders an adverse determination of a request for coverage of behavioral health services, such determination will be eligible for expedited external review, if it: (i) meets the criteria of New York Insurance Law Section 4914(b)(3) or New York Public Health Law Section 4914(b)(3), *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; (ii) relates to continued or extended behavioral health services; or (iii) relates to inpatient, residential, partial hospital, intensive outpatient mental health or substance use disorder treatment.
- b. When a member is eligible for expedited external appeal, as set forth in subpart (a) of this Paragraph, ValueOptions 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.
- d. For Emblem plans, when a member or such member's provider files an expedited external appeal of a denial of coverage for behavioral health services, ValueOptions must authorize the requested service until the external review agent renders a decision.
- e. Effective April 1, 2015, for all members, if a member or his/her health care provider files an expedited internal and external appeal within twenty-four (24) hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending, ValueOptions must provide coverage of the requested service until the external review agent renders a decision.

67. Residential Treatment: ValueOptions will provide coverage for medically necessary residential treatment for behavioral health conditions for members of MVP and Emblem plans, in accordance with the AODs for those entities. As described in ValueOptions' medical necessity criteria, residential treatment facilities provide 24 hours a day/7 days a 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. For all other plans, ValueOptions will work with and make recommendations to its clients to support their compliance with relevant mental health parity laws, which include providing coverage for residential treatment for behavioral health conditions. If ValueOptions has a good faith belief that not providing coverage for residential treatment for behavioral health conditions is legally permissible for a health plan, it will provide written notice to the OAG regarding its basis for same and will not implement same until thirty (30) days after parties have met and conferred.

68. Cooperation With Compliance Administrators: ValueOptions will cooperate with the Compliance Administrators (the “Administrators”) appointed pursuant to Assurance of Discontinuance No. 14-006 with MVP Health Care, Inc., and Assurance of Discontinuance No. 14-031 with EmblemHealth, Inc. (the “Assurances”). The Administrators’ main tasks are to: (i) evaluate the respective health plans’ compliance with the respective Assurances; (ii) evaluate the respective health plans’ utilization review system for behavioral health benefits; (iii) provide guidance to the respective health plans and to ValueOptions; and (iv) provide quarterly reports concerning items (i) through (iii) to the respective health plans and the OAG. In particular, ValueOptions will cooperate with reasonable requests by the Administrators for data sufficient for the Administrators to evaluate ValueOptions’ administration of the respective health plans’ behavioral health benefits. Data to be requested from ValueOptions by the Administrators may include: (i) claims review results; (ii) metrics demonstrating adequate access to effective behavioral health services, including, at a minimum:

adequacy of the provider network; penetration rate; dollar spend on behavioral health services; utilization review results; internal appeals and results thereof; external appeals and results thereof; and member satisfaction with behavioral health coverage; and (iii) adverse determination letters. Such data may be requested in the form of utilization analyses, key indicator reports, population analyses, and/or other reports generated in the normal course of business by ValueOptions.

69. Training: ValueOptions will provide training to all of its utilization review and customer relations staff serving New York members, regarding the requirements of this Assurance, 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. ValueOptions will provide a copy of such training materials to the OAG for approval before dissemination.

70. Grievances: For a three (3)-year period, ValueOptions will provide the OAG with a quarterly summary of grievances (as such term is defined in Insurance Law Section 4802) as made to ValueOptions or reported to ValueOptions by its clients regarding behavioral health coverage, without patient-identifying information. A grievance is a member or provider complaint to a health insurance company about a denial based on limitations or exclusions in the contract.

71. Disclosures: ValueOptions will provide to members, in clear and conspicuous language on its website, and by reference to its website in correspondence with members, disclosures regarding behavioral health coverage, as set forth in Exhibit B.

72. Annual Parity Compliance Report: For each of the three (3) years following the Effective Date or until the compliance reporting requirements end under both the MVP and Emblem AODs, whichever is earlier, ValueOptions will file an annual report with the OAG, certifying compliance with the terms of this Assurance and outlining how its administration of behavioral health benefits complies 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, at a minimum, evidence of the statements set forth in Exhibit B, as well as a completed parity compliance checklist for each of its health plan clients, the form of which ValueOptions will prepare, subject to approval by the OAG. In so doing, ValueOptions will obtain sufficient information from its health plan clients regarding administration of their medical/surgical benefits in order to complete the parity compliance checklists, in particular regarding covered benefits, copayment levels, and request and claim denial rates.

V. RETROSPECTIVE RELIEF

73. ValueOptions will cooperate with the retrospective relief provisions of the MVP AOD and the Emblem AOD. Those retrospective relief provisions call for notice to MVP and Emblem members regarding the opportunity to file independent appeals of medical necessity denials and to file claims for residential treatment for behavioral health conditions, for independent review of claims filed pursuant to such notice, and for restitution to such members determined to have received medically necessary care (“MVP AOD Appeals” and “Emblem AOD Appeals”). In cooperating with the retrospective relief provisions of the MVP AOD and the Emblem AOD, ValueOptions will also take the actions set forth below in Paragraphs 74 and 75.

74. MVP AOD Appeals Process. Effective immediately:
- a. ValueOptions will determine, within ten (10) business days of receipt, whether each MVP AOD Appeal application filed by an MVP member or his/her designee (“MVP Claimant”) is complete and eligible for independent review, and transmit complete and eligible appeals applications to MCMC, the independent entity conducting such review (the “Reviewer”). The Reviewer is an independent utilization review agent that has been selected by MVP and ValueOptions and has been approved by the OAG. ValueOptions previously provided notice by mail (including appeal applications) to potentially eligible MVP Claimants.
 - b. All MVP AOD Appeal applications filed by MVP Claimants must be decided within forty-five (45) days of the date that the application was deemed complete and eligible.
 - c. ValueOptions will make Behavioral Health Advocates (described above) and ValueOptions Appeals Specialists available to assist MVP Claimants in completing their appeal applications, including, where necessary, assisting MVP Claimants in their efforts to submit proof of out-of-pocket expenses and/or unpaid bills and invoices for treatment.
 - d. Where ValueOptions believes that an MVP AOD Appeal application is incomplete or that an MVP Claimant is ineligible for an appeal, it may not reject such application unless it has communicated to the MVP Claimant with specificity and in writing the reason for such

incompleteness or ineligibility, has reached out to the MVP Claimant telephonically to determine the reason for such incompleteness or ineligibility, reasonably concluded that the application is incomplete and/or the member is not eligible for an MVP AOD Appeal, and communicated the basis for this conclusion to the MVP Claimant and to the OAG. The application may be rejected if it remains incomplete and/or the member does not demonstrate eligibility for the MVP AOD Appeal on or after the thirtieth (30th) day from the date ValueOptions communicates to the MVP Claimant and the OAG the basis for its conclusion.

- e. ValueOptions will pay all claims of MVP Claimants eligible for restitution within thirty (30) calendar days of the Reviewer's decision, except for residential treatment claims, which shall be paid within thirty (30) calendar days of the Reviewer's decision or within thirty (30) days from the Effective Date of this Assurance, whichever is later.
- f. At the conclusion of the appeals process, ValueOptions will, at its own expense, engage an independent auditor, subject to the approval of the OAG, to confirm that: (i) all complete and eligible MVP AOD Appeal applications have been afforded independent review; and (ii) ValueOptions has distributed restitution payments to eligible MVP Claimants, pursuant to the terms of the MVP AOD.

75. Emblem AOD Appeal Process:
- a. ValueOptions will, at its own expense and with the OAG's approval, retain Rust Consulting, Inc. to serve as an independent third-party administrator ("Claims Administrator"), which shall be responsible for: (i) determining the completeness and eligibility of Emblem AOD appeal applications filed pursuant to the Emblem AOD by Emblem members ("Emblem Claimants"); (ii) contacting Emblem Claimants, their providers, ValueOptions and Emblem, as necessary, to obtain information regarding such applications; (iii) transmitting complete and eligible applications to the Reviewer, MCMC (which is an independent utilization review agent that has been selected by Emblem and ValueOptions and has been approved by the OAG); and (iv) ensuring that ValueOptions and Emblem distribute payments to Emblem Claimants pursuant to the terms of the Emblem AOD ("Claims Administrator's Plan").
 - b. Within ten (10) business days following the execution of this AOD, the Claims Administrator shall provide to the OAG and ValueOptions a written plan reflecting the processes and procedures that the Claims Administrator will follow (the "Claims Administrator's Plan") to: (i) determine the completeness and eligibility of Emblem AOD Appeal applications filed pursuant to the Emblem AOD by Emblem Claimants; (ii) contact Emblem Claimants, their providers, ValueOptions and Emblem, as necessary, to obtain information

regarding such applications (including proof of payment and/or unpaid bills and invoices for treatment); (iii) transmit complete and eligible applications to the Reviewer; and (iv) ensure, by means of an audit, that ValueOptions and Emblem distribute payments to Emblem Claimants pursuant to the terms of the Emblem AOD. Upon the OAG's approval, which shall take into consideration any comments or suggestions made by ValueOptions, the Administrator shall implement the processes and procedures set forth in the Administrator's Plan.

- c. ValueOptions, having previously provided notice by mail (including appeal applications) to potentially eligible Emblem Claimants, shall provide to the Claims Administrator all Emblem AOD Appeal applications that it receives from Emblem Claimants, immediately upon receipt of such applications. ValueOptions will also provide to the Claims Administrator the appeal application packages sent by ValueOptions to such claimants.
- d. The Claims Administrator will determine, in accordance with the time frame set forth in the Claims Administrator's Plan, whether each Emblem AOD Appeal application is complete and eligible for independent review.
- e. All Emblem AOD Appeal applications deemed complete and eligible by the Claims Administrator must be decided by the Reviewer within forty-five (45) days of such determination.

- f. ValueOptions will make Behavioral Health Advocates (described above) and ValueOptions Appeals Specialists available to assist Emblem Claimants in completing their appeal applications, including, where necessary, assisting Emblem Claimants in their efforts to submit proof of out-of-pocket expenses and/or unpaid bills and invoices for treatment.
- g. Where the Claims Administrator believes that an appeal application is incomplete or that an Emblem Claimant is ineligible for an appeal, it may not reject such application unless it has communicated to the Emblem Claimant with specificity and in writing the reason for such incompleteness or ineligibility, has reached out to the Emblem Claimant telephonically to determine the reason for such incompleteness or ineligibility, reasonably concluded that the application is incomplete and/or the member is not eligible for an Emblem AOD Appeal, and communicated the basis for this conclusion to the Emblem Claimant and to the OAG. The Claims Administrator will provide such information to the OAG on a weekly basis, unless otherwise agreed. The application may be rejected if it remains incomplete and/or the member does not demonstrate eligibility for the Emblem AOD Appeal on or after the thirtieth (30th) day from the date ValueOptions communicates to the Emblem Claimant and the OAG the basis for its conclusion.

- h. ValueOptions will pay all claims of Emblem Claimants eligible for restitution, including residential treatment claims, within thirty (30) calendar days of the Reviewer's decision.
- i. ValueOptions shall be required to continue to retain the Claims Administrator (or, if necessary, a replacement administrator that is acceptable to the OAG) until all restitution payments have been made to Emblem Claimants.
- j. The OAG, at its discretion, shall have the right to require ValueOptions to change the Claims Administrator upon a reasonable and good faith determination that the Claims Administrator has been ineffective in carrying out its duties pursuant to this Assurance.
- k. In the event ValueOptions reasonably determines that the Claims Administrator is not performing its duties in an objectively reasonable manner consistent with the terms of this Assurance and the Emblem AOD, ValueOptions shall notify the OAG and the Claims Administrator in writing and the parties shall meet and confer within five (5) days of such written notification in a good faith attempt to resolve the issues.
- l. The Claims Administrator shall not be permitted to subcontract its obligations under this Assurance to any other person or entity, except that, after notifying the OAG and subject to the OAG's approval, the Claims Administrator may retain additional persons or entities needed

for the Claims Administrator to carry out its obligations under this Assurance.

- m. This Assurance shall be attached to ValueOptions' contract with the Claims Administrator.
- n. ValueOptions shall provide a copy of its contract with the Claims Administrator to the OAG within two business days of its execution.
- o. ValueOptions shall bear any and all costs associated with retaining the Claims Administrator.
- p. ValueOptions shall cooperate with any and all requests by the Claims Administrator or by the OAG to assist in communicating with Emblem Claimants and their providers.
- q. The agreement between ValueOptions and the Claims Administrator shall require the Claims Administrator to treat all information provided by the OAG regarding claimants as confidential and not to share such information with any other person or entity.

VI. PENALTIES

76. Within sixty (60) days of the Effective Date, ValueOptions shall pay \$900,000 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. Such sum shall be payable by check to "State of New York Department of Law."

VII. LIQUIDATED DAMAGES

77. If ValueOptions violates any provision of this Assurance, or does not provide requested information specified in Sections IV and V of the Assurance and/or requested by the OAG pursuant to Paragraph 86 below, within thirty (30) days of such request, the OAG may elect as its exclusive remedy in lieu of Paragraphs 90 through 92 below, to demand that ValueOptions pay liquidated damages of \$1,000 per day for such non-compliance or failure to provide requested information. Before liquidated damages may be imposed, the OAG shall give ValueOptions written notice that ValueOptions may be subject to liquidated damages under this paragraph. In the event that ValueOptions does not cure the violation or provide the requested information within ten (10) days of receipt of the OAG's written notice, the OAG may impose liquidated damages pursuant to this paragraph. The damages period shall commence on the date that ValueOptions receives the OAG's written notice and end on the date that ValueOptions cures the violation or provides the requested information.

VIII. MISCELLANEOUS

Initial Compliance

78. ValueOptions shall submit to the OAG, within forty-five (45) days of its implementation of the prospective relief measures set forth in paragraphs 57 through 72 above, a letter certifying and setting forth, in detail, such implementation.

ValueOptions' Representations

79. The OAG has agreed to the terms of this Assurance based on, among other

things, the representations made to the OAG by ValueOptions 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

80. All communications, reports, correspondence, and payments that ValueOptions 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

81. 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 ValueOptions shall not make any representations to the contrary.

82. All notices, correspondence, and requests to ValueOptions shall be directed as follows:

Daniel M. Risku, Esq.
Executive Vice President & General Counsel
ValueOptions, Inc.
240 Corporate Boulevard
Norfolk, VA 23502
Daniel.risku@valueoptions.com

Valid Grounds and Waiver

83. ValueOptions 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

84. 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 ValueOptions' Practices

85. Acceptance of this Assurance by the OAG shall not be deemed or construed as approval by the OAG of any of ValueOptions' 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

86. To the extent not already provided under this Assurance, ValueOptions shall, upon request by the OAG, provide all documentation and information necessary for the OAG to verify compliance with this Assurance. ValueOptions may request an extension of particular deadlines under this Assurance, but OAG need not grant any such request. 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

87. 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 ValueOptions with respect to this Assurance, or ValueOptions' non-compliance with any applicable law with respect to any matters.

No Undercutting of Assurance

88. ValueOptions 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 ValueOptions' (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.

89. It is the parties' intention that none of the provisions in this Assurance may be used as evidence in any in any litigation or other legal proceedings to which the OAG is not a party. None of the legal and factual statements in this Assurance shall operate as an admission by ValueOptions in any litigation or other legal proceeding to which the OAG is not a party and ValueOptions reserves the right to deny, challenge or refute any such legal or factual assertions in any litigation or other legal proceeding to which the OAG is not a party.

Governing Law; Effect of Violation of Assurance of Discontinuance

90. 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.

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

92. If a court of competent jurisdiction determines that ValueOptions has breached this Assurance, ValueOptions 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

93. 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.

94. 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

95. No representation, inducement, promise, understanding, condition, or warranty not set forth in this Assurance has been made to or relied upon by ValueOptions in agreeing to this Assurance.

96. 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 ValueOptions regarding the subject matter of this Assurance.

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

98. 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

99. 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. “Successors” includes any entity which acquires the assets of ValueOptions or otherwise assumes some or all of ValueOptions’ current or future business administering behavioral health benefits for fully funded or state and local governmental health plans in New York.

Effective Date

100. 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:

March 4, 2015

ValueOptions, Inc.

By: 

DANIEL M. RISKU
Executive Vice President & General
Counsel
ValueOptions, Inc.

Dated: New York, New York

March 4, 2015

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, ValueOptions 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, include: diagnosis; symptoms; treatment goals; and, where appropriate, risks to the member from not continuing treatment.
2. Inform the provider, and member (where practicable), orally and in writing, of the specific information needed for making the medical necessity determination, the time frame to provide the information, and acceptable methods of submission.
3. Offer to make available to the member and provider a copy of ValueOptions' medical necessity criteria for the level of care at issue, as well as any checklist or questionnaire used by ValueOptions in making medical necessity determinations for the level of care at issue.
4. In a case in which ValueOptions determines that it lacks sufficient information to make a medical necessity determination, ValueOptions 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

Content of Parity Disclosures and Parity Compliance Reports

ValueOptions will disclose to members in writing, and will in its Parity Compliance Reports provide evidence of, the following statements:

1. ValueOptions administers broad-based coverage for the diagnosis and treatment of behavioral health conditions, and works with its clients to ensure that such coverage is at least equal to and no more restrictive than the coverage provided for other health conditions. Behavioral health conditions include mental health and substance abuse disorders.

2. On behalf of its clients, ValueOptions administers, subject to medical necessity, benefits for inpatient and outpatient behavioral health care, which are at least equal to and no more restrictive than medical/surgical benefits under the plan, as well as for residential treatment for behavioral health conditions if its client health plans offer a comparable medical/surgical benefit.

3. For outpatient behavioral health visits, ValueOptions recommends that its client health plans apply the member's primary care cost-sharing schedule.

4. The utilization review conducted by ValueOptions for behavioral health benefits is at least equal to, and no more restrictive than, and applied no more stringently than, the utilization review conducted for medical/surgical benefits by the health plans for which ValueOptions administers behavioral health benefits.

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

6. For plans it administers, ValueOptions does not apply any cost-sharing requirements that are applicable only to behavioral health benefits, unless there is a unique behavioral health benefit for which there is no comparable medical/surgical benefit, and ValueOptions has provided notice of same to the Office of the Attorney General.

7. ValueOptions does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at twenty (20) visits per year, or any other limitation required by law, for which ValueOptions has provided notice to the Office of the Attorney General.

8. The criteria for medical necessity determinations made by ValueOptions regarding behavioral health benefits are made available on a public website, and, upon request, to any current or potential participant, beneficiary, or contracting provider.

9. Where a plan administered by ValueOptions covers medical/surgical benefits provided by out-of-network providers, the plan covers behavioral health benefits provided by out-of-network providers.

10. ValueOptions members are charged a single deductible for all benefits, whether services rendered are for medical/surgical or behavioral health conditions, with the exception that some plans may charge a separate, combined deductible for prescription drugs.

11. MVP and Emblem, for which ValueOptions administers behavioral health benefits, offer members the services of Behavioral Health Advocates, who are trained to assist 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.