



Summary New York Attorney General and MVP Health Care Assurance of Discontinuance

Introduction

On March 20, 2014, the New York State Office of the Attorney General (“OAG”) announced a groundbreaking Assurance of Discontinuance—similar to a settlement agreement—with Schenectady-based MVP Health Care (“MVP”), which the OAG found had violated both state and federal laws that require insurers to provide mental health and substance use disorder benefits equally with medical and surgical benefits. Among other things, the Assurance of Discontinuance (“Assurance”) fined MVP a \$300,000 civil penalty, requires MVP to overhaul its claims review process, and requires MVP to reimburse its members who were improperly denied mental health and substance use disorder benefits since 2011, which could lead to more than \$6 million in reimbursements.

This document provides background information on the federal parity law, a summary of the provisions of the Assurance, and next steps for providers and others.

Background: Federal Parity Law

In 2008, the Mental Health Parity and Addiction Equity Act (“federal parity law”) was signed into law, requiring health insurers who choose to provide mental health and substance use disorder benefits to provide them equally—or at parity—with medical and surgical benefits. Final regulations implementing the 2008 law were released at the end of 2013, and become effective for insurance plan years beginning on or after July 1, 2014. The Legal Action Center (“LAC”) worked successfully with the substance use disorder and mental health fields toward the passage of the federal parity law, and has worked as a co-leader of the Coalition for Whole Health to ensure that the law is implemented effectively.

New York also has a state law, known as Timothy’s Law, which requires health insurers who choose to provide mental health benefits to provide them equally with medical and surgical benefits. Timothy’s Law (“state parity law”) does *not* apply to substance use disorder benefits.

Highlights: NY OAG and MVP Health Care Assurance of Discontinuance

The OAG’s investigation into MVP—which looked at the period from 2011 through 2013—found widespread violations of both the state and federal parity laws by MVP, which administered its mental health and substance use disorder benefits (“behavioral health benefits”) through ValueOptions. The violations include:

1) Utilization Review:

- MVP & ValueOptions applied more rigorous and more frequent utilization review for behavioral health benefits than for medical and surgical benefits. (Utilization Review is the process by which a health insurer examines members' claims to determine whether they are medically necessary and thus eligible for coverage.) Specifically, in the case of MVP & ValueOptions:
 - Behavioral health benefits comprised less than 3% of all benefits paid by MVP, but comprised 14% of all utilization reviews;
 - MVP denied 21% of all behavioral health reviews it performed, compared with 15% of medical and surgical reviews;
 - MVP denied 47% of members' claims for inpatient substance use disorder treatment, compared with a less than 18% denial rate for medical and surgical inpatient claims; and
 - When MVP did approve more intensive levels of behavioral health care, it often approved only a few days at a time.
- MVP used a utilization review tool for outpatient behavioral health benefits known as the Outpatient Outlier Model, under which a certain number of outpatient psychotherapy visits triggered a special form of intensive utilization review, which often led to denials. MVP had no equivalent to the Outpatient Outlier Model for medical and surgical benefits.

2) Denial Letters:

- MVP's denial letters were generic, and failed to sufficiently explain the basis for the denials—including what medical criteria were used and why the member failed to meet those criteria—thus depriving members of the ability to lodge meaningful appeals. Specifically, MVP's use of boilerplate language was found to violate the law.

3) Medical Criteria:

- MVP used inappropriate criteria to make level of care determinations for people with substance use disorders. Rather than using criteria approved by the New York Office of Alcoholism and Substance Abuse Services ("OASAS"), as substance use programs in New York State are required to do, MVP used criteria developed by ValueOptions.

4) Denial Classification:

- MVP did not classify denials of behavioral health benefits that were based on lack of preauthorization or lack of clinical information as medical necessity denials, thus depriving members of their appeal rights. (Notably, the OAG found that although less than 3% of members eligible for an external appeal file one, MVP is overturned 40% of the time when members do.)

5) Residential Treatment:

- Until 2014, most MVP benefit plans did not cover residential treatment for behavioral health conditions.
- Residential treatment for behavioral health conditions is comparable, under the state and federal parity laws, to skilled nursing for medical and surgical conditions.

6) Cost Sharing:

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

After the OAG determined that MVP violated both state and federal parity laws, the OAG and MVP signed the Assurance, which specifies how MVP will remedy its violations of the law. Going forward, MVP will implement the following changes:

1) Cost Sharing:

- Implement co-payments for most outpatient behavioral health visits that are equal to co-payments for outpatient primary care visits.

2) Utilization Review:

- MVP will no longer use the Outpatient Outlier Model.
- If MVP uses any utilization review tool that is based on quantity or frequency of outpatient visits, the tool must be developed and updated annually based on clinical evidence, and must be approved by a physician specializing in psychiatry or addiction medicine. Utilization review with such a tool will only be conducted if the quantity or frequency of visits is inconsistent with clinical evidence.
- A significant number of MVP's utilization review staff will be co-located (at the same physical site) with the staff of any entity that administers behavioral health benefits on behalf of MVP.
- MVP, and any entity administering behavioral health benefits on its behalf, must follow a specific protocol (laid out in the Assurance) when collecting information during utilization review.
- The utilization review process for determining whether inpatient substance use disorder treatment is medically necessary will reflect that there are individuals for whom it is medically necessary to begin inpatient substance use treatment without first undergoing outpatient treatment (e.g., MVP will not require members to "fail first" at outpatient treatment).
- MVP will adopt medical necessity criteria for substance use treatment for Medicaid patients that comports with guidelines set by the New York State Department of Health and/or OASAS.
- When an MVP member transitions between levels of treatment (e.g., from inpatient to outpatient), utilization review for the second level of treatment will be conducted as concurrent review.
- When MVP denies coverage of behavioral health services due to lack of clinical information and/or lack of preauthorization, and the request for preauthorization was submitted by a credentialed provider, the denial will be processed as a medical necessity denial (this affords appeal rights to members receiving such denials).
- MVP will not approve only one day or one visit for a behavioral health benefit; rather, the number of days or visits approved will be based on the treatment needs of the member.

- 3) Visit Limits:
 - There will be no day or visit limits for behavioral health services in any MVP plan, except for family counseling services.
- 4) Compliance:
 - MVP will designate a Compliance Administrator, who will serve for three years.
 - For three years, MVP will provide the OAG with a quarterly summary of complaints received regarding MVP's behavioral health benefits.
- 5) Denial Letters:
 - MVP's denial letters (known as adverse determination notifications) will be changed in a number of ways, including providing members with specific information about the medical necessity criteria used and why the member did not meet those criteria, and providing clear and specific information about how to appeal the denial.
- 6) Behavioral Health Advocates:
 - MVP will designate a minimum of three full-time employees to serve as Behavioral Health Advocates, who will assist members who have received denials of behavioral health benefits with complaints and appeals. Behavioral Health Advocates will also be accessible to providers.
- 7) Appeals:
 - MVP will offer members the assistance of Behavioral Health Advocates in pursuing internal appeals, and will continue coverage of treatment pending the completion of *internal appeals*.
 - MVP will make a number of changes to its *external appeals* process, including increasing eligibility for expedited external appeals, and permitting providers to file external appeals on behalf of their member patients for prospective, concurrent, or retrospective denials of coverage for behavioral health services.
- 8) Residential Treatment:
 - MVP will cover medically necessary residential treatment for behavioral health conditions.
- 9) Training:
 - MVP will train its utilization review and customer relations staff on the requirements of the federal and state parity laws as well as New York State Insurance Law provisions regarding substance use disorder and eating disorder treatment.

The Assurance also requires MVP to remedy the impact of its illegal practices between 2011 and 2013. MVP must:

- 1) Review and Reimbursement of Denials:
 - Members whose behavioral health treatment claims were denied by MVP between January 1, 2011 and March 19, 2014 on the grounds of lack of medical necessity will be eligible to have their denials reviewed by an independent entity and, if the independent entity determines that the denied treatment was medically necessary, MVP will reimburse the member for any out-of-pocket costs the member incurred in paying for the denied treatment.

- MVP will reimburse members who incurred out-of-pocket costs paying for residential treatment for behavioral health services between January 1, 2011 and March 19, 2014, if those members incurred the costs because MVP denied their claims on the grounds that residential treatment was not a covered service, or because they did not submit the claims to MVP. MVP is making \$1.5 million available for residential treatment reimbursement.
 - The Behavioral Health Advocates established under the Assurance will be made available to members who are seeking these types of review and reimbursement.
- 2) Fine:
- MVP must pay a \$300,000 civil penalty to the OAG.

What's Next

The OAG has made clear that it is committed to enforcing both New York State and federal parity laws. As the OAG noted in its press release regarding the MVP Assurance, “Persons with mental health or 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 treatment.” When health insurers violate parity laws, they create very real barriers to treatment for people with mental health and substance use disorders, often leading to grave consequences for patients and their families.

Providers or patients in New York State who are concerned that their rights under the state or federal parity laws are being violated are encouraged to call the OAG’s Health Care Bureau Helpline at 1-800-428-9071. Providers and patients can also contact the U.S. Department of Labor, the U.S. Department of Health and Human Services, or the U.S. Department of the Treasury to report violations of the federal parity law. Finally, when appealing adverse decisions by health insurers that seem to violate the parity laws, providers and patients should consider citing to the MVP Assurance to demonstrate what types of policies and practices have been found to be illegal.