NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH PLAN CONTRACTING AND OVERSIGHT
ARTICLES 44 AND 49 STATEMENT OF DEFICIENCIES

NAME OF MANAGED CARE ORGANIZATION	**TYPE OF SURVEY:**
Amida Care, Inc.	Focus Survey: Mental Health Parity and Addiction Equity Act Testing of Phase III Workbooks
STREET ADDRESS, CITY, STATE, ZIP CODE 14 Penn Plaza, 2nd Floor New York, NY 10122	**SURVEY DATES:** March 11, 2020 - November 30, 2020 Survey ID #: 1629380334

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

Deficiencies	**Plan of Correction with Timetable**
10 CRR-NY 98-1.16 Disclosure and filing **(h) In the event an MCO does not provide substantially complete reports or other information required under this Subpart by the due date, or provide requested information within 30 days of any written request for a specific analysis or report by the superintendent or commissioner, the superintendent or commissioner is authorized to levy a civil penalty, after notice and hearing, pursuant to section 12 of the Public Health Law or sections 307 and 308 of the Insurance Law.** **Deficiency:** Based on the review of Amida Care, Inc.'s Phase III nonquantitative treatment limitation (NQTL) workbook submissions, the MCO failed to follow parity reporting requirements and demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), P.L. 110-343, for 5 of 10 NQTLs examined, including retrospective review, outlier review, experimental/investigational determinations, fail first, and provider credentialing. • Specifically, Amida Care, Inc. failed to provide all required information and substantive comparative analyses in Steps 1 through 5 for outlier review in the inpatient, outpatient, and prescription drug benefit classifications and retrospective review and fail first in the prescription drug benefit	**10 CRR-NY 98-1.16 Disclosure and filing – Deficiency** *Amida Care reviewed our prior Phase III workbook responses and OMH's feedback for outlier review (inpatient and outpatient); prescription drug benefit classifications and retrospective review; fail first in the prescription drug benefit classification; experimental/investigational determinations (inpatient and outpatient); and provider credentialing in the inpatient and outpatient benefit classifications. Meetings were held with functional leads as well as the Chief Medical Officer and Chief Business Operations and Strategy Officer to address the root causes of areas of non-compliance. A meeting was also scheduled with Beacon to discuss and better understand the parity components. Below outlines some of the topics that resulted from these meetings:* • *Regarding prescription drug benefit classification, Amida Care has a Pharmacy and Therapeutic Committee that reviews any new drugs regardless of therapeutic class which includes BH medications that come into the market. The same policies and practices apply to all prescription drug benefit classifications. This committee is chaired by a Senior Clinical Pharmacist, Chris Milan and members include the Chief Medical Officer, Jerry Ernst, MD, and pharmacists from in-network outpatient sites and providers from in-network sites. The committee meets on a quarterly basis.* • *Prescription drug utilization review for all drug classes are reviewed simultaneously. Criteria is established for all drugs that require utilization*

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classification. The MCO also failed to provide all required information and substantive comparative analyses in Step 4, as written comparability and equivalent stringency, and Step 5, in-operation comparability and equivalent stringency, for retrospective review in the inpatient and outpatient benefit classifications. The MCO failed to provide all required information and substantive comparative analyses in Step 3, evidentiary standards comparability and equivalent stringency, Step 4, as written comparability and equivalent stringency, and Step 5, in-operation comparability and equivalent stringency, for experimental/investigational determinations in the inpatient, outpatient, and prescription drug benefit classifications. The MCO also failed to provide a substantive comparative analysis in Step 5, in-operation comparability and equivalent stringency, for provider credentialing in the inpatient and outpatient benefit classifications. Due to these findings, the State is not able to assess whether the MCO complies with MHPAEA for the above-referenced NQTLs. **PHL § 4406 Health maintenance organizations; regulation of contracts** **1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of one hundred or fewer employees or members, exclusive of spouses and dependents, or to any employee or member of the group, including dependents, applying for such contract at any time throughout the year. An individual direct payment contract shall be issued only in accordance with section four thousand three hundred twenty-eight of the insurance law. The**	*management and if a member meets the criteria, the review will be approved. Part of the criteria can be for member to try a covered alternative and/or if the member is unable to take covered alternative then medical necessity rational is required from the prescriber.* • *Retrospective review for prescription drugs is handled in the same manner as prospective reviews.* *We have determined that a more formal and comprehensive process is needed to compare the MH/SUD benefit to the Med/Surgical benefit to ensure they are comparable and that the MH/SUD policies are not more stringently applied than those for Med/Surgical.* *Effective 12/15/2021, Amida Care will develop a formal MHPAEA program led by Amida Care leadership which will include internal staff and representatives from Beacon. A standing committee called Benefit Design Strategy and Implementation Committee will be developed chaired by Jerry Ernst, Chief Medical Director. Membership will include: Associate Medical Director; Vice President of Operations; Michele Pedretti-Moussally, Vice President of Integrated Care and Behavioral Health; Annmarie Murphy Director of Operational Initiative; Esperanza Gabriel, Senior Director of Compliance/Compliance Officer; Nicolette Piscatelli, Senior Director Network Operations; Kevin Steffens, Vice President of Health Services; Nabil Umer, Director of Pharmacy and Javita Moreira, Director of Vendor Performance. This committee will meet monthly for 6 months to monitor completion of the comparative analyses and plan of correction. After 6 months, the committee will meet quarterly. The principal charge of the committee is to ensure compliance with MHPAEA. This committee will provide oversight and ensure that the following items are addressed and resolved:* • *Ensure and demonstrate that processes, strategies, evidentiary standards and other factors will be used to design and operationalize inpatient and outpatient retrospective review and prescription drug retrospective review for MH/SUD benefits that are comparable to those utilized for Med/Surg benefits* • *Ensure workbook reporting prompts are followed for prescription drug retrospective review, outlier review, and experimental/investigational determinations, fail first and for each service classification.* • *Ensure outlier review has substantive comparative*
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superintendent may, after giving consideration to the public interest, exempt a health maintenance organization from the requirements of this section provided that another health insurer or health maintenance organization within the health maintenance organization's same holding company system, as defined in article fifteen of the insurance law, including a health maintenance organization operated as a line of business of a health service corporation licensed under article forty-three of the insurance law, offers coverage that, at a minimum, complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to this chapter and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of this chapter. The requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, 1 title eleven-D of article five of the social services law, 2 title one-A of article twenty-five of this chapter 3 or title eighteen of the federal Social Security Act, 4 and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. **4303(g) 4303(k) and 4303(l) State Insurance Law** **<u>Deficiency:</u>** Based on the review of Amida Care, Inc.'s Phase III NQTL workbook submission (submitted August 14, 2020), the MCO failed to comply with MHPAEA for retrospective review. • Specifically, the MCO's submission for retrospective review in the inpatient and outpatient benefit classifications demonstrated in Steps 1 through 3 that the processes, strategies, evidentiary standards, and other factors used to	*analyses demonstrate that process, evidentiary standards and other factors will be used to design and operationalize the NQTL for MH/SUD inpatient and outpatient.* • *Ensure that prescription drug outlier is comparable to and no more stringently applied to those utilized for Med/Surg benefits* • *Ensure that experimental/investigational determinations provide substantive comparable analysis including evidentiary standards comparability, equivalent stringency, written comparability and in-operation comparability.* • *Ensure and demonstrate that fail first processes, strategies, evidentiary standards and other factors will be used to design and operationalize the NQTL for MH/SUD prescription drugs and are comparable to and no more stringently* • *Ensure that provider credentialing provide a substantive comparative analysis which includes in-operation comparability and equivalent stringency.* *As part of the process, a workgroup chaired by Johann Kirsch, Manager of Health Plan Operations, will provide oversight for the initial comparative analyses and completion of the plan of correction. Monthly updates will be reported to the Benefit Design Strategy and Implementation Committee.* *Additionally, a policy will be created and finalized that will detail this process. Once the Phase III workbooks have been updated, a meeting will be scheduled with Milliman requesting their review and feedback on whether our substantive comparative analyses, equivalent stringency, evidentiary standards comparability, in-operation comparability along with the required information meets the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).* *Staff training will be scheduled for relevant staff once the policy has been finalized and approved. When necessary, follow-up training will also be conducted to address additional changes for areas of potential non-compliance.* *Amida Care will include MHPAEA Compliance Issues within the scope of the Compliance Hotline reporting under the Compliance Program. Any such compliance issues shall be investigated appropriately including protection for the reporting individual from any retaliation. If Amida Care*
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implement retrospective review for mental health and substance use disorder (MH/SUD) benefits are not comparable to those utilized for medical and surgical (M/S) benefits. To wit, the MCO indicated that it considers factors such as high cost for M/S benefits and other, non-comparable factors related to clinical care for MH/SUD benefits.	*identifies any MHPAEA violations, immediate corrective action will be implemented to correct the violation.* *To ensure ongoing monitoring, Amida Care will designate a management staff responsible for assessing, monitoring, and managing Parity Compliance. Such management staff reports directly to Patrick McGovern, Chief Business Operations and Strategy Officer. Parity reports will be presented no less than annually to the Compliance Committee on the activities of the Mental Health Parity Program. The plan of correction will be implemented by March 30, 2022. Patrick McGovern, Chief Business Operations and Strategy Officer will be responsible for the implementation of the plan of correction.* **PHL § 4406 Health maintenance organizations; regulation of contracts - Deficiency** *Amida Care reviewed our prior Phase III workbook responses and OMH's feedback for retrospective review in the inpatient and outpatient benefit classifications demonstrated in Step 1 through 3. Meetings were held with involvement from functional leads as well as the Chief Medical Officer and Chief Business Operations and Strategy Officer to address the root causes of areas of non-compliance. A meeting was also scheduled with Beacon to discuss and better understand the parity components.* *We have determined that a more formal process is needed to compare the MH/SUD benefit to the Med/Surgical benefit to ensure they are comparable and that the MH/SUD policies are not more stringently applied than those for Med/Surgical.* *Effective 12/15/2021, Amida Care will develop a formal MHPAEA program led by Amida Care leadership which will include internal staff and representatives from Beacon. A standing committee called Benefit Design Strategy and Implementation Committee will be developed chaired by Jerry Ernst, Chief Medical Director. Membership will include: Associate Medical Director; Vice President of Operations; Michele Pedretti-Moussally, Vice President of Integrated Care and Behavioral Health; Annmarie Murphy Director of Operational Initiative; Esperanza Gabriel, Senior Director of Compliance/Compliance Officer; Nicolette Piscatelli, Senior Director Network Operations; Kevin Steffens, Vice President of Health Services; Nabil Umer, Director of Pharmacy and Javita Moreira, Director of Vendor Performance. This committee will meet monthly for 6 months to monitor completion of the comparative analyses and plan of correction. After 6 months, the committee will meet quarterly. The principal charge*

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	of the committee is to ensure compliance with MHPAEA. *This committee will provide oversight and ensure that the following items are addressed and resolved:* • *Ensure and demonstrate that processes, strategies, evidentiary standards and other factors will be used to design and operationalize inpatient and outpatient retrospective review for MH/SUD benefits that are comparable to those utilized for Med/Surg benefits.* *As part of the process, a workgroup chaired by Johann Kirsch, Manager of Health Plan Operations, will provide oversight for the initial comparative analyses and completion of the plan of correction. Monthly updates will be reported to the Benefit Design Strategy and Implementation Committee.* *A policy will be created and finalized that will detail this process. Once the Phase III workbooks have been updated, a meeting will be scheduled with Milliman requesting their review and feedback on whether our substantive comparative analyses, equivalent stringency, evidentiary standards comparability, in-operation comparability along with the required information meets the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).* *Staff training will be scheduled for relevant staff once the policy has been finalized and approved. When necessary, follow-up training will also be conducted to address additional changes for areas of potential non-compliance.* *Amida Care will include MHPAEA Compliance Issues within the scope of the Compliance Hotline reporting under the Compliance Program. Any such compliance issues shall be investigated appropriately including protection for the reporting individual from any retaliation. If Amida Care identifies any MHPAEA violations, immediate corrective action will be implemented to correct the violation.* *To ensure ongoing monitoring, Amida Care will designate a management staff responsible for assessing, monitoring, and managing Parity Compliance. This management staff reports directly to Patrick McGovern, Chief Business Operations and Strategy Officer. Parity reports will be presented no less than annually to the Compliance Committee on the activities of the Mental Health Parity Program. The plan of correction will be implemented by March 30, 2022. Patrick McGovern, Chief Business Operations and Strategy Officer will be responsible for the implementation of the plan of correction.*

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