

MARKET CONDUCT REPORT ON EXAMINATION

OF

MVP HEALTH PLAN, INC.

MVP HEALTH INSURANCE COMPANY

MVP HEALTH SERVICES CORP.

AS OF

DECEMBER 31, 2013

DATE OF REPORT

AUGUST 30, 2016

EXAMINER

JEFFREY L. USHER, CFE

TABLE OF CONTENTS

<u>ITEM NO.</u>		<u>PAGE NO.</u>
1.	Scope of the examination	3
2.	Description of the Companies	4
3.	Patient Protection and Affordable Care Act	6
4.	Prompt pay law	17
5.	Utilization review	18
5.	Medical Loss Ratio	19
6.	Compliance with prior report on examination	20
7.	Summary of comments and recommendations	22



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

August 30, 2016

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31183, 31185 and 31187, dated April 30, 2014, attached hereto, I have made an examination into the affairs of MVP Health Plan, Inc., a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law; MVP Health Insurance Company, a for-profit accident and health stock company licensed pursuant to the provisions of Article 42 of the New York Insurance Law; and MVP Health Services Corp., a not-for-profit health services corporation licensed pursuant to Article 43 of the New York Insurance Law, as of December 31, 2013. The following report is respectfully submitted thereon.

The examination was conducted at the home office of MVP Health Care, Inc., the ultimate parent company of the above three companies covered under this examination, located at 625 State Street, Schenectady, New York.

Wherever the designations "MVPHP" or the "HMO" appear herein, without qualification, they should be understood to indicate MVP Health Plan, Inc.

Wherever the designation “MVPHIC” appears herein, without qualification, it should be understood to indicate MVP Health Insurance Company.

Wherever the designations “MVPHSC” or the “Plan” appear herein, without qualification, they should be understood to indicate MVP Health Services Corp.

Wherever the designation the “MVP Companies” appears herein, without qualification, it should be understood to indicate MVP Health Insurance Company, MVP Health Plan, Inc. and MVP Health Services Corp., collectively.

Wherever the designation “MVP” appears herein, without qualification, it should be understood to indicate MVP Health Care, Inc., the ultimate parent of the MVP Companies.

Wherever the designation the “Department” appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

An examination was performed to review the manner in which the MVP Companies conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. The previous market conduct examinations of the MVP Companies were conducted as a combined examination of MVPHP, MVPHIC, MVPHSC and PAC (“Preferred Assurance Company, Inc.”) as of December 31, 2010. This market conduct examination covers the three-year period from January 1, 2011 through December 31, 2013. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A review was also made to ascertain what actions were taken by the MVP Companies with regard to the comments and recommendations (related to market conduct items) contained in the prior report on examination.

Separate examinations of the financial condition of the MVP Companies were conducted, as of December 31, 2013. The resulting reports on examination were filed on June 19, 2015 for MVP Health Insurance Company and for MVP Health Plan, Inc., and on February 12, 2016 for MVP Health Services Corp.

2. **DESCRIPTION OF THE COMPANIES**

MVP Health Plan, Inc.

MVP Health Plan, Inc. is a New York State not-for-profit corporation certified as a health maintenance organization to deliver health care services in New York and Vermont.

MVP Health Plan, Inc. was incorporated on July 30, 1982, pursuant to Section 402 of the New York Not-For-Profit Corporation Law, for the purpose of operating as a health maintenance organization, as such term is defined in Article 44 of the New York Public Health Law. The HMO's incorporators were the board of directors of the Schenectady County Foundation for Medical Care, Inc., a non-profit physicians association. Simultaneous with the incorporation of the HMO, the incorporators formed Mohawk Valley Medical Associates, Inc., a non-profit independent practice association (IPA), pursuant to Section 402 of the New York Not-For-Profit Corporation Law.

MVP Health Plan, Inc. is an IPA model HMO. On March 8, 1982, the HMO and Mohawk Valley Medical Associates, Inc. contracted, through an "Independent Practice Association (IPA) Service Agreement" to work together to provide for the administration of a comprehensive prepaid program of health care and for the delivery of health services. Subsequently, the HMO made similar arrangements with other independent practice associations to achieve the same goal.

On August 30, 2013, the New York State Department of Health (“DOH”) approved MVPHP’s request to acquire Hudson Health Plan, Inc. (“HHP”). The Department had issued a non-objection letter to DOH on August 29, 2013 relative to this acquisition. MVPHP is the sole corporate member of Hudson Health Plan, Inc. a Tarrytown, New York based Medicaid managed care organization. HHP is a not-for-profit prepaid health services plan that provides state-sponsored Medicaid Managed Care, Child Health Plus, and during the examination period, Family Health Plus insurance coverage to its members in New York’s Hudson Valley region.

MVP Health Insurance Company

MVP Health Insurance Company was incorporated on April 24, 2000 as a for-profit accident and health insurer. MVPHIC was licensed in June 2001, pursuant to Article 42 of the New York Insurance Law, to write insurance business as defined under Section 1113(a)(3) of the New York Insurance Law.

MVPHIC began operations by delivering health care services in the State of New York in July 2001. Also, MVPHIC received approval to operate as an accident and health insurer in the State of Vermont on May 14, 2002.

MVP Health Services Corp.

MVP Health Services Corp. was incorporated on October 8, 1992, and filed its Certificate of Incorporation with the New York Department of State on October 16, 1992.

The Plan was incorporated under Section 402 of the Not-for-Profit Corporation Law and licensed pursuant to Article 43 of the New York Insurance Law as a not-for-profit health services corporation. Prior to January 2002, MVPHSC offered point-of-service (POS) health insurance products. As of the examination date, the Plan provided only dental insurance to its subscribers.

The Plan is a Type D membership corporation as defined in Section 201 of the New York Not-for-Profit Corporation Law. MVPHSC is a subsidiary of MVPRT Holdings, Inc., which is a wholly-owned subsidiary of MVPHIC Holding Corp. MVPHIC Holding Corp. is a wholly-owned subsidiary of MVP Health Care, Inc. Pursuant to its by-laws, the Plan has one corporate member, MVPRT Holdings, Inc.

3. PATIENT PROTECTION AND AFFORDABLE CARE ACT **("PPACA")**

The Patient Protection and Affordable Care Act was passed by Congress and then signed into law by the President on March 23, 2010. Key features of PPACA include consumer protections, improvement of quality and lowering costs of health care services and increasing access to affordable health care. In this regard, in addition to existing laws, there have been subsequent passages of New York Insurance Law legislation which coordinate with federal law in such areas.

Preventive Services

Section 3216(i)(17)(C) and (E) of the New York Insurance Law, “Individual accident and health insurance policy provisions,” requires that certain preventive services shall not be subject to annual deductibles or coinsurance.

Section 3216(i)(17) of the New York Insurance Law states in part:

“(17)(A) Every policy that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.

(B) For the purposes of subparagraphs (A), (C) and (D) of this paragraph, preventive and primary care services means the following services rendered to a covered child of an insured from the date of birth through the attainment of nineteen years;...

(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not be subject to annual deductibles or coinsurance.

(D) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not restrict or eliminate existing coverage provided by the policy.

(E) In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (F) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for preventive care and screenings that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force;

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.”

Section 3221(1)(8)(D) and (E) of the New York Insurance Law, “Group or blanket accident and health insurance policies; standard provisions,” requires that certain preventive services shall not be subject to annual deductibles or coinsurance.

Section 3221(1)(8) of the New York Insurance Law states in part:

“(8)(A) Every insurer issuing a group policy for delivery in this state that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.

(B) In subparagraphs (A), (C) and (D) of this paragraph, preventive and primary care services means the following services rendered to a covered child of an insured from the date of birth through the attainment of nineteen years of age: ...

(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not be subject to annual deductibles or coinsurance.

(D) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not restrict or eliminate existing coverage provided by the policy.

(E) In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every group policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (G) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

(i) evidence-based items or services for preventive care and screenings that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force;

(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.

(F) The requirements of this paragraph shall also be applicable to a blanket policy of hospital, medical or surgical expense insurance covering students pursuant to subparagraph (C) of paragraph three of subsection (a) of section four thousand two hundred thirty-seven of this chapter.

(G) For purposes of this paragraph, “grandfathered health plan” means coverage provided by an insurer in which an individual was enrolled on

March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e).”

In addition, the following sections of the Patient Protection and Affordable Care Act also contain requirements regarding payments relative to preventive services.

42 U.S.C. § 300gg -13 states the following, in part:

“§ 300gg–13. Coverage of preventive health services

(a) In general A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—(1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.”

45 C.F.R. § 147.130 states the following, in part:

“§ 147.130 Coverage of preventive health services.

(a) Services—(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to

be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

The Patient Protection and Affordable Care Act mandates require health plans to provide at a minimum, coverage without cost-sharing, relative to preventive services rated A or B by the U.S. Preventive Services Task Force (“USPTF”). Such preventive services include recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

The examiners reviewed 42 of the 52 elements of the total population of preventive services identified by the USPTF. The examiners reviewed the claims from the aforementioned 42 elements for co-pay, deductible and coinsurance costs attributed to the member. The following are the results of the review:

The examiners noted 599 instances of preventive service claims in which cost sharing was applied to the member or the claims were denied in error in violation of Section 3221(1)(8) of the New York Insurance Law and 42 U.S.C. Section 300gg-13 and 45 C.F.R. Section 147.130. Such errors are summarized in the following table by preventive care topic:

TOPIC	DESCRIPTION	MVPHIC Paid	MVPHIC Denied	MVPHIP Paid	MVPHIP Denied	# Errors
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	44				44
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	99				99
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	31	1	21	2	55
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	84		3		87
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	26		11	3	40

TOPIC	DESCRIPTION	MVPHIC Paid	MVPHIC Denied	MVPHP Paid	MVPHP Denied	# Errors
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	2				2
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.			1		1
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.			1		1
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	17		13	3	33
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	70				70
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	7		2		9

TOPIC	DESCRIPTION	MVPHIC Paid	MVPHIC Denied	MVPHP Paid	MVPHP Denied	# Errors
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m ² or higher to intensive, multicomponent behavioral interventions	2	1	3		6
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.			3		3
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	2	1			3
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	3	78			81
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.		63			63

TOPIC	DESCRIPTION	MVPHIC Paid	MVPHIC Denied	MVPHP Paid	MVPHP Denied	# Errors
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	2				2
						599

The above total includes errors resulting from the MVP Companies not following their own claims payment policy, (i.e.), the claim lines reviewed included the correct information in accordance with the MVP Companies' claims payment policy however the MVP Companies erroneously applied cost sharing or denied the claim.

It is recommended that the MVP Companies comply with the above stated sections of the New York Insurance Law and Federal Patient Protection and Affordable Care Act relative to preventive services.

It is also recommended that the MVP Companies pay claims for preventive services in accordance with their own claims payment policy.

The MVP Companies indicated that a large portion of the aforementioned errors were due to configuration changes (systematic) within the claim system that did not include all facilities. Also a small portion of the errors identified were manual errors made by the MVP Companies' claims examiners.

It is recommended that the MVP Companies update their claims payment system and make the necessary configuration changes to include all facilities.

It is also recommended that the MVP Companies appropriately train its staff claims examiners relative to appropriate procedures for the claims adjudication of manual submitted claims in order to avoid the above manual errors in the future.

The examiners requested that the MVP Companies provide the communications to the participating providers regarding ACA mandates. The MVP Companies communicated the ACA requirements to providers via a claims payment policy within the MVP website. This policy is updated annually. The payment policy included a description of the preventive service, listed the procedure codes applicable to that preventive service and cost sharing directives. The examiner reviewed the MVP Companies' payment policy to its providers for clarity, completeness and compliance with the aforementioned New York State Insurance Laws and Federal Patient Protection and Affordable Care Act. The following was noted:

Clarity

For each of the CPT procedure codes used within the claims payment policy there were instructions to the provider. In some cases the instructions are not clear. In one instance, the MVP Companies' claims payment policy only stated; "No copay when submitted with the appropriate diagnosis code." There was no reference to the appropriate diagnosis code. Other areas of the payment policy indicated no copay, or

instructed the provider to use a diagnosis code, and/or to use modifier 33. The policy includes a considerable number of procedure codes whereby clear instructions were not given to the provider.

It is recommended that the MVP Companies revise their claims payment policy and provide clear and concise instructions to their providers.

It is also recommended that the MVP Companies update the claims payment policy more frequently as new mandates are added and/or revised.

Modifier 33/ Specifically Identifiable Preventive Service

It was noted in the MVP Companies' claims payment policy, wording which stated, "For separately reported services specifically identified as preventive, the modifier should not be used." The examiner requested 5 examples of specifically identifiable procedure code and/or diagnosis code descriptions. The MVP Companies were only able to provide 1 example. Also, the MVP Companies did not indicate the wording within the example that makes the service specifically identifiable as a preventive service.

It is recommended that the MVP Companies describe within their claims payment policy, using examples, specifically identifiable procedure code and diagnosis code descriptions to identify a preventive service for which cost sharing should not be applied. As such, the provider and the insurer will have the same understanding of preventive services claims payment procedures.

Completeness

The following preventive service and preventive services procedure codes were not included within the MVP Companies' payment policy.

- Falls prevention in older adults exercise or physical therapy: Procedure Codes: 97110 and 97112
- Hearing loss screening newborns: Procedure Codes: 92585, 92586, 92587 and 92588
- Obesity Screening and Counseling Children: Procedure Codes: G0447, 99381-99397

In a response to a request by the examiner, the MVP Companies provided the above procedure codes which were not included within their claims payment policy.

It is recommended that the MVP Companies update their claims payment policy to reflect all preventive services and the associated procedure codes, including diagnosis codes and modifiers which identify preventive services.

It is recommended that the MVP Companies consistently monitor the effectiveness of their payment policy in conjunction with actual claims paid.

4. PROMPT PAY LAW

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt of a claim that is transmitted via the internet or electronic mail or 45 days of receipt

of a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

A review of the MVP Companies' compliance with Section 32234-a was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, such instances did not exceed the limitation prescribed by Section 3224-a.

5. UTILIZATION REVIEW

Sections 4902, 4903 and 4904 of Article 49 the New York Insurance Law set forth the minimum utilization review program standards and requirements of utilization review determinations for prospective, concurrent and retrospective reviews and appeals of adverse determinations by utilization review agents. Comparable sections of Article 49 of the New York Public Health Law contain the same requirements for MVPHP's HMO policies.

The examiners conducted a review of hospital and medical utilization review cases and appeal cases for compliance with Art 49 of the New York Insurance Law.

No problem areas were noted.

6. MEDICAL LOSS RATIO REVIEW

The Patient Protection and Affordable Care Act requires insurers to spend a minimum percentage of premium dollars on medical services and activities designed to improve health care quality and submit a medical loss ratio (“MLR”) report to present this information. The Department reviewed the components of the MLR Report filings by utilizing the MLR Procedures Spreadsheet provided by the Center for Consumer Information and Insurance Oversight (“CCIIO”) to review and test, as deemed appropriate, the following items in accordance with 45 CFR Part 158.403 (a) and (b):

- Validity of the data regarding expenses and premiums that the issuer reported to the Secretary, including the appropriateness of the allocations of expenses used in such reporting,
- Whether the activities associated with the issuer’s reported expenditures for quality improving activities meet the definition of such activities,
- The accuracy of rebate calculations, and the timeliness and accuracy of rebate payments as applicable.

Per the examiner’s review, no items related to the MVP Companies – 2011 to 2013 MLR filings indicated an exception or finding that required additional disclosure were noted.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination included five (5) recommendations detailed as follows (page number refers to the prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Utilization Review</u>	
1.	<div style="display: flex; justify-content: space-between;"> <div style="flex-grow: 1;"> <p>It is recommended that the MVP Companies comply with Section 4903(e) of the New York Insurance Law and Section 4903(5) of the New York Public Health Law (MVPHP only) and issue a first adverse determination letter to affected members and hospitals whenever the MVP Companies change the level of care to a lower level of payment.</p> <p><i>The Plan has complied with this recommendation.</i></p> </div> <div style="text-align: right; vertical-align: top;">9</div> </div>
2.	<div style="display: flex; justify-content: space-between;"> <div style="flex-grow: 1;"> <p>It is recommended that MVPHP complies with Section 4903(4) of the New York Public Health Law and provide adverse determination letters within the required time frame.</p> <p><i>The Plan has complied with this recommendation.</i></p> </div> <div style="text-align: right; vertical-align: top;">10</div> </div>
3.	<div style="display: flex; justify-content: space-between;"> <div style="flex-grow: 1;"> <p>It is recommended that MVPHP complies with Section 4914(2)(b) of the New York Public Health Law and revise its adverse determination letter to include the mandated time frame for allowed response to an external appeal.</p> <p><i>The Plan has complied with this recommendation.</i></p> </div> <div style="text-align: right; vertical-align: top;">10</div> </div>
<u>Prompt Pay law</u>	
4.	<div style="display: flex; justify-content: space-between;"> <div style="flex-grow: 1;"> <p>It is recommended that MVPHP and PAC take steps to ensure full compliance with the provisions of Sections 3224-a(a) and (c) of the New York Insurance Law.</p> <p><i>The Plan has complied with this recommendation.</i></p> </div> <div style="text-align: right; vertical-align: top;">15</div> </div>

ITEM NO.

PAGE NO.

5. It is recommended that MVPHP and PAC take steps to ensure full compliance with the provisions of Section 3224-a(b) of the New York Insurance Law.

18

The Plan has complied with this recommendation.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Preventative Services</u>	
i. It is recommended that the MVP Companies comply with the above stated sections of the New York Insurance Law and Federal Patient Protection and Affordable Care Act relative to preventive services.	14
ii. It is also recommended that the MVP Companies pay claims for preventive services in accordance with their own payment policy.	14
iii. It is recommended that the MVP Companies update their claim system and make the necessary configuration changes to include all facilities.	15
iv. It is also recommended that the MVP Companies appropriately train the staff for any manual procedures that will address the manual errors in the future.	15
v. It is recommended that the MVP Companies revise their claims payment policy and provide clear and concise instructions to their providers.	16
vi. It is also recommended that the MVP Companies update the claims payment policy more frequently as new mandates are added and/or revised.	16
vii. It is recommended that the MVP Companies describe within their claims payment policy, using examples, specifically identifiable procedure code and diagnosis code descriptions to identify a preventive service for which cost sharing should not be applied. As such, the provider and the insurer will have a similar understanding of preventive services claims payment procedures.	16

<u>ITEM</u>	<u>PAGE NO.</u>
viii. It is recommended that the MVP Companies update their claims payment policy to reflect all preventive services and the associated procedure codes, including diagnosis codes and modifiers which identify preventive services.	17
ix. It is recommended that the MVP Companies consistently monitor the effectiveness of their payment policy in conjunction with the actual claims paid.	17

Respectfully submitted,

Jeffrey L. Usher, CFE
Principal Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

Jeffrey L. Usher, being duly sworn, deposes and says that the foregoing submitted report is true to the best of his knowledge and belief.

Jeffrey L. Usher, CFE

Subscribed and sworn to before me

This _____ day of _____ 2016

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine the affairs of

MVP Health Services Corporation

and to make a report to me in writing of the condition of said

Corporation

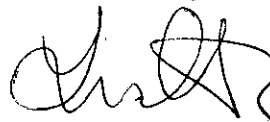
with such other information as he shall deem requisite.

*In Witness Whereof, I have hereunto subscribed my name
and affixed the official Seal of the Department
at the City of New York*

this 30th day of April, 2014

*BENJAMIN M. LAWSKY
Superintendent of Financial Services*

By:



*Lisette Johnson
Bureau Chief
Health Bureau*



NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine the affairs of

MVP Health Insurance Company

and to make a report to me in writing of the condition of said

Company

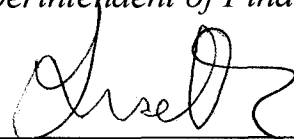
with such other information as he shall deem requisite.

*In Witness Whereof, I have hereunto subscribed my name
and affixed the official Seal of the Department
at the City of New York*

this 30th day of April, 2014

*BENJAMIN M. LAWSKY
Superintendent of Financial Services*

By:



*Lisette Johnson
Bureau Chief
Health Bureau*



NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

Jeffrey Usher

as a proper person to examine the affairs of

MVP Health Plan, Inc

and to make a report to me in writing of the condition of said

HMO

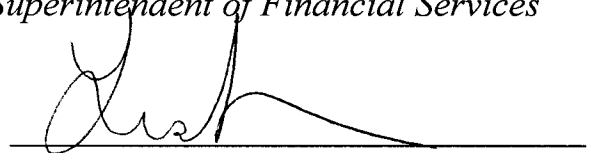
with such other information as he shall deem requisite.

*In Witness Whereof, I have hereunto subscribed my name
and affixed the official Seal of the Department
at the City of New York*

this 30th day of April, 2014

*BENJAMIN M. LAWSKY
Superintendent of Financial Services*

By:



*Lisette Johnson
Bureau Chief
Health Bureau*

