

**MARKET CONDUCT REPORT ON EXAMINATION**

**OF**

**MVP HEALTH PLAN, INC.**

**AND**

**MVP HEALTH SERVICES CORPORATION**

**AS OF**

**SEPTEMBER 30, 2001**

**DATE OF REPORT**

**MARCH 21, 2003**

**EXAMINER**

**ELSAID ELBIALLY, CFE**

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STATE OF NEW YORK  
INSURANCE DEPARTMENT  
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George E. Pataki  
Governor

Gregory V. Serio  
Superintendent

March 21, 2003

Honorable Gregory V. Serio  
Superintendent of Insurance  
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the directions contained in Appointment Numbers 21833 and 21834 dated February 4, 2002, attached hereto, I have made an examination into the affairs of MVP Health Plan, Inc. (MVP), a not-for-profit health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law and MVP Health Services Corporation (MVPHS), a not-for-profit corporation licensed pursuant to Article 43 of the New York Insurance Law. The following report, respectfully submitted, deals with the findings concerning the manner in which MVP and MVPHS conduct their business practices and fulfill their contractual obligations to policyholders and claimants.

The examination was conducted at the Companies' home office located at 625 State Street, Schenectady, New York.

Whenever the term "MVP Health Care" appears herein without qualification, it should be understood to refer to both MVP and MVPHS. Whenever a distinction needs to be made, the terms "MVP" and/or "MVPHS" shall be used.

## **1. SCOPE OF EXAMINATION**

The prior examinations of MVP and MVPHS were conducted as of December 31, 1999. The MVP report contained the following comments relative to the review of claims:

“During the course of the examination, the HMO did not provide paid claims data files that reconciled to the information reported by the HMO in Schedule H of its 1999 Annual Statement. As a result, the examiners were unable to utilize the Department’s sampling to test the integrity of the claims data the HMO reported in its 1999 annual statement. Accordingly, the integrity of that data could not be determined. Furthermore, this impacted the Department’s ability to adequately perform a review to test the HMO’s compliance with Section 3224-a of the New York Insurance Law (Prompt Pay Law).”

“Based upon the above, a more detailed review of the claims adjudication system at MVP Health Plan, Inc. is necessary. The Department will conduct a more detailed review of claims adjudication in general, and compliance with Section 3224-a (“Prompt Pay Law”) specifically, at a later date.”

The current examination, which is restricted to the treatment of claimants, covers the period January 1, 2001 through September 30, 2001. Transactions subsequent to the examination date were reviewed where deemed appropriate.

This report is confined to the manner in which MVP Health Care conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The report also contains comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

## 2. EXECUTIVE SUMMARY

This was a limited scope examination of MVP Health Care as of September 30, 2001 that focused on claims processing, treatment of policyholders and medical service providers. The result of this examination revealed some operational deficiencies that directly impacted its compliance with the New York Insurance Law and the New York Public Health Law. The most significant findings of this examination include the following:

- Inability to provide reconciled claims data in a timely manner.
- Failure to report accurate claim counts and properly classify claim amounts in Schedule H of its filed financial statements.
- Failure to send proper Explanation of Benefits statements (EOBs) to members
- Failure to fully comply with the requirements of the Prompt Pay Law.
- Inadequate written notices of grievance procedures.
- Inadequate notices of first/final medical adverse determinations.
- Failure to send proper notices of medical adverse determination to its participating providers.
- Improper response to the appeals of medical adverse determinations from its participating providers.
- Failure to report all appeals received by all departments in Schedule M of its filed Annual Statements.

The examination findings are described in greater detail in the remainder of this report

## 3. CLAIMS

### A. Claims Processing

MVP provides a comprehensive prepaid health program via written agreements with a number of regional Independent Practice Associations (IPAs) that, in turn, have contracts with a network of participating physicians to provide medical services to members within the HMO's service areas in New York and Vermont. MVP members select a participating primary care physician who coordinates their medical care. This

physician refers subscribers to other MVP physicians when particular medical specialties are required. Except for services specifically excluded or limited in MVP's contracts or riders, there is no limit to duration, frequency or type of health care provided as long as the care is directly provided or pre-authorized by MVP's medical director and/or the participating physician.

All agreements with IPAs are similar in nature. According to these agreements, MVP provides all administrative, marketing, enrollment, financial accounting, claims processing, claims payment, management information and other services, required to support its comprehensive prepaid health care program. The IPA is responsible for establishing contractual relationships with physicians, health care professionals and other providers of health care and for arranging for and facilitating the provision and delivery of health services to members of MVP Health Care. These agreements stipulate that such providers look solely to the IPA for compensation of covered services and, at no time, seek compensation from members except for nominal co-payments permitted under the subscribers' health service contracts.

Every month, MVP calculates the capitation amounts due to the three IPAs under risk contracts with MVP (based on a per member per month method), then makes a journal entry to debit claim expenses and credit its accounts payable "due to the IPAs". MVP invests the amounts due to the IPAs with its own funds in accordance with an investment pooling arrangement. Pursuant to the administrative duties specified in the IPA agreements, MVP processes and pays provider claims. MVP issues checks to IPA physicians, who are paid on a fee-for-service basis. MVP then transfers funds to IPA's bank accounts on a daily basis to cover the cost of all provider checks that are presented. Following the agreements between the IPAs and their participating physicians, MVP withholds varying percentages (15% or 20%) from the provider payments when issuing checks. The amounts withheld are credited to an IPA withhold liability. Amounts to be returned to the physicians are reviewed on an annual basis. Any amounts not returned are recorded as reductions of medical expenses, with corresponding reductions made to the related liability in the physicians' risk withholding account. In addition, MVP has risk

sharing arrangements with the IPAs to address the cost variance for certain medical costs. These risk-sharing arrangements differ between the IPAs. The premise is that MVP and its IPAs are responsible for certain medical costs that affect each other. Under the agreements, the actual medical costs of certain services are compared to budget amounts with the differences being shared by MVP and the IPA.

### Overall Claims Processing

This review was performed by using a statistical sampling methodology covering the examination period in order to evaluate the overall accuracy and compliance environment of MVP Health Care's claims processing.

This statistical random sampling process, which was performed using the computer software program ACL, was devised to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually or on a collective basis could be concluded for each item in the sample. The review incorporated processing attributes used by MVP Health Care in their own "Quality Analysis" of claims processing. The sample size was comprised of 167 randomly selected claims.

The term "claim" can be defined in a myriad of ways. The following is an explanation of the term for the purpose of this report. The receipt of a "claim," which is defined by MVP Health Care as the total number of items submitted by a single provider with a single claim form, is reviewed and entered into the claims processing system. This claim may consist of various lines, or procedures. It was possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into one line, which is the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid had to be accumulated and reconciled to the financial data reported by MVP Health Care for the period January 1, 2001 through September 30, 2001.

MVP Health Care provided the examiners with reconciled claims data. However, MVP Health Care did not provide the reconciled claims data in a timely manner. It should be noted that throughout the delay, certain data was intermittently provided to the examiners, however, it could not be reconciled to MVP Health Care's filed financial statements. Further, the data provided did not include an identifier for hospital and medical claims. This precluded the examiners from selecting separate samples and conducting a separate review for hospital vs. medical claims, which is the normal procedure. MVP Health Care's inability to provide reconciled data during the prior examination was previously cited herein as a reason for this examination. The inability of MVP Health Care to provide reconciled data in a timely manner caused a delay in the conclusion of this examination.

The examination review revealed that the projected accuracy rate for Medical and Hospital claims ranged between 88.9% and 96.7% of claims processed during the period under review. MVP Health Care reported an overall accuracy standard above 97%.

During the conduct of the claims processing review, the following observations were noted:

- i. In year 2001, MVP did not include its capitation payment of \$26 million to a Vermont State IPA (VMC) in Exhibit 8, Parts 1 and 2 of its filed financial statement.

It is recommended that MVP report all capitation payments to its Vermont IPAs in Exhibit 8, Parts 1 and 2 of its filed financial statements.

ii. MVPHS failed to comply with New York Insurance Department Regulation Number 64, {11 NYCRR 216.0(e)(6)}, which requires, in part, that such regulation be distributed to all persons responsible for the supervision, handling and settlement of claims.

It is recommended that MVPHS comply with New York Insurance Department Regulation Number 64, {11 NYCRR 216.0(e)(6)}, and distribute such regulation to all persons responsible for the supervision, handling and settlement of claims.

iii. MVP Health Care's membership data is adjusted periodically to reflect current enrollment information that has been received from member groups. Claims processed during the period between adjustments to membership data may be paid incorrectly (e.g. when an employee has left the group), or denied incorrectly (e.g. when a new employee has joined a group).

MVP HealthCare generates a weekly report of claims that should have been denied but may have been paid and makes diligent efforts to recover amounts paid that should have been denied.

MVP Health Care does not generate any report for claims that should have been paid may have been denied. For these claims no action unless a subscriber and/or provider submits a complaint. MVP HealthCare is working toward generating this type of periodic report.

**B. Schedule H Reporting**

A review of Schedule H as it appeared in MVP Health Care's 2000 and 2001 filed annual and quarterly statements was performed. In both years, MVP Health Care's outsourced claims were not included in column one of Section 3 of Schedule H in the annual and quarterly statements. MVP Health Care failed to include in its report of paid claims available from its Core Claim System (CSC), a report of its paid outsourced claims from its Trade Payable System (Lawson). In addition, MVP Health Care failed to

properly classify its claim dollar amounts by major claim type in column two of Schedule H, Section 3.

It is recommended that MVP Health Care properly classify its paid claims and report its paid outsourced claims data in Section 3 of Schedule H in both the annual and quarterly statements filed with the Department.

**C. Prompt Payment of Claims**

§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”) requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

Section 3224-a (a) states in part;

“...such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a healthcare provider within forth-five days of receipt of a claim or bill for service rendered.”

Section 3224-a (b) states in part;

“...an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:  
 (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or to request all additional information needed to determine liability to pay the claim or make the health care payment...”

Section 3224-a(c), states in part;

“... any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest...”

A review was made of the first nine months of year 2001 claims, using ACL audit software, for compliance with Section 3224-a. The examination included statistical samples for MVP Health Care to determine whether or not interest was appropriately paid pursuant to §3224-a(c) of the New York Insurance Law to those claimants not receiving payment or denials within the timeframes required by §3224-a(a) and (b) of the New York Insurance Law.

A claim was defined as the total number of items submitted on a single claim form to which MVP Health Care assigns a unique claim number. This definition was agreed to by both the examiners and MVP Health Care.

MVP Health Care paid 1,366,502 claims and wholly denied 375,937 claims for its New York State groups and providers / subscribers in the first nine month of year 2001. Of these claims, a population of 48,781 claims was identified where payment date was more than 45 days after the receipt date. A second population of 25,738 claims was identified where the claim was denied more than 30 days after the receipt date. A sample of 167 claims was drawn from each of the populations described above.

The examiner's review of the sampled claims revealed violations of Sections 3224-a (a), (b) and (c) of the New York Insurance Law as shown in the following chart:

Description	Paid claims over 45 days	Denied claims over 30 days
Claim population	48,781	25,738
Sample size	167	167
Number of claims with errors	13*	13
Calculated Error Rate	<u>7.78%</u>	<u>7.78%</u>
Upper Error limit	11.85%	11.85%
Lower Error limit	3.72%	3.72%
Upper limit Claims in error	<u>5,780</u>	<u>3,049</u>
Lower limit Claims in error	<u>1,815</u>	<u>958</u>

\* Of the 13 claims found to be in violation of Section 3224-a(a), 2 claims were also found to be in violation of Section 3224-a(c) because interest due of \$2 or more was not paid.

The upper and lower error limits represent the range of potential error (e.g. if 100 samples were selected the rate of error would fall between these limits 95 times).

It is recommended that MVP Health Care improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.

**D. Explanation of Benefits Statements**

Explanation of Benefits Statements (EOBs) are an integral part of the link between the subscriber/contract-holder and their insurer, providing vital information as to how a claim was processed.

New York Insurance Law Section 3234(a) states in part:

“Every insurer, including health maintenance organizations ... is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy...”

New York Insurance Law §3234(c) creates an exception to the requirements for the issuance of an EOB established in New York Insurance Law §3234(a) as follows:

“[insurers] shall not be required to provide the insured or subscriber with an explanation of benefits form in any case where the service is provided by a facility or provider participating in the insurer’s program and full reimbursement for the claim, other than a co-payment that is ordinarily paid directly to the provider at the time the service is rendered, is paid directly to the participating facility or provider.”

In addition, Section 3234(b) of the New York Insurance Law sets forth minimum standards for content of an EOB as follows:

- “The explanation of benefits form must include at least the following:
- (1) the name of the provider of service the admission or financial control number, if applicable;
  - (2) the date of service;

- (3) an identification of the service for which the claim is made;
- (4) the provider's charge or rate;
- (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
- (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
- (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made".

A review of MVP Health Care's paid and denied claims for members and providers residing or located in New York during the first nine months of year 2001 was performed. The review revealed that EOBs issued by MVP Health Care failed to contain all the language required by Section 3234(b) of the New York Insurance Law (including the appeal language). Its EOBs, in the form as presented to the examiners would not be sufficient to serve as a proper EOB.

Therefore, subscribers were neither properly informed of their appeal rights nor were they advised how their claims were processed.

The review of claims processed during the first nine months of year 2001 yielded 49,386 violations of Section 3234(a) where no EOB was issued for claims involving payments to New York subscribers and/or non-participating providers. In addition, out of the population of wholly or partially denied claims, the following violations of Section 3234(b), of the New York Insurance Law were noted during the period:

- i. 248,380 claims which were wholly denied to New York subscribers and/or providers.
- ii. 49,123 claims which were partially denied to New York subscribers and/or providers.

It is recommended that MVP Health Care issue EOBs that include all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.

#### **4. GRIEVANCES AND APPEALS**

A review of grievances and appeals filed with MVP Health Care was performed to ascertain compliance with Articles 48 and 49 of the New York Insurance Law and Articles 44 and 49 of the New York Public Health Law.

The review revealed the following:

A. Section 4408-a 2(a) of the New York Public Health Law states in part:

“An organization shall provide to all enrollees written notice of the grievance procedure in the member handbook and at any time that the organization denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract;...”

MVP provided its subscribers with written notice of denial, however, the notice did not contain the grievance procedure as required by Section 4408-a 2(a) of the New York Public Health Law, but instead, directs the subscriber to look for said procedures in the member handbook and their subscriber or group contract.

It is recommended that MVP provide written notice of the grievance procedures in accordance with Section 4408-a 2(a) of the New York Public Health Law.

B. Section 4408-a.9 of the New York Public Health Law states:

“within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgement of appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.”

The examiner’s review of MVP’s grievance files revealed that the acknowledgement letters sent to the insured does not comply with the aforementioned section as regards to the following:

- The letter does not include the name and telephone number of the individual designated by MVP to respond to the appeal.
- The acknowledgment letter does not request any additional information when such information is needed by MVP in order for them to render a decision, but instead states the following in a separate paragraph. “If the MVP physician medical director needs additional information, MVP will contact you.”

It is recommended that MVP revise its acknowledgement letter to comply with the requirements of Section 4408-a.9 of the New York Public Health Law.

C. MVP Health Care’s consumer services department’s central log that registers and monitors all complaint activity did not fully comply with the detailed requirements of New York Insurance Department, Circular Letter Number 11 of 1978. MVP Health Care’s consumer service department, however, maintained in its computer databases all of the information required by Circular Letter Number 11 of 1978. Therefore, although MVP Health Care did not maintain the central log in the format required, it nevertheless maintained in electronic format all of the information required by Circular Letter Number 11 of 1978.

It is recommended that MVP Health Care maintain a central log for monitoring all complaint activity that contains all information required by New York Insurance Department, Circular Letter Number 11 of 1978.

## **5. UTILIZATION REVIEW**

Article 49 of the New York Insurance Law and Article 49 of the New York Public Health Law both set forth the minimum utilization review program requirements including standards for: registration of utilization review agents; utilization review determinations; and appeals of adverse determinations by utilization review agents. The aforementioned Articles establish the insured's/enrollee's right to an external appeal of a final adverse determination by a health care plan. In addition, relative to retrospective adverse determinations, an insured's/enrollee's health care provider shall have the right to request an external appeal.

An examination review was made of MVP Health Care's utilization review files for the first nine months of year 2001. The review revealed the following:

A. Section 4901(a) of the New York Insurance Law states:

“Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section.”

MVPHS failed to file the utilization management documentation with the New York Insurance Department as required pursuant to Section 4901 (a) of the New York State Insurance Law.

When the examiners brought this issue to the MVPHS attention in year 2002, it agreed with the finding and filed its utilization management documentation with the New

York Insurance Department as required by Section 4901(a) of the New York Insurance Law.

B. Section 4903(5) of the New York Public Health Law states:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

(a) the reasons for the determination including the clinical rationale, if any;

(b) instructions on how to initiate standard and expedited appeals pursuant to section forty nine hundred four and an external appeal pursuant to section forty nine hundred fourteen of this article; and

(c) notice of the availability, upon request of the enrollee, or the enrollee’s designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal”.

MVP did not fully comply with Section 4903.5 of the New York Public Health Law in that MVP’s prospective review denial letter did not contain instructions on how to initiate standard and expedited appeals but instead directs the subscriber to look for the description of the appeal process in the subscriber’s contract. Referring the subscriber to their contract is insufficient to satisfy the requirements of Section 4903.5 of the New York Public Health Law. MVP used an attachment to the denial letter that referred to the appeals process. However, the language was not sufficient to meet the standards set forth in Section 4903.5. A notice of adverse determination should set forth the time, place and manner in which an appeal is initiated, including a description of standard, expedited and external appeals.

It is recommended that MVP fully comply with Section 4903.5 of the New York Public Health Law and include all required information in its notice of adverse determination when prospective utilization review of pre-authorization is requested.

Subsequent to the examination period MVP Health Care revised the wording of the attachment to fully comply with the requirements of Section 4903.5 of the New York Public Health Law. In year 2002, MVP Health Care submitted the new attachment with its utilization management documentation to the New York Insurance Department as required by Section 4901(a) of the New York Insurance Law.

C. Many claims were denied retrospectively because the services rendered did not qualify as medically necessary. A retrospective claims utilization review was conducted which revealed the following:

(i) Section 4903(e) of the New York Insurance Law states:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

- (1) the reasons for the determination including the clinical rationale, if any;
- (2) instructions on how to initiate standard and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and
- (3) notice of the availability, upon request of the insured, or the insured’s designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal”.

Section 4903.5 of the New York Public Health Law is applicable to HMOs and contains the similar language.

Further, Section 4904(a) of the New York Insurance and Section 4904.1 of the New York Public Health Law both state:

“An insured, the insured’s designee and, in connection with retrospective adverse determinations, an insured’s health care provider, may appeal an adverse determination rendered by utilization review agent”

MVP Health Care failed to send written notification of either the first adverse determination or final adverse determination to participating providers in an undetermined number of retrospective claim utilization reviews conducted by the claim operations department. Also, MVP Health Care failed to send proper first adverse determination letters to participating providers because it refers to final adverse determinations instead of a first adverse determination of retrospective claim utilization review. This practice is a violation of Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of New York Public Health Law.

It is recommended that MVP Health Care send a proper notice of adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law as applicable.

(ii) Both Section 4904(d) of the New York Insurance Law and Section 4904.4 of the New York Public Health Law state:

“Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.”

For claims from participating physicians with the three Independent Practice Associations (IPAs) under risk contract with MVP, in an undetermined number of cases, the same physician who rendered first adverse determination, also rendered, after an appeal, the second and final adverse determination. This practice violates Section 4904(d) of the New York Insurance Law or Section 4904.4 of the New York Public Health Law.

It is recommended that MVP Health Care revise its policy concerning provider appeals and comply with Section 4904(d) of the New York Insurance Law or Section 4904.4 of the New York Public Health Law, as applicable, when conducting provider appeals.

(iii) Both Section 4904(c) of the New York Insurance Law and Section 4904.3 of the New York Public Health Law state, in part:

“...The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal....”

In an undetermined number of appeals by participating providers, MVP Health Care failed to send letters acknowledging receipt of an appeal of the first medical adverse determination in violation of Section 4904(c) of the New York Insurance Law or Section 4904.3 of the New York the Public Health Law.

It is recommended that MVP Health Care comply with Section 4904(c) of the New York Insurance Law or Section 4904.3 of the New York Public Health Law by sending letters to acknowledge receipt of an appeal of medical adverse determination from its participating providers.

(iv) Section 4904(c) of the New York Insurance Law states, in part:

“...The notice of the appeal determination shall include:

(2) a notice of the insured’s right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health...”

Section 4904.3 of the New York Public Health Law, which is applicable to HMOs, contains similar language.

Further, Section 4910(b) of the New York Insurance Law and Section 4910.2 of the New York Public Health Law both state, in part:

“An insured, the insured’s designee and, in connection with retrospective adverse determinations, an insured’s health care provider, shall have the right to request an external appeal...”

In addition, New York Department of Health Regulation, Part 98-2.9 (e) {10 NYCRR98-2.9 (e)} states:

“Each notice of final adverse determination of expedited or standard utilization review appeal under section 4904 of the Public Health Law shall be in writing, dated and include the following:

- (1) a clear statement describing the basis and clinical rationale for the denial as applicable to the enrollee;
- (2) a clear statement that the notice constitutes the final adverse determination;
- (3) the health care plan’s contact person and his or her telephone number;
- (4) the enrollee’s coverage type;
- (5) the name and full address of the health care plan’s utilization review agent;
- (6) the utilization review agent’s contact person and his or her telephone number;
- (7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility under/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
- (8) a statement that the enrollee may be eligible for external appeal and the time frames for requesting an appeal; and
- (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 days time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal.”

A review was made of a sample of 167 appeal cases where MVP Health Care made an adverse determination. In two of those cases, MVP Health Care did not send notice of final adverse determination. Therefore the member was not aware of the availability of the external appeals process along with the associated time frames for requesting such an appeal.

It is recommended that MVP send proper notice of final adverse determination of expedited or standard utilization review appeals in accordance with Sections 4904(c) and 4910(b) of the New York Insurance Law or Sections 4904(3) and 4910.2 of the New York Public Health Law and/or Part 98-2.9 (e) {10 NYCRR98-2.9 (e)} as applicable.

(v) MVP Health Care understated the number of appeals reported on Schedule M of its Annual Statement because it did not include retrospective utilization review appeals taken by participating providers.

It is recommended that MVP Health Care report retrospective utilization review appeals by providers on Schedule M of their annual statement along with all other utilization review appeals.

## **6. FRAUD PREVENTION AND DETECTION**

A review was performed of the organization and structure of MVP Health Care's special investigations unit (SIU), and their compliance with Article 4 of the New York Insurance Law, and Insurance Department Regulation Number 95 (11NYCRR86). The review revealed that the SIU complies with all mandates, and has the strong support and commitment of senior management.

## **7. INTERNAL CONTROLS**

During the on-site portion of this examination, in July of 2002, MVP Health Care discovered that their Chief Marketing Officer had falsified certain documentation over a three-year period and embezzled approximately \$98,000. Upon discovery, a comprehensive internal investigation was performed which led to this individual's termination of employment. In addition, MVP Health Care turned over its discovered evidence to the Schenectady County District Attorney's Office. The court has since accepted a guilty plea of the former Chief Marketing Officer.

MVP Health Care has since undertaken the following additional actions with the assistance of external CPAs, Legal Counsel, and Fraud Investigators:

- A. Reviewed all transactions of a similar nature within the Marketing Department since 1997. This review revealed no other improper conduct.
- B. Reviewed and improved the internal policies, procedures, and controls surrounding the requisition, purchasing and accounts payable processes.
- C. MVP health Care has recovered all misappropriated funds.

## **8. SUMMARY OF COMMENTS AND RECOMMENDATION**

<u>ITEM</u>		<u>PAGE NO.</u>
A	MVP Health Care provided the examiners with reconciled claims data. However, MVP Health Care did not provide the reconciled claims data in a timely manner. MVP Health Care's inability to provide reconciled data during the prior examination was cited in this report as a reason for this examination. The inability of MVP Health Care to provide reconciled data in a timely manner caused a delay in the conclusion of this examination.	6
B	It is recommended that MVP report all capitation payments to its Vermont IPAs in Exhibit 8-Parts 1 and 2 of its filed financial statement.	6
C	It is recommended that MVPHS comply with New York Insurance Department Regulation Number 64, {11 NYCRR 216.0(e)(6)}, and distribute such regulation to all persons responsible for the supervision, handling and settlement of claims.	7
D	It is recommended that MVP Health Care properly classify paid claims and report its paid outsourced claims data in Section 3 of Schedule H in both the annual and quarterly statements filed with the Department.	8
E	It is recommended that MVP Health Care improve its internal claim procedures to ensure full compliance with Section 3224-a (a), (b) and (c) of the New York Insurance Law.	10
F	It is recommended that MVP Health Care issue EOBs that include all of the requisite information required by Section 3234(a) and (b), of the New York Insurance Law. Accordingly, subscribers will be properly informed of their appeal rights and how their claims are processed.	12

<u>ITEM.</u>		<u>PAGE NO.</u>
G	It is recommended that MVP provide written notice of the grievance procedures in accordance with Section 4408-a 2(a) of the New York Public Health Law.	12
H	It is recommended that MVP revise its acknowledgement letter to comply with the requirements of Section 4408-a.9 of the New York Public Health Law.	13
I	It is recommended that MVP Health Care maintain a central log for monitoring all complaint activity that contains all information required by New York Insurance Department, Circular Letter Number 11 of 1978.	14
J	MVPHS failed to file its utilization management documentation with the New York Insurance Department as required by Section 4901(a) of the New York Insurance Law. This was corrected in 2002.	14
K	It is recommended that MVP fully comply with Section 4903.5 of the New York Public Health Law and include all required information in its notice of adverse determination, when prospective utilization review of pre-authorization is requested.  Subsequent to the examination period MVP Health Care revised the wording of the attachment to fully comply with the requirements of Section 4903.5 of the New York Public Health Law. In year 2002, MVP Health Care submitted the new attachment with its utilization management documentation to the New York Insurance Department as required by Section 4901(a) of the New York Insurance Law.	15
L	It is recommended that MVP Health Care send proper notice of adverse determination to its participating providers, when claims are denied retrospectively for medical reasons as required by Sections 4903(e) and 4904(a) of the New York Insurance Law or Sections 4903.5 and 4904.1 of the New York Public Health Law as applicable.	17

<u>ITEM.</u>		<u>PAGE NO.</u>
M	It is recommended that MVP Health Care revise its policy concerning provider appeals and comply with Section 4904(d) of the New York Insurance Law or Section 4904.4 of the New York Public Health Law as applicable, when conducting provider appeals.	17
N	It is recommended that MVP Health Care comply with Section 4904(c) of the New York Insurance Law or Section 4904.3 of the New York Public Health Law by sending letters to acknowledge receipt of an appeal of medical adverse determination from its participating providers.	18
O	It is recommended that MVP send proper notice of final adverse determination of expedited or standard utilization review appeals in accordance with Sections 4904(c) and 4910(b) of the New York Insurance Law or Sections 4904(3) and 4910.2 of the New York Public Health Law and/or Part 98-2.9 (e) {10 NYCRR98-2.9 (e)} as applicable.	19
P	It is recommended that MVP Health Care report retrospective utilization review appeals by providers on Schedule M of their annual statement along with all other utilization review appeals.	20

Appointment No. 21833

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York,  
pursuant to the provisions of the Insurance Law, do hereby appoint:

**ElSaid ElBially**

*as a proper person to examine into the affairs of the*

**MVP Health Plan**

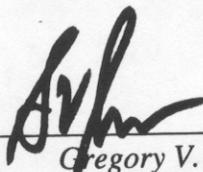
*and to make a report to me in writing of the said*

**Company**

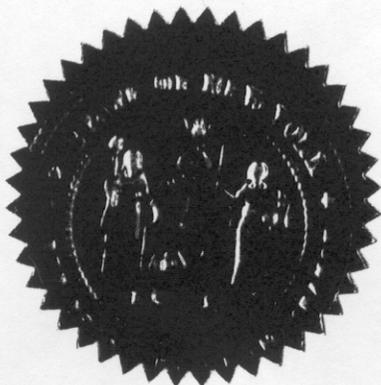
*with such information as he shall deem requisite.*

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

*this 4th day of February 2002*



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Gregory V. Serio  
Superintendent of Insurance



Appointment No. 21834

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York,  
pursuant to the provisions of the Insurance Law, do hereby appoint:

**ElSaid ElBially**

*as a proper person to examine into the affairs of the*

**MVP Health Services Corporation**

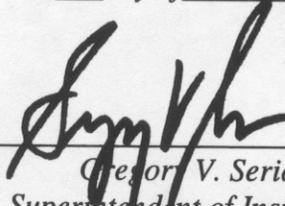
*and to make a report to me in writing of the said*

**Company**

*with such information as he shall deem requisite.*

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

*this 4th day of February 2002*



*Gregory V. Serio  
Superintendent of Insurance*

