ProPublica emailed questions to multiple state agencies that oversee Medicaid plans, as well as several state insurance departments.

We did not receive responses to our questions from the Virginia Department of Medical Assistance Services, Mississippi Division of Medicaid, Florida Agency for Health Care Administration, Kansas Department for Aging and Disability Services, Kentucky Cabinet for Health and Family Services, Louisiana Department of Health, Missouri Department of Social Services, New Jersey Department of Human Services, Ohio Department of Medicaid and Wisconsin Department of Health Services.

Multiple agencies replied to our questions, and here are their responses:

Minnesota Department of Commerce

On May 14, 2024, we published this press release:

MN Department of Commerce consent order requires UnitedHealthcare to revamp processes for mental health coverage to comply with parity laws

The press release includes a link to the full consent order.

The press release and consent order would encompass our response.

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Minnesota Department of Health

- **Are you aware that UnitedHealthcare is using a similar program to the one that was sanctioned by New York and the federal government?**
  - MDH only monitors programs used by HMOs in Minnesota.
- **Do United's utilization management practices comply with Minnesota and federal mental health parity law?**
  - The Minnesota Department of Commerce has provided you with its response to this question (see below for reference):

    "On May 14, 2024, Commerce published this press release: MN Department of Commerce consent order requires UnitedHealthcare to revamp processes for mental health coverage to comply with parity laws. The press release includes a link to the full consent order. The press release and consent order would encompass the response to this question."

- **Have you reviewed their practices?**
  - MDH is in the process of completing its quality audit of United Healthcare (UHC IL), the results of which will be published soon.

- **Have you received any complaints about how UnitedHealthcare, as a contracted Medicaid managed care organization, handles the utilization review process for outpatient mental health claims in your state? If so, can you share a summary of them?**
  - The Minnesota Department of Human Services (DHS) is the intake point for complaints about Medicaid in Minnesota. We would refer you to the Minnesota Department of Human Services for questions about Medicaid complaints related to United Healthcare.

- **How has the MN Department of Health ensured Optum's program and its utilization management practices in general were not violating MHPAEA?**
  - MDH is responsible for regulation of Health Maintenance Organizations (HMOs), while the Minnesota Department of Commerce is responsible for health insurance regulation. Optum is neither an HMO nor insurance company.
- **Does the department consider these practices a NQTL, and if so, can the department confirm whether the same process is being applied to medical/surgical care?**
  - N/A
- **Is the department concerned that a utilization management system that relies on reducing outliers may be targeting the most vulnerable patients and those that need the most care?**
  - N/A
- **What has UnitedHealthcare/Optum told Minnesota's Department of Health about the ALERT program?**
  - MDH has had no communication with United Healthcare about the ALERT program.
- **Was Minnesota's Department of Health aware that the program had previously been investigated and sanctioned?**
  - N/A
- **What oversight do you provide for this plan?**
  - N/A
- **Can you tell us more about what UnitedHealthcare/Optum has described to you about their utilization management practices for outpatient mental health care for plans under your jurisdiction?**
  - MDH conducts quality audits of HMOs every three years as part of its regulatory responsibilities. During those exams, MDH reviews utilization management policies. If deficiencies are found, MDH further conducts a mid-cycle audit to ensure deficiencies are corrected. Information on MDH's exam process can be found at: https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html.

- Earlier this year, the Office of Inspector General of the Department of Health and Human Services conducted an audit of the Centers for Medicaid and Medicare Services and found that the state agencies that regulate Medicaid plans aren't making sure that MCOs are following MHPAEA, and that CMS was failing to ensure that states were adequately overseeing MCOs (https://oig.hhs.gov/documents/audit/9831/A-02-22-01016.pdf).
    - **What is the Minnesota Department of Health's response to this report?**
    - **How is the department ensuring that it is following MHPAEA, and its members who have plans with MCOs have adequate access to mental health care?**
    - **How is the agency working with CMS to ensure compliance?**
        - We would refer you to the Minnesota Department of Human Services for questions regarding Medicaid in Minnesota.

- According to the audit, the state is required to publicly post parity analyses of the MCOs that provide mental health benefits.
    - **Can you share the link of the department's parity analysis of United? Where can I find the documentation that shows compliance online?**
        - Please refer to the Minnesota Department of Commerce's press release, including a link to consent order, regarding United Healthcare

- Private insurers that manage Medicaid plans are often paid a fixed amount per person, regardless of the frequency or intensity of services used. If they spend less than the state's allotted payment, plans are typically allowed to keep some or all of what remains. Experts, senators, and federal investigators have long raised concerns that this kind of payment model may be incentivizing insurers to limit or deny patients access to necessary services to bolster their bottom line.
    - **What is the department doing to ensure that MCOs, like United, are not denying or limiting care to save money?**
        - Questions specific to United Healthcare's role as an MCO should be addressed to the Minnesota Department of Human Services.
        - MDH conducts quality audits of HMOs every three years as part of its regulatory responsibilities. deficiencies are found, MDH further conducts a mid-cycle audit to ensure deficiencies are corrected. Information on MDH's exam process can be found at: https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html.

- Mental health advocates expressed concern to ProPublica about state Medicaid agencies' ability to oversee and regulate MCOs, particularly when it comes to mental health benefits, saying that state Medicaid agencies and departments were not designed to be watchdogs, and that they do a really poor job of oversight, with little accountability. We were told that "insurers can run roughshod over them."

- **What is your department's response to these concerns from mental health advocates?**
  - We would refer you to the Minnesota Department of Human Services for questions regarding Medicaid in Minnesota.

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Minnesota Department of Human Services

Are you aware that UnitedHealthcare/Optum is using a similar program to the one that was sanctioned by New York and the federal government, called Outpatient Care Engagement? Do United/Optum's utilization management practices comply with Minnesota and federal mental health parity law? Have you reviewed their practices? Have you received any complaints about how UnitedHealthcare/Optum handles the utilization review process for outpatient mental health claims in your state? If so, can you share a summary of them?

- We should note first that Minnesota's legislature acted this past legislative session to require that all Medicaid managed care HMOs are non-profit and as a result, Minnesota's contract with United Health Care will end as of December 31, 2024. We will also note that the Minnesota Department of Health is the regulatory agency that oversees Minnesota's HMOs to ensure compliance with HMO statute.
- United's policies have been deemed compliant with the federal mental health parity law. The Minnesota Departments of Health and/or Commerce would need to reply regarding compliance with state requirements.
- When United began their contract with the Department of Human Services (DHS) in 2022, DHS initially received some complaints from behavioral health providers regarding prior authorization for a few behavioral health services. When we presented the complaints to United they adopted the DHS fee-for-service prior authorization policy for outpatient behavioral health services and the complaints regarding this issue ceased.

· What has UnitedHealthcare/Optum told Minnesota's Department of Human Services about the ALERT program? Was Minnesota's Department of Human Services aware that the program had previously been investigated and sanctioned? What oversight do you provide for this plan?

- United included this information about the ALERT program in their initial RFP response to participate in Minnesota's program:
  - § For Behavioral Health (BH) services, we verify outpatient providers are rendering appropriate care through our outpatient practice management program and ALERT outpatient management system. Our process uses claims algorithms and clinician reviews to retrospectively evaluate the delivery of care against evidence-based algorithms. The model emphasizes

early identification and monitoring of high-risk cases, allowing us to focus our clinical resources where we can add the most value. Results from the algorithms that indicate risk of overutilization or underutilization trigger a staff BH clinician to outreach to the treating clinician to collaborate on care plan activities. ALERT accurately identifies and stratifies at-risk enrollees early in the treatment process and quantitatively measures outcomes. ALERT measures clinical status and response to treatment, resulting in outcomes management that is cost-effective and reduces administrative burden for providers.

- We were not aware that the program had previously been investigated.
- We provide oversight of the contractual requirements included in the three contracts United has with DHS.

· Can you tell us more about what UnitedHealthcare/Optum has described to you about their utilization management practices for outpatient mental health care for plans under your jurisdiction?

- We have attached the Utilization Management section of United's Service Delivery Plan which includes the requested information.

Attachment link: https://www.documentcloud.org/documents/25318655-2023-uhc-fc-sdp-um

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Washington State Health Care Authority

ALERT system
United Health Care does not use the ALERT program. It was discontinued in 2021.

HCA is firmly committed to ensuring WA Apple Health members receive medically necessary services when requested and are not inappropriately denied care. We have robust monitoring practices to ensure compliance and protect patient access to necessary care. These are detailed below.

Parity reports

· HCA's parity reports are available publicly on our Managed Care Reports webpage. The report published in 2023 demonstrates that all Washington Medicaid managed care organizations (including UHC) meet parity compliance.

· HCA requires an annual parity assessment within the contract that is due to HCA on November 1 of each year. This requirement can be found in section 14.23 of the integrated managed care contract.
https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf

- Each year, MCOs provide HCA with their assessment of behavioral health parity, which may include:
  - A Non-Quantitative Treatment Limit comparative analysis that includes coding edits provider/facility reimbursement; concurrent review, credentialing, experimental investigation, medical necessity, network management, prior authorization, provider facility reimbursement services; and retroactive review.
  - Information on fail first or failure to complete/initiate within behavioral health and medical/surgical standards;
  - Steps to ensure access to out-of-network providers; and
  - Differences in prior authorization and concurrent review requirements between behavioral health and medical/surgical benefits.

Monitoring practices

Unlike some state Medicaid agencies noted in the referenced OIG report, HCA routinely reviews samples of MCO prior authorization denials and monitors overall trends in denials, appeals, and administrative hearings. We use these trends to adjust future monitoring and target areas of concern. MCOs are also required to submit an annual evaluation of their utilization management (UM) program, including compliance, denial trends, and evaluation of decision-making consistency.

- **Annual compliance review**

  HCA conducts an annual compliance review and monitors a targeted sample of prior authorizations from each MCO. During this process, our TEAMonitor (TM) staff selects 30 files from each MCO and reviews them in full. This includes approvals, denials, and appeals. We review these files for all relevant documentation, medical records, medical necessity criteria, notices to members and providers, and timelines. These reviews cover physical health, behavioral health, and pharmacy requests.

  Additionally, MCOs must maintain NCQA accreditation, which involves a rigorous evaluation of their UM and prior authorization processes. NCQA reviews align closely with HCA's TEAMonitor program, ensuring consistent oversight of prior authorization decisions.

- **Quarterly reports**

  MCOs submit quarterly reports on prior authorizations, grievances, and appeals (the GAA Report), providing client information, service requests, outcomes, and more. These reports are reviewed for patterns or trends in denials and help inform our TM file selection.

  Our interdisciplinary team of clinicians, including nursing, social work, and pharmacy professionals, reviews the GAA reports and selects files across disciplines. We document any deficiencies in the TM report, publicly available in our External Quality Review Organization's annual technical report (available here).

When deficiencies are identified, MCOs must complete a corrective action plan, reviewed and approved by HCA subject matter experts (SMEs). Our SMEs also provide technical assistance through presentations, meetings, and reviews of the MCO's corrective measures.

- **Administrative Hearings**

  When members exhaust all appeal options, they may request a hearing with an administrative law judge. HCA SMEs review all hearing requests to ensure decisions are clinically appropriate and contractually compliant. This process helps identify trends in administrative hearings that may inform future monitoring and technical assistance.

  Our administrative hearing reviews include evaluating Adverse Benefit Determination and Appeal Resolution notices for clarity and compliance. If there are concerns, SMEs contact the MCO to provide technical assistance and request a re-review before the hearing. Any required notice corrections are issued to the member or provider.

Conclusion

HCA's robust monitoring program is designed to ensure WA Apple Health members receive the medically necessary services they need, and we continuously seek opportunities to improve the program's efficacy with each cycle.

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Oklahoma Health Care Authority

The Oklahoma Health Care Authority contracts with UnitedHealthcare subsets for care coordination of individuals who are dually eligible for Medicare and Medicaid. While the contracts do not explicitly state whether clinical or peer reviews are conducted as part of the care coordination process, all services provided must comply with federal and state regulations.

The D-SNP plans are only obligated to provide the state with information regarding care coordination. This includes a summary of benefits and a direct customer service phone number connecting members to the D-SNP's Oklahoma care coordination manager or team.

If you have questions about the services provided, please reach out to the companies for clarification. OHCA's role in this process is to ensure real-time access to data for eligibility purposes, provide a list of services the member is eligible for and deliver a monthly data file of participating Medicaid providers. Our goal is to ensure that our members receive the highest quality of services.

To request these contracts, please submit an Open Records Request to the Oklahoma Office of Management and Enterprise Services.

For people in Oklahoma that have D-SNP Medicaid-Medicare dual coverage, are MCOs that manage or coordinate these benefits required to follow the Mental Health Parity and Addiction Equity Act, as MCOs that manage Medicaid benefits are required to? In Oklahoma, MCOs do not manage benefits for members with D-SNP coverage. Are there any state entities that directly oversee the benefits of D-SNP plans? We have agreements with Medicare plans to share information about dual-eligible members. This collaboration helps us coordinate care more effectively for Medicaid benefits.

How is the Oklahoma Health Care Authority ensuring Optum's program and its utilization management practices in general are not violating MHPAEA? What has the Oklahoma Health Care Authority been told of these practices? Is the Oklahoma Health Care Authority concerned that a utilization management system that relies on reducing outliers may be targeting the most vulnerable patients and those that need the most care? It's important to note that these plans are Medicare plans, and the State of Oklahoma does not have regulatory oversight over Medicare. Unlike some states that manage dual-eligible benefits under a managed care model, Oklahoma's dual-eligible population is served under a fee-for-service model. Our priority with D-SNP plans is to enhance care coordination for dual-eligible members, ensuring they can access the full spectrum of available services. Additionally, we are investing in systems and technology updates to improve communication between HCBS Case Management and D-SNP Case Managers, facilitating more streamlined and effective care for our members.

As a MCO operating in Oklahoma, has UnitedHealthcare conducted a parity analysis? If so, has this parity analysis been made available to the public? If so, could you point me to the link? The Oklahoma Health Care Authority is not contracted with UnitedHealthcare for managed care services. For information on a parity analysis, please reach out directly to UnitedHealthcare.

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California Department of Managed Health Care

Question 1: Is the department aware that UnitedHealthcare/Optum is using a similar program to the one that was sanctioned by New York and the federal government and cited in California for limiting mental health care, called Outpatient Care Engagement? Is your department aware of whether United/Optum is operating an Outpatient Care Engagement program in California for mental health care?

DMHC Response: The Department is not aware of any such program through our review of filings and medical surveys (audits).

Question 2: Has the department reviewed United/Optum's utilization review practices for mental health care since the 2018 survey report?

DMHC Response: The Department reviewed mental health care utilization management (UM) practices for UHC of California (UnitedHealthcare of California) and its delegate U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California) in the July 2018 Focused Survey of Mental Health Parity And Addiction Equity Act (MHPAEA).

The DMHC reviews health plan UM practices through routine medical surveys, which are essentially audits of health plan operations. The plan's UM practices were reviewed during the last routine survey. The DMHC is currently reviewing UnitedHealthcare of California's UM practices in a routine survey set to be released in the coming months.

Additionally, the DMHC is in the process of conducting Behavioral Health Investigations (BHI), with the goal of better understanding the challenges health plan members experience with accessing behavioral health services. The BHI for UnitedHealthcare of California is currently being conducted, where the plan's UM practices are being reviewed.

Question 3: What were the terms of the corrective action plan in 2018? Are you able to share the plan with ProPublica? Were any penalties imposed related to the corrective action plan?

DMHC Response: The corrective action plan can be found starting on page 19 of the July 2018 Focused Survey of MHPAEA, noting the following:

The Plan will direct its behavioral delegate to cease and desist from applying the ALERT process to medical necessity criteria for outpatient MH/SUD services in the absence of any comparable process for the delegated medical/groups. (page 20)

In the follow-up survey, the DMHC confirmed the plan implemented the corrective action plan, and provided evidence that delegates discontinued utilization of the ALERT system.

The Department did not issue any penalties related to the corrective action plan.

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Massachusetts Executive Office of Health and Human Services

Statement: "MassHealth has a longstanding commitment to providing equitable access to mental health care for all its members. As part of this commitment, and in accordance with state and federal requirements, we routinely review utilization management practices employed by all managed care entities (MCEs) to ensure that mental health parity rules are being followed by

our MCEs. These reviews include analysis of, among other things, data on member appeals and grievances and utilization management practices." - MassHealth Spokesperson

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New York State Department of Health and New York State Office of Mental Health

"All New Yorkers should have access to behavioral health care coverage. As such, the New York State Office of Mental Health and Department of Health will continue to work jointly with our state partners so that insurance companies are transparent with their practices and comply with all applicable federal and state parity laws."

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New York Department of Financial Services

The Department cannot comment on ongoing supervisory and enforcement actions.

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Michigan Department of Health & Human Services

- In Michigan's Medicaid programs, many behavior/mental health coverages are carved-out (not paid for or managed by) our contracted Medicaid MCOs
- Michigan Medicaid is working to update our Medicaid parity assessment this fiscal year with the support of a university partner. This work will entail a review of utilization management policy and operations for all nine currently contracted Medicaid Health Plans (physical health and mild/moderate behavioral health) and our 10 Prepaid Inpatient Health Plans (specialty behavioral health). Our previous parity assessment is attached, but it was not Medicaid MCO specific given that the evaluation involved 66 different Michigan health plan - Prepaid Inpatient Health Plan combinations across the state.

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Arizona Health Care Cost Containment System

AHCCCS regularly addresses and evaluates legal, provider, and member concerns with the managed care organizations' (MCOs) quality and performance, and takes concerns about violations of Mental Health Parity requirements seriously. AHCCCS is following up with key internal and external stakeholders to gather more information about any potential impacts in Arizona. As usual, AHCCCS will also work with CMS to ensure the agency is in compliance with federal requirements. It is news like this that helps us identify potential gaps in processes and care, so we can continue to strengthen Arizona's Medicaid program for the communities we work with and the members we serve.

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Nebraska Department of Health and Human Services

Is your department aware that UnitedHealthcare/Optum is using a similar program to the one that was sanctioned by the NY AG office and the federal government, called Outpatient Care Engagement? Do United/Optum's utilization management practices comply with Nebraska state and federal mental health parity law? Have you recently received any complaints about how UnitedHealthcare/Optum handles the utilization review process for outpatient mental health claims as a MCO in your state? If so, can you share a summary of them?

All MCOs under contract with the State of Nebraska are required to follow all federal and state regulations. The state has received no indications they are violating any laws, rules, or procedures.

Do these findings concern your department? Is Nebraska's Department of Heatlh and Human Services aware that United's MCO is using the Outpatient Care Engagement program in Nebraska? Does the company's utilization review system abide by MHPAEA and state laws?

The Department prioritizes quality care and access for Nebraskans and takes adherence to MHPAEA and state laws very seriously. All DHHS vendors are contractually obligated to follow all state and federal regulations.

Is the department concerned that a utilization management system that relies on reducing outliers may be targeting the most vulnerable patients and those that need the most care? Why or why not?

What is your department's response to this description, considering the revelations about ALERT/Outpatient Care Engagement, for which the company was sanctioned in New York, California and Massachusetts, and now appears to have been rebranded and operating in other states?

What is the department's response to this report? How is the department ensuring that Nebraska's MCO plans are following MHPAEA, and Nebraska members who have coverage with a MCO have adequate access to mental health care? Is the department working with CMS to ensure compliance?

What is the department doing to ensure that MCOs, like United, are not denying or limiting care to save money?

The Department is mindful of findings across the country and how those issues may or may not have direct application to our program and contracts. The Department, by contract, requires all MCOs fully adhere to all federal and state laws. The Department engages in

several activities to ensure compliance with laws and clinical best practices. Some of those activities are as follows:

- **The Department contracts with an External Quality Review organization that does a full compliance review of all MCOs with a focus on compliance with applicable laws and contract provisions. A component of this review pertains to utilization review activities.**
- **On a monthly basis the Department reviews data from all the MCOs to evaluate their comparative prior authorization approval and denial rates to identify any anomalous variation between MCOs and in a monthly trend. This analysis isolates mental health claims to ensure the measure has sufficient sensitivity to detect variance.**
- **On a monthly basis the Nebraska Medical Services Director meets with the MCOs' clinical leadership to discuss specific cases, including appeals and grievances.**
- **At a regular cadence, the Department reviews all appeals and grievances to determine if there are specific cases or broader trends to be addressed. The Department also fields complaints voiced directly to our contract managers and addresses them with the contacted MCOs through a structured issue resolution process.**
- **All prior authorization denials have an available appeal and hearing process.**

Through these regular activities, the Department has not had any indication of any inappropriate utilization reviews for behavioral health services but will continue to scrutinize the utilization process for issues.

Can you share the link of the department's parity analysis of the United MCO? Where can I find the documentation online that shows compliance?

There is no link to publicly available parity analysis.

What is the department's response to these concerns from mental health advocates?

The Department meets on a regular basis with mental health advocates and welcomes the opportunity to discuss and address concerns.

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North Carolina Department of Health and Human Services

NC Medicaid is not aware of the program you reference and has not received any reports from beneficiaries or providers that they are experiencing any of these issues. At its core, NC Medicaid is dedicated to providing critical health care for some of the most vulnerable individuals and families in the state. NC Medicaid works closely with mental health providers and beneficiaries to ensure people are getting access to the care that is right for them and at the right time.

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Rhode Island Executive Office of Health and Human Services

- Is your department aware that UnitedHealthcare/Optum is using a similar program to the one that was sanctioned by the NY AG office and the federal government, called Outpatient Care Engagement? Do United/Optum's utilization management practices comply with Rhode Island state and federal mental health parity law?
    - RI RESPONSE: *Rhode Island demands adherence to parity laws for all contracted Managed Care Entities. As a part of RI's Active Contract Management of Managed Care Organizations (MCO), each MCO submits monthly, quarterly and annual reports on grievances & appeals related to UM and PA, care coordination, claims adjudication (stratified by Medical/surgical and Behavioral Health respectively) and care coordination etc. RI's reports direct the health plans to disclose complaints related to parity. RI monitors MCO performance via these reports and they guide MCO oversight meetings/ agendas to ensure compliance.*
    - Have you recently received any complaints about how UnitedHealthcare/Optum handles the utilization review process for outpatient mental health claims as a MCO in your state? If so, can you share a summary of them?
        - RI RESPONSE: *RI has not received any formal complaints related to Optum's utilization management (UM) practices; in an abundance of caution and in light of concerns at the national level, RI has directed its Managed Care Organizations (MCO) plans to share all methodology around non-quantitative treatment limitations along with quantitative treatment limitations to gauge a better understanding of policy in practice*. *RI includes Optum subcontractor oversight in its routine MCO oversight meetings and often has the MCOs share data and findings accordingly*.
- Do these findings concern your department? Is Rhode Island's Office of Health and Human Services aware that United's MCO is using the Outpatient Care Engagement program in Rhode Island? Does the company's utilization review system abide by MHPAEA and state laws?
    - RI RESPONSE*: RI seeks to be proactive to promote access to care, so RI worked with each of its MCOs to ensure that there is no Prior Authorization related to Applied Behavior Analysis (ABA) direct services. Additionally, RI works with its providers to ensure that they are aware of opportunities to escalate concerns around more stringent application of utilization management practices in behavioral health when compared to a like-services on the medical-surgical side. RI has asked its MCOs to report trends in this area and when applicable, sought ad-hoc or ancillary reports that provide tangible and actionable data as a part of Active Contract Management (ACM.)*
- Is the department concerned that a utilization management system that relies on reducing outliers may be targeting the most vulnerable patients and those that need the most care? Why or why not?

- RI RESPONSE*: RI is concerned any time there are restrictions that limit one's access to care in all practice and services areas. RI also promotes patient-choice, and person-centered care at the core of service delivery. To that end, RI seeks to provide a robust array of services that include the least restrictive care settings for all its members. RI seeks to foster individualized care that promotes healthy outcomes and not a fee-for-service model that promotes quantity over quality while ensuring equity across lines of business e.g. reducing unnecessary exposure to radiation in the medical surgical side.*

- Mental health advocates have described the insurance regulation system as an uneven patchwork, which can allow questionable practices to persist, even when an insurer is sanctioned in one jurisdiction. One advocate described this kind of system of regulation as "whack-a-mole" because insurance companies are not regulated all in the same jurisdiction or in the same way, which benefits them, because they can move their scrutinized practices to other products in different locations. What is your department's response to this description, considering the revelations about ALERT/Outpatient Care Engagement, for which the company was sanctioned in New York, California and Massachusetts, and now appears to have been rebranded and operating in other states?
    - **RI RESPONSE:** *RI has required more transparency related to subcontractor oversight (which is where Optum falls in RI.) This shift means that MCOs must report data on an as-needed basis and focus on provider engagement strategies to ensure equity in all areas. Additionally, RI conducted an inventory of all Utilization Management (UM) practices and worked with its MCOs to lift prior authorization for Intensive outpatient treatment which RI considers to be a significant success for providers and members alike. RI has sought real-time demonstrations of Prior Authorization (PA) practices to be presented during oversight meetings and has mandated that any changes in vendor or Utilization Management practices must be approved by RI prior to implementation.*

Questions Related to Rhode Island's MCO MHPAEA Oversight

- Earlier this year, the Office of Inspector General of the Department of Health and Human Services conducted an audit of the Centers for Medicaid and Medicare Services and found that the state agencies that regulate Medicaid plans aren't making sure that MCOs are following MHPAEA, and that CMS was failing to ensure that states were adequately overseeing MCOs (https://oig.hhs.gov/documents/audit/9831/A-02-22-01016.pdf [oig.hhs.gov]). What is the department's response to this report? How is the department ensuring that Rhode Island's Managed Care Organization (MCO) plans are following the Mental Health Parity and Equity Act (MHPAEA), and Rhode Island members who have coverage with a MCO have adequate access to mental health care? Is the department working with CMS to ensure compliance?
    - **RI RESPONSE**: RI has conducted a parity analysis of all its Managed Care Organizations (MCO) and related policies. To monitor policy in practice, RI receives routine reports from each MCO (referenced above). RI has also recently reviewed new/ proposed templates from CMS related to parity compliance and has provided CMS with

recommendations to streamline and standardize while honoring each state's uniqueness.

- According to the audit, the state is required to publicly post parity analyses of the MCOs that provide mental health benefits. Can you share the link of the department's parity analysis of the United MCO? Where can I find the documentation online that shows compliance?
    - https://eohhs.ri.gov/consumer
- Private insurers that manage Medicaid plans are often paid a fixed amount per person, regardless of the frequency or intensity of services used. If they spend less than the state's allotted payment, plans are typically allowed to keep some or all of what remains. Experts, senators, and federal investigators have long raised concerns that this kind of payment model may be incentivizing insurers to limit or deny patients access to necessary services to bolster their bottom line. What is the department doing to ensure that MCOs, like United, are not denying or limiting care to save money?
    - **RI RESPONSE**: RI has lifted any/all edits around Maximum allowable in an effort to ensure access to care when needed. While there may be soft limitations related to care coordination, RI's benefit packages allow for a member's needs to be paramount. RI has worked with providers and insurers to address the misnomer re: maximums etc.
- Mental health advocates expressed concern to ProPublica about state medicaid agencies' ability to oversee and regulate MCOs, particularly when it comes to mental health benefits, saying that state Medicaid agencies and departments were not designed to be watchdogs, and that they do a really poor job of oversight, with little accountability. We were told that "insurers can run roughshod over them." What is the department's response to these concerns from mental health advocates?
    - **RI RESPONSE:** RI takes pride in providing a robust array of BH services to its Medicaid members and is continually seeking opportunities to improve oversight and transparency. RI seeks technical assistance from CMS routinely. Additionally, as a part of establishing accountability, RI has used its' 1115 waiver to provide opportunities that promote an even playing field in the BH system, with hopes of integrating physical and behavioral health care as well as member access to care. A notable example of this is RI's Accountable Entity demonstration which is currently focused on sustainability by promoting a behavioral health investment opportunity that will extend beyond the demonstration.

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Tennessee Division of TennCare

As one of the nation's longest running Managed Care Medicaid programs, TennCare has developed very strong oversight and partnerships with our managed care partners. These efforts certainly extend into ensuring that our members have access to all medically necessary services generally and behavioral health services specifically. In fact, TennCare over the past several years has made over $100M investments into the behavioral health workforce and

increased service offerings for TennCare members. TennCare requires that all of our MCOs routinely monitor network adequacy and are in compliance with federal and state access standards. Additionally, TennCare has a robust process to specifically ensure and monitor mental health parity. Under state law, all MCOs participating in the TennCare program are required to report annually on their strategies and processes for ensuring that access to behavioral health services is comparable to and not more restrictive than access to medical/surgical services, including demonstrating that the MCO's policies and processes are in compliance with MHPAEA. TennCare's most recent parity report is available here - https://www.tn.gov/tenncare/policy-guidelines/mental-health-parity.html. TennCare is in the process of updating this analysis now and will be working closely across the state and our MCOs to ensure that our members continue to have robust access to behavioral health services that is delivered equitably with access to medical/surgical services in accordance with MHPAEA. If any member is experiencing needs to access needed behavioral health services, all three of our managed care organizations have dedicated care coordination team members who offer care support services to members to help them schedule appointments and receive additional health care supports.

Outpatient Care Engagement is a voluntary program based on claims data, wherein clinicians are connected to providers serving patients identified via data outliers (e.g., high frequency of services) for higher-level engagement (e.g., case management). Outpatient Care Engagement is not tied to prior authorization, utilization management, or any denials of care. It is a collaboration program aimed at ensuring providers deliver evidence-based care to patients.

There are two (2) Outpatient Care Engagement (OCE) programs in use for TennCare that utilize algorithms: The OCE Collaboration program and the OCE UM program.

Under the OCE Collaboration program, algorithms are used to identify outlier MH/SUD routine outpatient services (e.g., psychotherapy) for the purpose of engaging providers in voluntary collaborative conversations on best practices for addressing complex clinical cases with the goal of achieving optimal patient outcomes. Unlike the ALERT program, the OCE Collaboration program does not entail medical necessity reviews and does not result in coverage denials. Moreover, because the OCE Collaboration program is voluntary, there are no adverse consequences for providers who elect not to participate.

Under the OCE UM program, algorithms are used to identify outlier MH/SUD non-routine outpatient services (e.g., Home and Community Based Services/psychosocial rehabilitation) for the purpose of subjecting them to medical necessity review. The OCE UM program is separate and distinct from the ALERT program because unlike the ALERT program, it does not subject outlier MH/SUD routine outpatient services (e.g., psychotherapy) for medical necessity review. The OCE UM program is parity compliant because medical/surgical non-routine outpatient services are also subject to medical necessity review. Moreover, the OCE UM Model is less stringent than the UM requirements applied to medical/surgical non-routine outpatient services as it subjects only outlier psychosocial rehabilitation cases (≈3-10% of cases) to medical

necessity review whereas all medical/surgical non-routine outpatient services subject to utilization review receive medical necessity reviews.

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Illinois Department of Healthcare and Family Services

As part of an effort to ensure access to high quality behavioral health services, the Illinois Department of Healthcare and Family Services (HFS) requires all Managed Care Organizations provide Mental Health and Substance Use Disorder coverage and Illinois managed care contracts require MCO compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). HFS has an established contract with an External Quality Review Organization (EQRO) to regularly monitor MCO performance of established quality measures and metrics with regards to managed care. The Department's EQRO performs annual MCO parity audits and produces an annual report with findings and recommendations. As a part of the Parity Analysis, MCOs are required to submit an attestation of any changes in policies and procedures during the monitoring period. The 2024 report is available on the Department's **website.** HFS' contracts with the MCOs include provisions for a medical loss ratio (MLR) guarantee, which is designed to prevent excess MCO profits and ensure that the vast majority of the payments to MCOs are being spent on care for customers and quality improvements. The MLR contract provision requires the MCOs to spend 88% of their payments on medical services or quality improvement initiatives. If an MCO does not spend up to that level, the Department recoups funds from the MCO in future years, which is over and above what is federally required. Additionally, HFS operates a complaint portal, where providers can report issues and concerns about MCOs.

As the report states, Illinois formally requested and was granted a modified timeline. The extension was granted because at the time, the state was undergoing significant changes to its Medicaid managed care program. Illinois did submit its parity analysis in December 2017 and complied with all established requirements. Through those changes, managed care coverage of the Medicaid population increased from 65% to 80%, and coverage was expanded to every county in the state.

State statute requires that HFS perform annual mental health parity audits of its managed care plans. MCO contracts mandate compliance with all reporting requirements and compliance with MHPAEA. HFS contracts with an EQRO to perform annual MCO parity audits and produce an annual report with findings and recommendations. As a part of the Parity Analysis MCO are required to submit an attestation of any changes in policies and procedures during the monitoring period.

Medicaid customers in Illinois deserve access to high quality behavioral health services as a part of their overall healthcare. The federal parity requirements are an important part of ensuring those care needs are met. Illinois has utilized a combination of external review, oversight and a feedback portal as tools to align with those federal requirements and ensure that behavioral healthcare access is equitable for all Illinois residents.

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Texas Health and Human Services Commission

1. **Is the agency working with CMS to ensure compliance?**

Texas ensures Medicaid managed care members receive access to mental health care through a variety of mechanisms, including contracts, readiness reviews and operational plan reviews.

Contracts

Managed care contracts detail the Behavioral Health Network and Services requirements for managed care organizations (MCOs) contracted to provide Texas Medicaid mental health services. They also require that MCOs provide, or arrange to have provided, all medically necessary behavioral health (BH) services to members.

MCOs are contractually obligated to maintain a BH services provider network that includes psychiatrists, psychologists and other BH service providers. MCOs must also maintain a process to help members know where and how to obtain BH services, provide members with information on accessible network providers, and have an emergency and crisis BH services hotline staffed by trained personnel 24 hours a day, seven days a week, toll-free throughout the service area.

Managed care contracts require primary care physicians (PCPs) to have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. They also allow PCPs to provide any clinically appropriate BH services within the scope of their practice. Additionally, MCOs must permit members to self-refer to any network BH services provider without a referral from the member's PCP.

Managed care contracts require MCOs comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations, including 42 C.F.R. Part 438, Subpart K and 42 C.F.R §457.496. The MCO must work with HHSC to follow parity and must provide HHSC with non-quantitative treatment limitation (NQTL) assessment tools, surveys or corrective action plans related to compliance with MHPAEA.

According to general provider network requirements, MCOs must enter into provider contracts with any willing Local Mental Health Authority or Local Behavioral Health Authority, and Texas Certified Community Behavioral Health Clinic that meets the MCOs credentialing requirements and agrees to the MCO's contract rates and terms.

Readiness Reviews & Operational Plan Reviews

HHSC also conducts readiness reviews as part of the contracting and procurement process. During readiness reviews, HHSC reviews an MCO's policies and procedures, and may conduct interviews with key MCO staff, to ensure compliance with contract requirements.

To comply with MHPAEA, Texas removed limits on mental health/substance use disorder (MH/SUD) services and modified state regulations and policies related to MH/SUD services. Further, Texas established minimum performance standards across all MCOs and required MCOs to submit corrective action plans to address identified areas of non-compliance.

2. According to the audit, "None of the four States that were required to conduct parity analyses across their delivery systems (including Texas) conducted these analyses or provided documentation of compliance to the public by the compliance date."
    1. **What is HHSC's response to this finding?**
    2. **Has HHSC corrected the compliance issues since then?**
    3. **What did HHSC do to correct the compliance issues?**

Texas completed the analysis and posted the results of the analysis to the state's website in December 2017. CMS subsequently sent a letter to Texas regarding the OIG audit findings and noted its appreciation for the corrective actions Texas took to bring the identified issues into compliance.

Texas amended the Medicaid State Plan to remove limits on MH/SUD services and modified state regulations and policies related to MH/SUD services. Further, Texas established minimum performance standards across all MCOs and required the MCOs to submit corrective action plans to address identified areas of non-compliance. Texas amended existing language in the contract in 2022 to clarify the CFR reference; however, the original parity contract language was included in 2017.

3. Texas was one of the states examined in the OIG audit. Federal auditors looked at MCOs and whether they were complying with laws related to Quantitative treatment limitations (QTL) or Non-quantitative treatment limitations (NQTL). They found that MCOs did not comply with parity requirements for QTLs or NQTLs in Texas. Additionally, "in six States (including Texas), parity analyses determined that the MCOs imposed QTLs on MH/SUD benefits that were more restrictive than those for medical/surgical benefits."
    1. **What is HHSC's response to this finding?**
    2. **Has HHSC corrected the MCO plans in question?**
    3. **How is HHSC ensuring that plans do not include non-compliant NQTLs and QTLs in their plans?**

    Effective Jan. 1, 2019, HHSC modified its Medicaid SUD treatment policy and rules to remove strict limits and allow additional individual and group SUD counseling with documentation supporting medical necessity for continued treatment services. MCOs must comply with these requirements.

At this time, there are no compliance issues with MH/SUD parity requirements.

4. According to the audit, the state is required to publicly post parity analyses of the MCOs that provide mental health benefits.
    1. **Can you provide the link of HHSC's parity analysis of the United MCO?**
    2. **Where can I find the documentation online that shows compliance?**

    42 CFR §438.920(b) requires states to provide documentation of parity compliance to the public and post the information on the State Medicaid Website. It does not require the documentation to include compliance findings for specific MCOs. For details on the Texas parity analysis process and findings, please visit the Mental Health and Substance Use Parity webpage.

5. Private insurers that manage Medicaid plans are often paid a fixed amount per person, regardless of the frequency or intensity of services used. If they spend less than the state's allotted payment, plans are typically allowed to keep some or all of what remains. Some are concerned that this may incentivize insurers to limit or deny patients access to necessary services to bolster their bottom line.
    1. **What is HHSC doing to ensure that MCOs are not denying or limiting care to save money?**

    HHSC ensures that MCOs and dental maintenance organizations comply with the terms and performance standards specified in the managed care contracts and the Uniform Managed Care Manual (UMCM). Monitoring activities are conducted on a routine basis to detect trends. HHSC conducts biennial operational reviews of MCOs. These operational reviews are generally comprised of an in-depth review of MCO operational compliance and performance across several areas to ensure policies and practices align with performance standards.

    HHSC also created the Acute Care Utilization Review (ACUR) unit to monitor MCOs, as required by Senate Bill 8 of the 83rd Legislature Regular Session. This oversight of behavior health services includes evaluation for under- and over-utilization via

detailed chart review, contractual compliance of operations, and readiness review when new systemic processes or systems are introduced.

6. In 2021, UnitedHealthcare was sanctioned by the NY Attorney General's Office and the Labor Department for using an aggressive review system for outpatient mental health care that they found violated state and federal mental health parity law. The review system, known as ALERT (Algorithms for Effective Reporting and Treatment), led to denials of care. ProPublica found that program has been rebranded as "Outpatient Care Engagement" (OCE) and is currently being used in multiple states, including Texas. It uses claims and clinical data to identify mental health patients with "higher-than-average intensity and/or frequency of services," according to recent company documentation, to ensure "that members are receiving the right level of care at the right time."

    1. **Has HHSC recently received any complaints about how UnitedHealthcare/Optum handles the utilization review process for outpatient mental health claims as a MCO in your state? If so, can you share a summary of them?**

No provider complaints have been received for United Healthcare related to outpatient mental health claims within the past twelve months.

7. Mental health advocates expressed concern to ProPublica about state Medicaid agencies' ability to oversee and regulate MCOs, particularly when it comes to mental health benefits, saying that state Medicaid agencies and departments were not designed to be watchdogs, and that they do a poor job of oversight, with little accountability.
    1. **What is HHSC's response to these concerns from mental health advocates?**

See response for question #5.

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South Carolina Department of Health and Human Services

The South Carolina Department of Health and Human Services has been engaged with CMS on the topic of mental health parity compliance prior to the OIG audit report being published. SCDHHS' contract with its managed care organizations includes network adequacy reporting requirements and requires compliance with MHPAEA. The agency has been strengthening, and continues to identify opportunities to further enhance, these contractual requirements; has engaged external partners; and has expanded quality assurance reviews. This has been a part of a concerted effort to increase access to behavioral health services, which has also included adding 10 additional community-based behavioral health covered services over the last two years. Maintaining federal compliance remains a priority for the agency, and we are confident these efforts will result in compliance and advance health outcomes for South Carolina's Healthy Connections Medicaid members.

The South Carolina Department of Health and Human Services' actuary conducted an analysis of compliance with the MHPAEA in 2022 and found the agency was in full compliance with the MHPAEA's financial requirements. This is documented on page eight of the OIG report. Specific to evaluating oversight of NQTLs and QTLs, SCDHHS has been conducting updated reviews for each MCO and will continue to work with the OIG and CMS to ensure compliance with the federal requirements.

United does not offer a Medicaid managed care plan in South Carolina. The mental health parity analyses of the state's managed care plans can be found in section G of the plans' external quality reports, which are publicly available via the link below. Please note, some of the states' MCOs are still completing their 2024 reports.
https://www.scdhhs.gov/resources/programs-and-initiatives/quality-initiative/reports-and-resources/external-quality-review

United does not operate a Medicaid managed care plan in South Carolina. SCDHHS requires service authorization reporting from its MCOs, which the agency uses as a component of its monitoring program. The agency also has financial tools in place to ensure plans are not inappropriately limiting access to care including enforcing a medical loss ratio, which allows the state to recoup money from its MCOs in line with established criteria.

MCO monitoring and compliance with the requirements of the state's contract with its MCOs are important tools SCDHHS uses to ensure its managed care plans are helping improve health outcomes for the state's Medicaid members. The managed care model offers a level of care coordination that is not replicated through the fee-for-service Medicaid delivery model. This care model incentivizes preventative services, which is particularly important in discussing behavioral health care in South Carolina. Often, we see the downstream effects of limited access to lower intensity treatment lead to poor outcomes and a need for more expensive forms of treatment for Medicaid members. In addition to the 10 community-based behavioral health services SCDHHS has added over the last two years, it has also added requirements in its MCO contract to provide additional case management and intensive case management for individuals with

severe mental illness who are enrolled with an MCO. These provisions take effect on Jan. 1, 2025. Finally, SCDHHS is reviewing the mental health parity toolkits CMS is developing that will help streamline the agency's monitoring and better align MCO reporting on parity from plan to plan. The agency looks forward to working with CMS as it finalizes these toolkits, which will enhance the agency's ability to efficiently monitor parity.