CMS Responses:

November 15, 2024:

The following is attributable to the Centers for Medicare & Medicaid Services (CMS) or a CMS spokesperson: CMS is committed to ensuring that all people with Medicare can access covered services, whether that is through Traditional Medicare or Medicare Advantage (MA). CMS has taken many steps to address the use of prior authorization by MA plans and Dual Eligible Special Needs Plans (D-SNPs) and ensure that people enrolled in these plans have timely access to care and receive access to the same covered services they would receive in Traditional Medicare. CMS continues to receive many inquiries about the use of prior authorization, and any additional changes to CMS policies would be proposed through rulemaking. In addition, CMS sought comment and recommendations on enhancing MA data capabilities and increasing transparency, including on prior authorization. CMS is considering the comments received.

We refer you to our previous response for all we can share at this time. CMS' authority is bound by law and regulation, federal mental health parity laws do not apply to Medicare Advantage/D-SNPs.

September 30, 2024:

The following is attributable to the Centers for Medicare & Medicaid Services (CMS) or a CMS spokesperson: Ensuring compliance with parity requirements in Medicaid and the Children's Health Insurance Program (CHIP) in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) is a key priority for CMS as it is fundamental to improving access to care for enrollees who need mental health and/or substance use disorder treatment. CMS partners with state Medicaid and CHIP agencies to implement MHPAEA requirements in Medicaid Managed Care Organizations, Medicaid alternative benefit plans, and separate CHIP programs. CMS issued a request for public comments on processes for ensuring compliance with federal parity requirements. This document also provides more details on how the agency works with states to ensure compliance with these critical protections for millions of Medicaid and CHIP beneficiaries.

Additionally, CMS works closely with state Medicaid agencies to ensure compliance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit that requires states to provide children and adolescents access to all medically necessary care including care for mental health conditions and substance use disorders (SUD). CMS recently highlighted for states these EPSDT requirements and best practices for improving access to mental health and SUD treatment for children and adolescents in a Center for Medicaid and CHIP Services Informational Bulletin "Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth." In addition, CMS is conducting reviews of states' compliance with EPSDT benefit with plans to issue additional guidance on best practices.

CMS takes the OIG's findings published in March 2024 seriously. CMS is actively engaged with states and other stakeholders to improve compliance and oversight of parity requirements in Medicaid and CHIP. CMS issued guidance on June 12, 2024 on these parity requirements. CMS is currently developing a set of templates and instructional guides for state agencies to document parity compliance to CMS, and on Sept. 9, 2024, CMS issued a request for comment on these draft resources. As noted above, CMS has also issued a detailed Parity Compliance Toolkit and a Parity Implementation Roadmap, as well as sets of Frequently Asked Questions to support implementation of the Medicaid and CHIP parity requirements by states.

In another demonstration of the Biden-Harris Administration's unwavering commitment to children's health, yesterday CMS released comprehensive guidance to support states in ensuring the 38 million children with Medicaid and the Children's Health Insurance Program (CHIP) coverage – nearly half of the children in this country – receive the full range of health care services they need.

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US Department of Labor Responses

Questions Related to UnitedHealthcare/Optum's Practices

- As we previously discussed, around 2016, the Department of Labor along with the New York Attorney General's office, opened up an investigation into UnitedHealthcare's practices related to its administration of mental health care benefits. What was the impetus for this investigation? Was it spurred on by patient or provider complaints? Was it prompted by findings in the NYSPA lawsuit against UnitedHealthcare, or by filings in the Wit vs. United Behavioral Health case, which began in 2014? Any details on how the investigation originally came about would be greatly appreciated.

  Response for ProPublica: We did not open the investigation based on patient or provider complaints. As a matter of agency policy, we do not disclose the bases for opening our investigations.

- During the DOL and NYAG investigation of United's practices, the regulators found that the company had been using algorithms to identify people who were giving or getting too much therapy, then pushing care advocates with quotas to scrutinize and cut off care. Company and court records reveal that ALERT comprised a suite of algorithms – totaling more than 50 at one point – that analyzed clinical and claims data to catch what it considered unusual mental health treatment patterns, flagging up to 15% of the patients receiving outpatient care. The algorithms could be triggered when care was overly frequent: if patients had two therapy sessions in one week or 20 sessions in under six

months. Providers drew scrutiny if they saw patients for more than eight hours a day, used the same diagnosis code with most clients or worked on weekends or holidays — even though such work was often necessary with patients in crisis. Once patients or therapists were flagged, care advocates, who were licensed practitioners, would "alert" providers, using intervention scripts to assess whether care was medically necessary. According to court records, United gave bonuses based on productivity, such as the number of cases handled, and pushed workers to reduce care by modifying a therapist's treatment or referring them to peer review in 20% of assigned cases. At one point, care advocates were referring 40%, court records show. Each peer review tended to last less than 12 minutes, offering providers little time to prove they had a "clear and compelling" reason to continue treatment. The DOL and the NYAG found that from 2013 through 2020, United had denied claims for more than 34,000 therapy sessions in New York alone, amounting to $8 million in denied care. The regulators also found, according to court records, that by using ALERT to ration care, United had calculated it saved the company about $330 per member each time the program was used. Cut off from therapy, some patients were hospitalized. According to the department's understanding of the case, is this an accurate representation of the program, as well as the investigation's findings?

Response for ProPublica: Our investigation focused on compliance with MHPAEA. Following the regulatory standard, we examined -under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, and other factors used in applying the nonquantitative treatment limitation (the outlier management programs) to mental health/substance use disorder (MH/SUD) benefits were comparable to, and applied no more stringently than those used in applying the nonquantitative treatment limitation to medical/surgical (M/S) benefits. DOL alleged in its complaint that the UBH outpatient outlier management program failed this fundamental test and the outlier management programs were more stringent as applied to MH/SUD benefits than to M/S benefits.

As noted in EBSA's complaint, we found that ALERT used over 50 proprietary algorithms to identify what UBH considered unusual treatment patterns (e.g., high numbers of visits) in mental health care, and in many cases, to deny further coverage. For example, nine of the algorithms used by UBH as part of the ALERT outlier management program could lead to denials of outpatient services. ALERT's outlier management was applied to all psychotherapy visits. Four of the algorithms used by UBH as part of the ALERT outlier management program identified outliers based solely on frequency of visits. For example, the UBH "high utilization" ALERT algorithms were triggered after 21 mental health visits by a

participant of beneficiary in a six-month period. When a case triggered one of these ALERT algorithms, this resulted in outreach by a "UBH Care Advocate," a licensed behavioral health professional. The UBH Care Advocate would reach out to the provider to discuss the case and treatment plan. Where the UBH Care Advocate determined that the level of care and intensity did not meet medical necessity guidelines, and the UBH Care Advocate and the provider did not agree on an adjustment to the participant or beneficiary's treatment plan, the UBH Care Advocate referred the case to a doctoral-level "UBH Peer Reviewer." When referred, the UBH Peer Reviewer would discuss the case with the provider and often ask the provider for additional information. Using this information, the participant or beneficiary's records, and UBH's medical necessity guidelines, the UBH Peer Reviewer then made a coverage decision, which could lead to an adverse benefit determination, in which case UBH would cause the Client Plan to stop providing benefits.

- By the end of 2021, United's practices had been deemed illegal in three states: not only did New York (along with the DOL) determine that their utilization management practices had violated MHPAEA, in 2020, the Massachusetts Attorney General also found that the ALERT program violated MHPAEA; and in 2018, the California Department of Managed Health Care, which oversees insurers in the state, also found ALERT violated the mental health parity act. All concluded that while United may not have set official caps on coverage, it had done so in practice by limiting mental health services more stringently than medical care. Therefore, it was breaking the federal parity law. According to the department's understanding of the other cases, is this an accurate representation of the cross-jurisdictional regulatory scrutiny of United's use of ALERT?

  Response for ProPublica: The states are in the best position to characterize their findings and actions. Section 502 of ERISA prohibits the Department from directly enforcing "any requirement of part 7 [including MHPAEA] against a health insurance issuer." Accordingly, our investigation primarily focused on self-insured plans, and we obtained relief with respect to such plans on a nationwide basis. We also worked, however, with the State of New York on fully-insured plans within New York.

- The company, which did not have to admit liability or wrongdoing, agreed to pay more than $4 million in restitution and penalties in 2021. Notably, it also agreed to not use ALERT to limit or deny care. The final terms of the settlement only applied to plans under New York and federal regulators' jurisdiction. Why did the

settlement allow United to not have to admit liability or wrongdoing? Has the company followed up related to their utilization management practices with the department since the settlement? Has the department found any other issues with the company's utilization management practices since 2021?

Response for ProPublica: The settlement required the re-adjudication of affected claims, payment of millions of dollars to plans, their participants and beneficiaries, and the imposition of additional civil penalties. While contested litigation could have resulted in a finding of liability, the Department believed that it was more important to obtain the relief necessary to make participants whole. As the complaint and settlement made clear, the Department had determined that United had broken the law. The scope and size of the relief were more than sufficient to demonstrate the strength of the Department's conclusions.

Following the settlement, the NYRO ~~did have~~ has had some post-settlement discussions ~~to ensure~~ concerning the proper implementation of settlement terms. NYRO also continues to follow up on inquires from participants about United's UM practices, and we handle those on a case-by-case basis.

To the extent the question calls for the Department to indicate whether it has any open investigations concerning United's compliance or its implementation of ALERT or similar programs, the Department does not comment on the existence or absence of ongoing investigations, as a matter of agency policy.

- None of the scrutiny has stopped United from continuing to police mental health care with arbitrary thresholds and profit driven quotas, our reporting has found. Internal documentation reviewed by ProPublica shows that similar tactics are very much alive, putting countless patients at risk of losing mental health care. In the three years since the settlement, ALERT has been rebranded. The "Outpatient Care Engagement" program continues to use claims and clinical data to identify patients with "higher-than-average intensity and/or frequency of services," according to internal company documents, to ensure "that members are receiving the right level of care at the right time." Up to 10% of cases are flagged for scrutiny, public company documents show. If care advocates take issue with a therapist's care, it can be elevated to a peer review, which can result in a denial. The script is nearly the same as the one used for ALERT. Care advocates are even calling therapists from the same phone number. The program is overseen by the former director of ALERT, who led the algorithmic system for eight years from 2013 through 2021, according to her LinkedIn page. The team's more than 50 care advocates are tasked with ensuring that "outpatient care follows clinical and coverage guidelines;" they're supposed to

reduce "overutilization and benefit expense when appropriate," according to company documents. The team conducts thousands of reviews each month, disproportionately for Medicaid members but also for people with Medicare coverage and for workers with fully insured plans, according to internal documentation. The team conducts two types of reviews. With its "consultation" reviews, the team flags members seeking therapy who have high use (more than 30 sessions in eight months) or high frequency (twice-a-week sessions for six weeks or more) to engage their providers in "collaborative" conversations about the treatment plan. Internal records indicate that the company uses the consultative model for about 20 state Medicaid programs, including Washington, Minnesota, Mississippi, Virginia and Texas. In Louisiana, the original ALERT program is still operational, according to a recent company manual for its state Medicaid plan. The company is using a more rigorous process to question medical necessity for routine therapy on its members with dual Medicare-Medicaid plans in nearly 20 states. A more stringent review method is also being applied to review psychological testing services and ABA therapy for people with Medicaid coverage in about 20 states. The documentation reveals that Optum has continued to use quotas with its medical necessity reviews, setting productivity targets for how many cases its employees scrutinize. According to documentation from this year, the target was 160 reviews per employee, which the company exceeded with 180 reviews per employee. An internal Optum report explains that the company is focused on limiting "unwarranted" treatment and estimates that its "outlier reduction" strategy with Medicaid plans will contribute to savings of up to $52 million. Mental health experts and advocates told ProPublica that there is no real clinical rationale behind such an utilization management program that focuses on outliers in this way, and that it appears to be driven by financial considerations. What is the department's response to United's use of a similar program that uses analytics to flag frequent users of outpatient mental health care for people on Medicaid plans? Does the department find these practices concerning?

Response for ProPublica:
We would be concerned about "consultation" reviews that are conducted in a way that violates MHPAEA. As indicated above, we cannot comment on whether we have an open investigation concerning such practices by any particular issuer or plan. You should bear in mind, however, that DOL does not have jurisdiction over Medicaid plans.

- United has told ProPublica that the company is compliant with the terms of the settlement and that it has taken concrete steps over the last several years to

improve access to quality care. What is the department's understanding of United's current utilization management practices? Has the department received any complaints related to United's utilization management of outpatient mental health care?

- Response for ProPublica: United has represented to DOL that ALERT no longer results in denials of care. United can administer other utilization management review programs that result in denials of care as long as that program is ERISA compliant. To the extent there are issues with United's utilization review management practices in relation to ERISA-covered plans, and those practices appear to be disparately applied to MH/SUD benefits, anyone should feel free to reach out to DOL EBSA's toll free benefits advisor number at 1-866-444-3272. As indicated above, the Department, as a matter of agency policy, does not comment on the existence or absence of ongoing investigations of specific entities.

Questions Related to Regulatory Oversight of Insurance Companies

- United's ability to continue to deploy a similar playbook to limit care lays bare a glaring flaw in the way American health insurance companies are overseen. While the insurer offers plans to people in every state, it answers to no single regulator. The federal government oversees the biggest pool, most of the plans that employers sponsor for their workers. States are responsible for plans that residents buy on marketplaces; they also regulate those funded by the government through Medicaid but run through private MCOs. In essence, more than 50 different state and federal regulatory entities each oversee a slice of United's vast network. So when California cited United for ALERT in 2018, its corrective plan applied only to group market plans in California. When Massachusetts' AG forced it to restrict the system in 2020 for one of the largest health plans there, its power ended at the state line. And when the NY AG and DOL conducted one of the most expansive investigations in history of an insurer's limitations on mental health care — one in which they scored a landmark, multi-million-dollar victory against United — none of it made an ounce of difference to the millions whose plans fell outside their purview. For United's practice to be curbed, every single jurisdiction in which it operates would have to successfully bring a case against it. One mental health advocate described the regulatory landscape for insurance companies as "whack-a-mole," saying the fractured regulatory landscape "benefits them to have that because they can just move their scrutinized practices to other products in different locations." What is the department's response to this? When the department uncovers questionable practices with insurance companies under their purview, what actions can it take

to communicate and work across jurisdictions to ensure that unscrupulous practices are curbed? In the case of United in 2021, beyond New York, did the Department of Labor communicate to other jurisdictions (ie state Medicaid agencies or state insurance departments) the issues that it had uncovered in its investigation? If so, what was the response from the other regulatory entities? What more could be done to ensure consistent oversight across jurisdictions?

Response to ProPublica: Under the statutory framework for MHPAEA (and other provisions for group health plans that amended Part 7 of ERISA, Title XXVII of the Public Health Service Act, and Chapter 100 of the Internal Revenue Code) set by Congress, the Departments of Labor, Health and Human Services (the Departments) share interpretive jurisdiction, but split enforcement jurisdiction. The Department of Labor (DOL), Employee Benefits Security Administration (EBSA) has enforcement jurisdiction with respect to approximately 2.6 million private sector, employment based group health plans (self-insured and fully-insured) covering roughly 136 million Americans. Enforcement of MHPAEA under other types of plans and coverage is split as follows:

- The Department of Health and Human Services (HHS) has jurisdiction over self-insured, non-Federal governmental plans.
- States have jurisdiction over health insurance issuers. If a State fails to substantially enforce MHPAEA, HHS can make a finding and directly enforce MHPAEA's requirements.
- The Department of the Treasury, Internal Revenue Service has jurisdiction over church plans.

The Departments have and will continue to coordinate regularly with each other and the States (including through meetings with the National Association of Insurance Commissioners) on MHPAEA implementation and enforcement efforts.

EBSA has noted in the past that additional tools from Congress could greatly augment efforts to enforce MHPAEA and enhance access to mental health and substance use disorder treatment. The January 2022 Report to Congress included recommendations for EBSA authority to assess civil monetary penalties for MHPAEA violations against entities that provide administrative services to ERISA plans (including health insurance issuers and third-party administrators,

among others.[1] The July 2023 Report to Congress reiterated these recommendations.[2]

- The Centers for Medicare & Medicaid has the primary responsibility of overseeing state Medicaid agencies to ensure that the MCOs they contract with are following the mental health parity act. However, in a recent audit, the Office of Inspector General for HHS found that CMS has failed to ensure state Medicaid agencies were adequately overseeing MCOs. Does the department have any role in MCO oversight? If so, can you share more about what the department is doing to assist CMS with its regulatory responsibilities of state Medicaid agencies?

  Response to ProPublica: The Department of Labor and the Employee Benefits Security Administration does not have oversight authority over Medicaid MCOs.

[1] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mental-health-parity-report-to-congress.pdf

[2] https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis