

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance)
With Mental Health and Substance Abuse) OHIC-2014-3
Laws and Regulations)

Examination Report of UnitedHealthcare Insurance Company, and UnitedHealthcare of
New England, Inc. in accordance with R.I.G.L. § 27-13.1-5(b).

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

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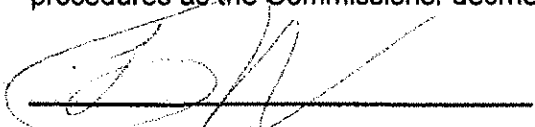
March 11, 2020

Honorable Marie Ganim
Health Insurance Commissioner
State of Rhode Island

Dear Commissioner Ganim:

In accordance with your instructions and pursuant to statutes of the State of Rhode Island, a targeted Market Conduct Examination was conducted to ascertain compliance with applicable statutes and regulations relating to coverage of mental health and substance abuse benefits by all four major health insurance carriers in Rhode Island. This Examination Report addresses compliance by United Healthcare Insurance Co. and United Healthcare of New England. Other Examination Reports address compliance by the other carriers.

The examination was conducted by Linda Johnson, former OHIC Operations Director (as of October 15, 2019 OHIC Independent Contractor), and Herbert W. Olson, Esq. (former OHIC General Counsel), with the assistance of OHIC and EOHHS staff, and with clinical expertise from behavioral health clinicians associated with the Law and Psychiatry Service at Massachusetts General Hospital. In conducting the examination, the Examiners observed those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners, together with other appropriate guidelines and procedures as the Commissioner deemed appropriate.




Linda Johnson, (Contractor, Former Operations Director)
RI Office of the Health Insurance Commissioner

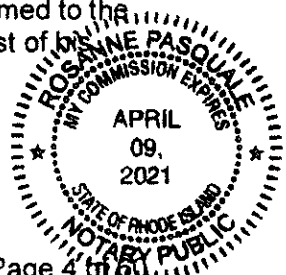
Herbert W. Olson, Esq.
Hillsboro Mountain PLC

On this ____ day of _____, 20__, before me, the undersigned notary public, personally appeared Linda Johnson, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of her knowledge and belief.

Notary Public

On this 16th day of March, 2020, before me, the undersigned notary public, personally appeared Herbert W. Olson, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of his knowledge and belief.



Notary Public

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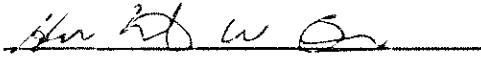
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Linda Johnson, (Contractor, Former Operations Director)
RI Office of the Health Insurance Commissioner



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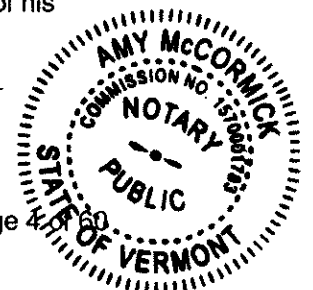
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Notary Public

Com. Exp. 1/31/21



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Notary Public

1. Introduction.

This market conduct examination ("Examination") commenced with a Warrant of Examination issued by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") on January 8, 2015. The Commissioner appointed as Examiners (among others) Linda Johnson, former OHIC Operations Director (as of October 15, 2019 OHIC Independent Contractor), and Herbert W. Olson, Esquire (former OHIC General Counsel). The Examination is a targeted examination of the four largest health insurance carriers in the Rhode Island insured market: Blue Cross Blue Shield of Rhode Island ("Blue Cross"), Neighborhood Health Plan of RI ("Neighborhood"), Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "Tufts"), UnitedHealthcare Insurance Company, and UnitedHealthcare of New England, Inc. (collectively "United RI") (collectively "the Carriers").

The purpose of the Examination is to review compliance by the Carriers with federal and state laws and regulations relating to health insurance coverage of mental health and substance use disorder benefits (collectively, mental health and substance use are referred to in this Report as "behavioral health", or "BH").

This Examination Report addresses compliance by United RI. Other Examination Reports have or will address compliance by the other Carriers.

The Examination targeted two broad areas of regulatory compliance: first, compliance with federal and state behavioral health parity laws and regulations. The second targeted area of regulatory compliance for the Examination has been carrier compliance with state and federal requirements relating to utilization review policies, procedures, and their implementation.

The Examination initially targeted Carrier records and operations during the 2014 calendar year period; however, where necessary because of limited numbers of records available for review in connection with some Carriers, the Examination also included a review of records and operations during 2015 and 2016.

Initial requests for information were submitted to the Carriers in September 2015. The Examination was suspended in June 2016 following adjournment of the Rhode Island Legislature, and was re-commenced in December 2016.

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2. Applicable statutes and regulations

- a. Carriers must use clinically appropriate utilization review criteria. Carriers are obligated to provide coverage for members with behavioral health conditions by virtue of their obligation to comply with their approved health benefit plan forms. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. The approved health benefit plans of United RI promise to cover behavioral health services, including a continuum of care for members with mental health and substance abuse conditions. Carriers are also obligated to provide coverage for members with behavioral health conditions by virtue of RIGL § 27-38.2, which includes both an obligation to provide coverage for the treatment of mental health and substance use conditions and disorders defined and identified in the Diagnostic and Statistical Manual of Mental Disorders, as well as an obligation that coverage be provided under the same terms and conditions as coverage that is provided for medical and surgical conditions. Typical "terms and conditions" of coverage include the utilization review process.

The utilization review process can be a legitimate affordability mechanism designed to allocate finite insurance carrier premium revenue in a cost-effective manner, for the benefit of all consumers; however, when utilization review procedures are applied to potentially limit the underlying obligation to provide behavioral health coverage, the utilization review process must be fair and equitable, and must be applied in accordance with reasonable standards. RIGL § 27-9.1-4(a)(3) and (4) (Unfair Claims Settlement Practices Act). In order to fulfill those obligations, the Carrier must use clinically appropriate criteria when making its utilization review determinations. If inappropriate clinical criteria were used, the utilization review process would be neither fair nor equitable and would not use reasonable standards in making claim determinations. Instead, the Carrier would be acting in an arbitrary manner to deny coverage for behavioral health services that are otherwise required by law to be covered.

The Title 27 obligation to use clinically appropriate utilization review criteria was consistent with RI Department of Health Regulation R23-17.12 (DOH Utilization Review Regulation) § 3.2.20, which requires utilization review agents to use "written medically acceptable screening criteria." Thus, the obligation to

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use clinically appropriate criteria in determining whether to approve or deny coverage for behavioral health services is independently grounded in both Title 27, RIGL, and in the DOH Utilization Review Regulation. Since the commencement of this Examination, authority for enforcement of Rhode Island's current utilization review related statutes has been transferred to the Office of the Health Insurance Commissioner (R.I.G.L. § 27-18.9 effective 1/1/11.)

- b. Carriers must apply their utilization review criteria in a clinically appropriate manner. Carriers are also obligated to apply utilization review criteria in a clinically appropriate manner. If criteria are not applied in a clinically appropriate manner, the utilization review process would be neither fair nor equitable in using reasonable standards and procedures to make utilization review decisions. Unfair Claims Settlement Practices Act. The obligation to apply utilization review criteria in a clinically appropriate manner is consistent with the legal obligation under the DOH Utilization Review Regulation to use and apply utilization review criteria and procedures in a clinically appropriate manner. DOH Utilization Review Regulation § 3.2.20. Thus, the obligation to apply clinically appropriate criteria in determining whether to approve or deny coverage for behavioral health services is independently grounded both in Title 27, RIGL, and in the DOH Utilization Review Regulation.
- c. Carriers must adopt and implement reasonable utilization review standards and procedures, and must make prompt, fair and equitable utilization review decisions. Health insurance companies are subject to the Unfair Claims Settlement Practices Act. The Unfair Claims Settlement Practices Act, in particular, prohibits "[f]ailing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies." RIGL § 27-9.1-4(a)(3). The Unfair Claims Settlement Practices Act also prohibits "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlement of [valid] claims". RIGL § 27-9.1-4(a)(4). Together, the Unfair Claims Settlement Practices Act, as applied to the utilization review process, requires Carriers to establish reasonable utilization review standards and to act in a prompt, fair, and equitable manner in reviewing requests for approval of coverage for behavioral health services. The DOH Utilization Review Regulation and the RI Department

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of Health Regulation R23-17.13 (DOH Health Plan Certification Regulation) prohibit many practices which also constitute violations of the Unfair Claims Settlement Practices Act. Thus, Carriers' obligation to establish reasonable utilization review standards, and to act in a prompt, fair, and equitable manner in acting upon requests for approval of coverage for behavioral health services is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.

- d. Carriers must provide coverage of benefits and services without unreasonable delay and without impeding care. A Carrier must provide coverage of benefits described and promised in a member's health benefit plan. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. Coverage must be provided in a reasonably prompt manner. RIGL §27-9.1-4(a)(3). The DOH Utilization Review Regulation and the DOH Health Plan Certification Regulation similarly prohibit many practices which would also constitute violations of Carriers' obligation to provide coverage of benefits and services without unreasonable delay and without impeding care. Thus, Carriers' obligation to cover services provided for in the member's health benefit plan without impeding care, and in a reasonably prompt manner is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.
- e. Carriers must maintain documentation of utilization review decisions sufficient to allow the Commissioner to determine compliance with legal obligations. A Carrier must provide documentation of its operations in a manner so that the Commissioner can readily ascertain the Carrier's compliance with RI insurance laws and regulations. RI Insurance Regulation 67 ("Regulation 67"), § 4.A. In the case of health insurance companies, the obligation includes maintaining documentation of the practices of the Carrier regarding utilization review. Regulation 67 § 4.B. A health claim file must contain communications to and from members or their provider representatives, health facility pre-admission certification or utilization review documentation, any documented or recorded telephone communication relating to the handling of the claim, and any other documentation necessary to support claim handling activity. Regulation 67, § 6.A. Thus, the regulation makes clear that a Carrier's utilization review

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documentation must be sufficient to demonstrate to the Commissioner during a market conduct examination that the Carrier is in compliance with state insurance laws, including laws and regulations within Title 27, and health insurance laws and regulations authorized under Title 23.

- f. Mental health and substance use disorder coverage must be provided at parity with medical-surgical coverage. State law requires parity in coverage for mental health and substance use conditions with medical-surgical conditions. Rhode Island's parity law was originally enacted in 1994 and amended in 2014 to reflect the federal behavioral health parity law enacted in 2008, and to reflect final federal regulations adopted in 2013. The core legal principals and parity obligations for carriers have remained the same throughout the examination period: (1) carriers must provide coverage for the treatment of mental health and substance use disorders, and (2) such coverage must be provided under the same terms and conditions as coverage is provided for other illnesses and diseases. RIGL § 27-38.2-1(a).

Federal law also requires parity in coverage for mental health and substance abuse conditions with medical-surgical conditions. Among other requirements, federal law prohibits the application of non-quantitative treatment limitations unless the behavioral health limitation is comparable to, and no more stringently applied than the treatment limitation applicable to medical-surgical treatment. 42 U.S.C. § 300gg-26. Federal regulation further requires coverage of medically necessary behavioral health services in the individual and small group markets. 45 C.F.R. § 156.110(a)(5).

Utilization review standards and procedures are considered "non-quantitative treatment limitations" ("NQTL's") which may not be imposed on coverage of behavioral health services unless the behavioral health utilization review standards and procedures, and the manner in which they are developed, are comparable to, and applied no more stringently than utilization review standards and procedures applied to medical-surgical benefits and coverage. RIGL § 27-38.2-1(d). 45 C.F.R. § 146.136(c)(4). Utilization review programs administered for behavioral health services are not "comparable to" medical-surgical services: (i) if prior authorization is required or recommended in a more

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pervasive manner for behavioral health services as compared to the scope of medical-surgical services for which prior authorization is required or recommended, (ii) if prior authorization is required or recommended for a medically necessary continuum of care for chronic behavioral health conditions, but is not comparably required or recommended for chronic medical conditions, (iii) if prior authorization is applied in a more stringent manner to behavioral health conditions than for medical-surgical conditions, or (iv) if benefit plan exclusions apply exclusively to behavioral health conditions or services. 45 C.R.F. § 146.136(c)(4) (examples 9 and 10). While federal parity regulations changed in some respects between the Interim Final Regulations adopted in 2010 and the Final Regulations adopted in 2014, the provisions of the federal regulations applicable to this Examination and applied by the Examiners in their findings and conclusions of law in this Examination Report did not change between 2010 and 2014.

g. Other applicable statutes. RIGL §§ 27-13.1-1 et seq. (Examination Act).

3. Examination methodology and process.

- a. The Commissioner initially appointed Linda Johnson, former OHIC Operations Director (as of October 15, 2019 OHIC Independent Contractor),, Herbert W. Olson, Esq. (former OHIC General Counsel), Jack Broccoli, Chief Insurance Financial Examiner, RI Department of Business Regulation, and Charles DeWeese, OHIC actuary, as Examiners. Linda Johnson and Herbert Olson were in charge of the Examination. Assisting the Examiners were the following OHIC staff: Emily Maranjian, OHIC Legal Counsel, John Garrett, Principal Policy Associate, Cheryl Del Pico, Special Projects Coordinator, Victor Woods, Health Economic Specialist, Alyssa Metivier, Health Economic Specialist, and James Lucht, RI EOHHS Deputy Director of Analytics.
- b. The Examiners reviewed the policies and procedures of the Carriers related to utilization review and behavioral health parity, with an emphasis on policies and procedures already submitted to the RI Department of Health in connection with the Health Plan Certification and Utilization Review regulatory programs.
- c. The Examiners requested and received from the Carriers Case Records of utilization review decisions (Case Records). Case Records are an important

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feature of the Examination, because they permit the Examiners to measure the actual implementation of a Carrier's policies and procedures against their legal obligations relating to utilization review and parity. The Examiners reviewed the Case Records for compliance with procedural or non-clinical requirements. The Examiners also identified Case Records which needed review by behavioral health clinicians in order to evaluate the clinical appropriateness of Carrier utilization review criteria, utilization review decisions, and other matters requiring clinical judgment.

- d. In accordance with the Examination Act, the Examiners retained expert clinicians in behavioral health associated with Massachusetts General Hospital (MGH Clinicians), under the direction of Ronald Schouten, MD, JD, Director, Law and Psychiatry Service. The Examiners identified the clinical issues to be reviewed by the MGH Clinicians and provided instructions for the review process. The Examiners' findings related to clinical issues are based in part on the clinical review of Case Records by the MGH Clinicians.
- e. The Examiners' data sampling methodology was developed by James Lucht, RI EOHHS Deputy Director of Analytics, in consultation with the Insurance Division of the RI Department of Business Regulation. The essential elements of the sampling methodology are described below:

In order to produce a random representative sample of cases for examination, a Random Stratified Sample with Proportional Distribution was used. For behavioral health claims, the main factors were disposition (approved vs. denied), client age, diagnosis, and setting. For prescription drug claims the main factors were disposition, diagnosis, and drug type. Basic steps are as follows:

1. Create aggregate columns for diagnosis, age, setting, and drug type to lessen the number of unique sampling categories.
2. Create pivot table that counts each unique combination of categories for approvals and denials.
3. Determine sample size for approvals and denials.
4. Using the pivot table, determine percentage of approval and denials in each unique combination category. Multiply this

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percentage by the sample size. Results with a value less than one were rounded up to one. If key categories of interest have very low numbers (< 3) add one or more cases (oversampling).

5. Sort by Date of Service
6. Generate random number column in Excel using RAND function.
7. Sort by key categories (Setting, Simplified Diagnostics, Age Category) and random number.
8. Choose the specified number of cases from each category starting from the top of each grouping in the spreadsheet, mark new Sample column with a 1.
9. Filter on Sample =1 and copy/paste into new sheet.
10. Pare down number of columns to just the number needed for the carrier to identify the case.

The biggest challenge was to get a representative sample among smaller case groupings. For example, juvenile cases and some combinations of diagnoses and settings are so few that we can't hope to say anything about that class of case unless we greatly oversample. To overcome this, we began with a random proportional sample, assessed classes of cases with low numbers, and then combined categories based on similarity.

Summary of Findings and Recommendations

Behavioral health - findings.

4. In accordance with the methodology described in Para. 3, above, the Examiners selected a total of 301 cases; 210 classified by United RI as BH authorizations cases, 58 classified by United RI as BH denials cases and 33 classified by United RI as BH cases that were appealed. Of those selected cases, OHIC Examiners reviewed, in detail, 50 of the 210 authorization cases with 10 of these forwarded to the MGH Clinicians for review of clinically-related issues. Of the 58 BH denial Case Records, all 58 were reviewed in detail by the Examiners and 14 of the 58 cases were forwarded to MGH Clinicians for further review of clinically-related issued. Finally, the Examiners reviewed all 33 appeal cases in detail and forwarded 10 of these appeal cases to the MGH Clinicians for review of clinically-related issues. When, in the course of reviewing a subset of the cases requested, the Examiners found a widespread pattern and practice and/or United RI confirmed standard procedures supporting an

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identified pattern of practice, the Examiners determined that a review of all cases for that particular pattern and practice was not necessary in order to find that the pattern and practice and any United RI non-compliance associated with the pattern and practice was consistent across the majority if not all of the cases submitted.

5. During the time periods examined, United RI delegated to United Behavioral Health the utilization review function for behavioral health services. United Behavioral Health was an operating division within Optum, Inc. ("Optum"). Since the examination period, Optum has reorganized so that Optum is now directly responsible for performance of the utilization review function for behavioral health services for all health insurance subsidiaries operating under the parental control of UnitedHealth Group, the corporate entity that also controls Optum. UnitedHealth Group is also the corporate entity that controls United RI. For purposes of this Examination Report, United Behavioral Health and Optum will both be referred to as "Optum". Notwithstanding such delegation, and notwithstanding Optum's independent legal responsibilities, United RI is responsible for any failure of compliance by Optum with RI health insurance laws and regulations.

6. The Examiners find that the conduct, policies or procedures described in Paras. 7 through 13 constitute patterns or practices which violate the requirements of RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), DOH Utilization Review Regulations, and/or DOH Health Plan Certification Regulations. The Findings of Fact and Conclusions of Law set forth in Paras. 50 - 99 are incorporated by reference in the Summary of Behavioral Health Findings and Recommendations (Paras. 4 - 19).

7. Clinically inappropriate utilization review criteria. Optum failed to use clinically appropriate utilization review criteria for behavioral health services in violation of RIGL § 27-9.1-4(a)(3) and (4) and DOH Utilization Review Regulation § 3.2.20. For example:

- a. Utilization review criteria used by Optum staff were not based on objective, measurable, clinical criteria. Instead, the Optum utilization review criteria employed relied on subjective, vague, and generalized conclusions or judgments. As a result, the criteria can be subject to variable interpretation by Optum staff, and the criteria failed to give sufficient notice to the treating provider concerning what clinical information needs to be shown in order for medically necessary services to be approved for coverage for patient. Variable decision-making lends itself to the possibility of arbitrary and unwarranted denials of coverage for

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treatment. For example, in one Case Record, Optum denied coverage for treatment in a partial hospitalization program for a patient who had serious medical complications requiring surgical intervention and needed treatment for substance abuse. This patient had suffered from a long-term substance use disorder and was at significant risk if the patient did not remain sober so that surgery could be performed. On or about page 20 of the Case Record¹ Optum asserted that the attending provider (AP)² request was for Partial Hospitalization Program (PHP) with boarding despite that there was no evidence in the file to support that this was the AP's request. There was no Optum clinical criteria set for approved PHP with boarding. Thus, the Optum reviewers' decision in the absence of written criteria supports the conclusion that Optum employs a subjective approach to using criteria in its decision making. There were also no criteria used in the denial for the authorization of care requested throughout this case that addressed the relationship between this patient's mental health, substance use and medical/surgical needs. The Examiners identified three additional Case Records to demonstrate this practice.

- b. Utilization review criteria used by Optum incorporate a "Why Now?" concept to make decisions on a clinically appropriate level of care, without defining the concept or how it should be used to approve or disapprove treatment approval requests. Optum Level of Care Guidelines, 2014 and 2015. In one Case Record, a patient was discharged from a state hospital then relapsed presenting to a residential treatment facility for detoxification. In this case the decision rationale to deny coverage of residential treatment for detoxification was, in part, due to a "Why Now?" factor as documented in the Case Record. The Case Record included the statement "Residential Detoxification is typically indicated when the "why now" factors that precipitated admission indicate that the member requires detoxification in a safe and stable living environment." This "Why Now?" factor was routinely used by Optum. The Examiners identified eight additional Case Records to demonstrate this practice.

¹ For technical reasons, the specific page numbers of any one Case Record can vary slightly.

² Attending provider (AP) shall have the same meaning as a treating and ordering provider.

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- c. Utilization review criteria to include admission criteria failed to properly, and with sufficient detail, address patients whose mental health condition resulted in an inability to maintain basic self-care and to protect oneself in the community. For example, one Case Record evidenced a denial of coverage for continued inpatient stay for a patient with ongoing, significant psychotic harm. After a nine-day inpatient stay, the AP noted that the transition of the patient was not confirmed as the patient's medication was being titrated slowly due to the patient's seizure disorder (on or about page 32 of Case Record). A denial was issued based on the generalized conclusion that the patient had "gotten better", the patient was not at risk of harm to self or others and that there were no signs of medication complications. There was no evidence of an objective assessment of the need for medication titration for safety of the family members and the patient and whether the patient's self-care needs required continued stay at the inpatient level of care until the patient could be safely discharged.
- d. Utilization review criteria and utilization review decisions included general references to numerous clinical guidelines, internal and external to Optum's written guidelines as presented to the Examiners. The guidelines were improperly, informally and arbitrarily incorporated by Optum reviewers into Optum's criteria, and as a result failed to give sufficient notice to the treating provider concerning what clinical information needed to be shown in order for requests for medically necessary services to be approved for the patient. For example, one Case Record presented a detoxification followed by residential treatment for a patient with diagnoses of alcohol use disorder (ETOH), bipolar, ADHD as well as current and chronic suicidal ideation. Optum denied continued coverage for inpatient residential treatment for this patient stating that the patient could be safely treated at a lower level of care despite a clear risk of imminent relapse aggressive/impulsive behavior and risk of suicidality that required continued stay to address these unresolved issues (per the AP presentation during communications with Optum staff and during the appeal process.) Optum's decision did not present a denial that had been based on a proper assessment of the patient's clinical status and according to the 2014 UHC BH Level of Care Guidelines. The decision to deny coverage referenced numerous

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different clinical guidelines sets in support of the denial, without identifying the specific, disqualifying guideline(s).

- e. United RI stated to the Examiners that Optum's Behavioral Health 2014 and 2015 Level of Care Guidelines were the utilization review criteria established during the time-period examined and should have been used by Optum staff in making utilization review decisions during the period of time examined. Instead, the Examiners found that in a number of cases Coverage Determination Guidelines (CDG) were used, and in a number of cases it is unclear whether Optum's Behavioral Health Level of Care Guidelines or Coverage Determination Guidelines were used. The Examiners identified two Case Records to demonstrate this practice.
- f. The definition of medical necessity used by Optum when making utilization review decisions is too subjective, and incorporated a discretionary clause, thereby allowing Optum to be the sole judge of whether a particular service was medically necessary, regardless of the clinical facts and the clinical judgment of the treating provider. Optum's Behavioral Health Level of Care Guidelines. RIGL § 27-18-79 (discretionary clauses).

8. Clinically inappropriate application of utilization review criteria. Optum failed to apply its utilization review criteria in a clinically appropriate manner, in violation of RIGL§ 27-9.1-4(a)(3) and (4) and DOH Utilization Review Regulations §§ 3.2.20 and 5.1.1(b)(i) and (iv) and DOH Health Plan Certification Regulation § 3.2.3. For example, and in numerous cases:

- a. The observations, conclusions and decisions made, or the facts asserted by Optum to support a denial are either not supported in the Case Record or are contradicted in the Case Record. For example, in one Case Record summarized in Para. 7(a) above, the documented rationale for the denial (noted on or about pages 24-26 of the Case Record) was based on, at least in part, a peer review despite the fact that there was no evidence in the file that a peer review occurred. In this case there was also clear evidence, as presented by the AP, that not all the patient's comorbid clinical information was considered by Optum in making the denial. There was also a failure to consider all the facts in this case as evidenced in the notification letters. The Examiners identified eleven additional Case Records to demonstrate this practice.

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- b. Failure to adequately consider all information:
- i. Optum failed to properly consider the patient's clinical condition and clinical information in denying requests for approval of coverage for treatment. For example, in three Case Records noted in Paras. 7(a), (c), (d) and 8(a), the clinical condition of the patient as presented by AP or AP staff was not adequately considered to ensure the patient's welfare and safety in making a denial.
 - ii. Optum failed to properly consider the treating provider's clinical recommendation and rationale for treatment. For example, in one Case Record a patient with depressive disorder, suicidal ideation (SI) and homicidal ideation (HI) as well as PTSD was stepping down from an inpatient stay to PHP but Optum does not document existence of SI and HI until the appeal level (see on or about page 31 of the Case Record.) The denial occurred in response to a request by the AP for further PHP treatment. At the time of the denial, there was inadequate attention paid by Optum to the member's current clinical status or to the AP's recommendation for next treatment steps despite the fact that the request by the AP was in keeping with the carrier's guidelines for depression treatment delineated in CDG. On appeal, the third Optum reviewer considered what had previously been documented by the AP as new information and partially overturned the denial despite the fact that minimal new information with pertinence to the decision was provided for the appeal. The Examiners identified two additional Case Records to demonstrate this practice.
 - iii. Optum failed to give sufficient weight to the recommendations of the treating provider, even when there was no dispute as to the facts and circumstances relating to the patient's condition or treatment. For example, one Case Record demonstrates this practice when Optum denied coverage of treatment for a patient with diagnoses of autism/autism spectrum disorder, major depression and generalized anxiety disorder who was admitted to inpatient following three weeks of worsening and dangerous behavior (see Para. 7(c) above.) In this case

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- the AP's clinical judgement was that the patient should continue treatment while working on issues to facilitate a safe discharge. Despite no material dispute as to the patient's condition and circumstances, Optum disregarded the treating provider's clinical judgement, denied coverage for the continued stay, and thereby potentially impeding the patient's care.
- iv. Though it was common practice for Optum and United RI to fail to fully consider all of the information documented in the Case Records as presented in Paras. 8(a) and (b) above, the Examiners specifically identified twenty-four additional Case Records to demonstrate this practice.
- c. Short-term, frequent concurrent reviews; voluntary modification agreements.
 - i. Optum engaged in a practice of short-term, frequent concurrent reviews, and recommended a shorter length of stay or lower level of care than requested by the treating provider, without a clinical basis for the short-term, frequent concurrent reviews, or for the recommendation of a shorter length of stay or a lower level of care. For example, in one Case Record summarized in Paras. 52, 85, 87 and 94, a patient was admitted to an inpatient level of care with severe psychotic symptoms and was subjected to 7 concurrent reviews over 15 days. In this case, Optum frequently reduced the number of days requested though Optum's Case Records did not evidence the AP's voluntary agreement to the reduced number of days. In addition, Optum did not provide a clinical basis for either its frequency of reviews or the shorter duration of its "approvals." The Examiners identified eleven additional Case Records to demonstrate this practice.
 - ii. Optum reduced the provider-recommended length of stay or lowered the provider-recommended level of care without evidence of a voluntary agreement by the attending provider to modify the treatment request. RI laws and regulations required evidence of a voluntary, bona fide agreement before the provider's request can be reduced, otherwise the decision cannot be classified as an approval. For example, in one Case Record a request was made for 7 units of PHP for a patient with

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diagnoses of ETOH abuse, anxiety and depressive disorder. On or about pages 7 & 8 of the Case Record, there is a portal documentation category titled Estimated Length of Stay and that section is filled in with "7 days". However, an authorization by Optum granted only 3 days "to determine if there is a need for additional authorization through the weekend." Under the "Outcome" section of the portal it states "facility verifies that they are in agreement" with the approved days as (3). But there is no evidence in the Case Record of a conversation substantiating this agreement nor is this consistent with the screen shot on or about page 14 that evidences 5 authorized days. In this case, the portal completion by Optum staff (based on documentation from a telephone request) does not present accurate documentation as to what was requested, documentation of explicit agreement by the provider to fewer units or documentation of what was finally approved. When reducing the number of days requested, the Portal process does not properly document these as denials or afford the AP or the patient proper notification of denial and subsequent appeal rights.

- iii. In one Case Record identified by the Examiners a patient was discharged to PHP for BH treatment after detoxification. On or about page 17 of this Case Record the Portal documentation indicates the AP request was for 5 days of PHP. On or about page 18 of the Case Record, the Portal documentation contains the following statement: "in an effort to expediate needed care, will you accept fewer number of days/units requested, while reserving your rights to request additional days/units. Note the alternative number of days/units is not to be considered a denial that the requested number is not medically necessary, but rather a recommended change to your requested number of days/units based on the clinical information provided, our clinical guidelines and program requirements for concurrent Review." The AP requesting services can answer yes or no to this question. On or about page 18 of the Case Record, the "Outcome category of the Portal documents the authorization of 4 PHP units. Of note, the AP is asked to respond to this "Yes" or "No" question prior to knowing what modification Optum may propose. This case was

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documented as an authorization when it should have been documented as a denial. The Portal process in this case does not accurately reflect the lower number of units authorized, does not properly document a denial, does not acknowledge that the AP did not accept a modified number of units and does not facilitate or afford the appropriate appeal process. The Examiners identified seven additional Case Records to demonstrate this practice.

- iv. Optum standard protocols record pro forma attestations or verifications that the provider has agreed to a modification in the provider's request for treatment approval, without credible or sufficient evidence that the provider's agreement was voluntary. An example of this practice is found in one Case Record identified above in Para. 8(c)(ii). The Examiners identified four additional Case Records to demonstrate this practice.
 - v. Thirty-one additional Case Records identified by the Examiners demonstrate Optum's pattern of practice for offering or approving coverage for fewer days of treatment than requested by the provider, without a clinical basis and/or voluntary agreement for the fewer days approved, resulting in unnecessary and time-consuming additional utilization reviews.
- d. Inappropriate coverage decisions for discharge.
- i. Optum recommends a denial of coverage for a continued care/stay indicating the patient was appropriate for discharge notwithstanding that the lower level of care is not available. For example, in one Case Record a patient with a diagnoses of depressive disorder, PTSD from physical and sexual abuse, eating disorder, and traumatic brain injury was denied coverage for two PHP units as requested by the attending provider. In denying this request for coverage of further PHP, Optum did not follow its clinical best practices for discharge planning (column # 4 of the Level of Care Guidelines). In the records available, no mention is made of discharge planning until the reviewer cites the expectation of a step down the day before discharge as a reason why coverage criteria are no longer met. From the records available, the member seems to have been

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discharged with no Intensive Outpatient Program (IOP) in place. Optum's documented best practices specify that: a) members be discharged to further treatments that "mitigate the risk that the 'why now' factors which precipitated admission will reoccur" and b) members agree with the discharge plan (p. 6 of the Level of Care Guidelines). We have no evidence that either was true in this case. The evidence does show that the member's AP and its staff believed additional days were necessary and that an appropriate IOP step-down was unavailable. Nonetheless, coverage for additional days were denied by Optum, and the member was discharged. Another Case Record was also identified by the Examiners as an example of this practice.

In another Case Record, Optum recommended denial of coverage for continued care indicating the patient was appropriate for discharge based not on the patient's clinical condition, but rather on Optum's subjective judgment that the patient was making insufficient progress, or that the provider was not treating the patient aggressively enough. In this case, a patient presents for mental health (MH) PHP admission with a diagnosis of Major Depression. On or about page 49 of the Case Record, it documents a decision to deny coverage, in part, due to the lack of progress and the lack of an aggressive treatment plan.

- ii. Optum recommends denial of coverage for continued care indicating the patient was appropriate for discharge based on an unsupported conclusion that the treatment recommended by the patient's provider is primarily custodial. For example, in one Case Record a request was made for continued PHP for a patient post residential treatment for ETOH abuse. The patient also has diagnoses of sedative, hypnotic, or anxiolytic dependence and depressive disorder per the case presentation. On or about pages 36/37 of the Case Record it implies, under the Portal "Outcome" section, that criteria were not met for continued PHP as treatment is primarily custodial and IOP available. There is no evidence of the details in the "live review" found on or about page 39 of the Case

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Records to indicate that the patients care was custodial or that the provider was in agreement with a discharge from PHP to a lower level of care.

- iii. One additional Case Record was identified by the Examiners as an example this practice.
- e. Continuity of care and transition of care; safety and welfare.
 - i. Optum failed to adequately consider the patient's need for continuity and transition of care, and for the patient's safety and welfare when denying coverage requests for treatment approval. One Case Record, covers inpatient MH treatment followed by residential treatment. Patient was admitted to inpatient at one point due to aggressive and assaultive behavior in residential treatment. On or about page 649 of the Case Record it indicates the patient required residential treatment but there was no residential treatment bed available, so the coverage for continued inpatient stay was denied. The patient did not have a safe option for discharge and Optum did not consider the necessary transition and continuity of care in making the denial.
 - ii. The Examiners identified fourteen additional Case Records to demonstrate this practice.

9. Coercive utilization review practices. Optum engaged in coercive utilization review practices. For example:

- a. Optum's standard protocols suggest that provider requests for authorized treatment will be delayed unless the provider agrees to a shorter length of stay or lower level of care. The Examiners found two Case Records to demonstrate this practice, and these cases are summarized in Paras. 8(c)(ii), 84, and Paras. 78, 79, 80 & 87 respectively.
- b. Optum told providers that authorization for continued treatment can begin immediately if the provider agrees to a reduced length of stay or lower level of care; otherwise, a new and time-consuming pre-certification process would need to be conducted. For example, in one Case Record a denial for coverage of residential treatment after an inpatient detoxification is presented. The Optum staff person offered IOP then PHP after a peer review occurred. An Optum Staff

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note found on or about page 54 states "...CA informed UR staff that the authorization for PHP SA can be given starting today if [provider] agrees & accepts the level of care starting today, but advised if that if no acceptance for PHP SA is made today a new assessment & pre-cert request will be required on or after...[date of service]".

- c. Optum tells providers during the concurrent review process that if the provider does not respond to Optum's request for information by a time set by Optum, the provider's medical necessity request will be considered an administrative denial. An administrative denial limits appeal rights for providers and patients. For example, on or about page 12 of the Case Record there is documentation of a voicemail at 10:43 AM CST "reminded clinical update is needed today by 2PM est...remin[d]ed of need to authenticate mbr and facility prior to processing clinical information. Offered live review times as well as facility can access review [online] for completion of update...if update is not received by 2PM est., case would then be reviewed for administrative abd based on lack of compliance with UM Process".
- d. Optum schedules provider communications and peer to peer review consultations within unrealistic timeframes, forcing providers to choose between attending to their other professional obligations, and responding to Optum. Provider communications and consultations are less likely to occur in these circumstances. In one Case Record identified by the Examiners, as summarized in Paras. 9(a) & (b) above, Optum notes found on or about page 35 of the Case Record that state "I left a message on the voicemail [Optum Staff name] for [AP name] to schedule a peer review. I offered 8:30AM (CST)/9:30(EST) on [date]. I advised that the [Optum MD reviewer name] would place an outreach call to [AP name] [AP telephone number] at the scheduled time and in the event that our UBH MD does not reach the [AP name], then there is a 15-minute call back to complete the review." This was Optum's standard peer review practice and if the AP were not available, reviews were completed, and decisions made. One additional Case Record identified by the Examiners demonstrate this practice.
- e. The Examiners identified forty-five additional Case Records to demonstrate Optum's pattern or practice of using coercive communication processes.

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10. Additional unlawful utilization review practices. Optum engages in additional unlawful utilization review practices in violation of RIGL § 27-9.1-4(a)(3) and (4) and DOH Utilization Review Regulation §§ 4, 5, and 6. For example:

a. Peer to peer consultations.

- i. Optum engages in improper peer to peer consultation practices: (i) by scheduling inadequate and unreasonable time for provider consultations, (ii) by asserting that a peer to peer consultation occurred when it is more likely than not that the consultation did not occur or did not occur before the denial decision was made, and (iii) by failing to properly consider the provider's rationale for the treatment approval request. The Examiners identified five Case Records to demonstrate this practice.
- ii. The Examiners identified fifty-seven additional Case Records to demonstrate Optum's routine practice of inadequate or improper peer to peer communications and consultations.

b. Notices of Adverse Benefit Determination.

- i. Optum's Notices of Adverse Benefit Determination were unreasonable in that: (i) the language used in Notices can be dismissive and discouraging towards patients, (ii) the language used in Notices has the potential to undermine the patient's treatment, and the patient-provider relationship, and (iii) the information provided in Notices was incorrect or incomplete. For example, see one Case Record that is summarized in Paras. 7(a), 8(a), 77, 79, and 96. In this case, Optum's denial letter tells the patient that the residential treatment recommended by the treating provider was not necessary, thereby undermining the patient's relationship in circumstances in which maintaining sobriety in the face of the need for surgery posed a serious risk to the patient. The Examiners identified thirteen additional Case Records to demonstrate these practices.
- ii. Optum made denial decisions without stating the specific utilization review criteria or guidelines not met, thereby not stating the principal reason for the denial. For example, in one Case Record summarized in Para. 90, Optum denied coverage for continued stay in a partial hospitalization program, despite the patient's struggles and ongoing

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symptoms. The denial decision stated in general that criteria for partial hospitalization were not met but did not state the specific partial hospitalization criteria not met, or the facts and circumstances supporting a conclusion that specific criteria were not met. The Examiners identified two additional Case Records to demonstrate this practice.

- iii. Optum failed to notify patients and providers of their right to appeal an adverse benefit determination. The Examiners identified eleven Case Records to demonstrate this practice.
 - iv. The Examiners identified twenty-one Case Records that demonstrate Optum's practice of issuing denial notices that are inaccurate, insufficient, or unreasonable.
 - v. The Examiners identified twelve a Case Records to demonstrate Optum's practice of sending inappropriate letters to patients.
- c. Decision and appeal timeframes.
- i. Optum failed to comply with decision and appeal timelines. For example, in one Case Record summarized in Paras. 10(b)(ii) and 90, Optum denied continued partial hospitalization coverage because Optum asserted the patient was making insufficient progress and the facility was not providing sufficiently aggressive treatment. The provider requested an urgent appeal. Four days after the request the appeal had not been acted on. Optum terminated the appeal process after the patient was discharged, without acting on and processing the appeal as required. The Examiners identified two additional Case Records to demonstrate this practice.
 - ii. The Examiners identified twenty-one Case Records to demonstrate Optum's non-compliance with appeal due process and decision timelines.
- d. Optum failed to collect sufficient clinical information concerning the patient's clinical condition. The Examiners identified three Case Records to demonstrate this practice as summarized in Paras. 8(d)(ii), 13(c), 8(b)(ii), 8(c)(iii) and 87. The Examiners identified three additional Case Records to demonstrate this practice.
- e. Optum improperly classified denials as authorizations. In any case where there was no evidence of provider voluntary agreement to a lower level of care or lesser units of care than requested, the case should have been classified as a

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denial. As indicated in one Case Record, this frequently did not occur. This case has multiple concurrent reviews, with short duration approvals. In one instance during the course of this PHP, the treating provider requested 5 days of treatment in a program and Optum approved only 3 days without sufficient evidence of the provider's voluntary, bona fide agreement to reduce the number of days requested. The decision was classified as an approval but should have been classified as a denial. The Examiners identified eight additional Case Records to demonstrate this practice.

- f. Optum classified administrative denials as medical necessity denials. The Examiners identified one Case Record to demonstrate this practice.

11. Potentially impeding patient care. As a result of Optum's unlawful utilization practices described in Paras. 6 through 10, above, Optum has the potential to impede patient care, in violation of RIGL § 27-9.1-4(a)(3) and (4) and DOH Utilization Review Regulation § 3.2.12. For example, in one Case Record, Optum denied coverage for residential treatment following a detoxification admission, thereby potentially impeding treatment for a patient with significant psychiatric complications, poor refusal skills, high impulsivity, tendency to isolate, high levels of grief, shame and remorse and high levels of cravings. The patient had a bipolar disorder but was not yet being treated for the bipolar condition. The patient needed the 24-hr. structure and intervention of residential treatment to avoid relapse and risk of suicide. See also, three additional Case Records summarized in Paras. 8(b)(ii), 8(c)(ii), 84 and 69 respectively to support this finding. The Examiners identified thirteen additional Case Records to demonstrate the potential for impeding patient care.

12. Inadequate documentation. Optum's utilization review documentation practices were grossly inadequate in that they failed to consistently meet the documentation requirements of RI Insurance Regulation 67 and DOH Utilization Review Regulation § 4.1. Due to the lack of information provided in the Case Records reviewed by the Examiners, the Examiners may have been unable to identify other examples of unlawful utilization review practices which may have occurred. Further examination of Case Records will need to occur after documentation standards and procedures have improved. Examples of inadequate documentation practices include the following:

- a. Optum failed to collect and maintain adequate documentation of the patient's clinical condition to make an effective utilization review decision. All Case

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Records, including nine Case Records specifically identified by the Examiners to demonstrate this practice.

- b. Optum failed to evidence to the Examiners the collection and maintenance of documentation of the patient's medical records. The Examiners identified five Case Records to demonstrate this practice.
- c. Optum failed to adequately document the principal reasons for denial, including a response to the provider's request, and the specific criteria in relation to the patient's clinical condition and circumstances. The Examiners identified five Case Records to demonstrate this practice.
- d. Optum failed to adequately document the provider's rationale for the treatment approval request, and the clinical details offered by the provider in support of the request. The Examiners identified four Case Records to demonstrate this practice.
- e. Optum failed to adequately document the provider's agreement to a modification of the treatment coverage request. The Examiners identified eight Case Records to demonstrate this practice.
- f. Optum failed to document the clinical basis for reducing the provider's recommended length of stay or lowering the provider's recommended level of care. The Examiners identified five Case Records to demonstrate this practice.
- g. Optum failed to adequately document the content of the provider communications and peer to peer consultations. The Examiners identified eight Case Records to demonstrate this practice.
- h. Optum failed to adequately document providers' requests. The Examiners identified forty-four Case Records to demonstrate Optum's failure to adequately document the provider's treatment coverage approval request.
- i. Optum's documentation is poorly organized and includes incorrect, conflicting, and confusing information. This is evidenced in all Case Records, including nine Case Records specifically identified by the Examiners.
- j. Optum failed to adequately and correctly document the events and facts describing each utilization review. This is a common practice across all Case Records. Examples of this practice include nine Case Records specifically identified by the Examiners.

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- k. The credible evidence suggests, and the Examiners so find, that Optum manipulated the information documented in Case Records in order to make it appear that appeal process requirements were complied with. Case Records identified by the Examiners to demonstrate this practice include one Case Record summarized in Paras. 10(b)(ii) and 90, and an additional Case Record also summarized in Para., 90.
- l. The Examiners identified fifty-two Case Records to demonstrate Optum's practice of reducing the number of days or lowering the level of care requested by the provider without adequately documenting the provider's voluntary agreement to modify the request.
- m. The Examiners identified sixty-six Case Records to demonstrate Optum's practice of inadequate or insufficient documentation.

13. Behavioral health parity. Optum and United RI violated their behavioral health parity obligations under RIGL Chapter 27-38.2-1, and 42 U.S.C. § 300gg-26, in the following manner:

- a. A review of United RI's health benefit plans submitted via SERFF (System for Electronic Rates & Form Filings) issued for use in calendar years 2014 and 2015 revealed coverage exclusions that were unique to behavioral health conditions or services. As a result, coverage for behavioral health services during calendar years 2014 and 2015 was not "comparable to", or "subject to the same terms and conditions", as coverage for medical-surgical conditions and services. Since 2014 and 2015, these coverage exclusions have been eliminated from United RI's health benefit plans primarily at the request of OHIC during its annual benefit document review process.
- b. Optum applied its utilization review program to a much broader scope of behavioral health services than is the case with medical surgical services. Utilization review is applied to potentially deny coverage to the entire spectrum and continuum of care for patients with behavioral health conditions, excepting only out-patient behavioral health services. In contrast, utilization review of medical surgical levels of care is applied only to hospitalization and post-hospital settings, leaving some intensive hospital outpatient surgery and services, and some intensive procedures conducted in a doctor's office unaffected by the utilization review process.

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- c. The benefit plans issued by United RI in 2014 applied a restrictive exclusion related to medical necessity for all mental health services and substance use disorder services that is not applied as an exclusion to medical surgical services. See the SG Certificate of Coverage, UHLC 201, form number 53. Compare Section 2(H) (Mental Health) and Section 2(Q) (Substance Use Disorders), with Section 2(N) (Providers) and Section 2(M) (Procedures and Treatments).
- d. Optum's utilization review program for behavioral health services was applied in a more stringent manner than was the case with medical surgical services. For example, in one Case Record Optum denied coverage in an intensive outpatient program for a patient with ongoing opioid and cocaine dependence and who was at risk of suicide. Optum determined that the patient had stayed too long in the program. If a patient with diabetes came in to the hospital with a diabetic crisis with unstable blood sugar levels, after days of inpatient stay, diet restrictions, and med changes, the insurance company would not deny coverage requests to extend the stay because the patient had been in the hospital too long. Optum stated that substance abuse disorder is a chronic illness that should be treated in a long-term care, custodial treatment mode, and therefore asserted the patient did not need treatment in a supportive environment represented by the treatment program recommended by the provider. These statements of Optum demonstrate an archaic, discriminatory perception of behavioral health conditions and treatments, and are not comparable to how chronic medical-surgical conditions are addressed.
- e. The benefit plans issued by United RI in 2014 applied a restrictive exclusion related to medical necessity to all mental health services and substance use disorder services that was not applied as an exclusion to medical surgical services.
- f. Optum's utilization review program was applied in a more stringent manner than was the case with medical surgical services. The Examiners identified seven additional Case Records to demonstrate this practice.

Behavioral health - recommendations.

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14. United RI shall² implement the following necessary and appropriate Recommendations to remediate the violations described in Paras. 4 through 13 and 35 through 41. On or before July 31, 2020, United RI shall file a proposed Plan of Correction to implement each of the following Recommendations, for the Commissioner's consideration. On or before August 31, 2020, United RI shall file a final Plan of Correction approved by the Commissioner to implement each of the following Recommendations.

15. United RI shall provide effective oversight of Optum's policies and procedures, and its administration of United RI's utilization review programs, to ensure full compliance with state and federal laws, and to discontinue the patterns and practices of non-compliance documented in this Report.

16. United RI shall establish revised behavioral health utilization review criteria, in the manner set forth in (a) through (h), below:

- a. Only objective, clinically appropriate, clinically based, and measurable written criteria shall be used to deny provider requests for coverage of behavioral health services.
- b. The practice of frequent, short duration concurrent reviews *unrelated* to the clinical condition of the patient shall be prohibited. United RI shall adopt a clinically appropriate national utilization review criteria set which includes an estimated length of stay (ELOS) component when available or, a comparable process approved by the Commissioner, and such approval shall not be unreasonably withheld. The development and application of such criteria shall include a documented process to address the patient's clinical condition and the provider's ELOS in order to avoid unnecessary frequent short duration reviews and shall account for dually diagnosed patients.

² This Examination primarily targeted Carrier records and operations relating to the 2014 calendar year. OHIC recognizes that since 2014 United RI and Optum have revised some of the criteria, policies and practices at issue in this Examination. Although OHIC uses the term "shall" throughout its recommendation sections, OHIC further recognizes that United RI may provide documentation in the plan of correction process for approval by the Commissioner that demonstrates for the Commissioner that United RI's and/or Optum's current (revised) criteria, policies and/or practices adequately and appropriately address and remediate violations described in Paras. 4 through 13 and 35 through 41.

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- c. United RI shall identify the specific formal criteria that will be used to make utilization review decisions. There shall be no ambiguity concerning which criteria are applicable for example, Level of Care Guidelines versus Coverage Determination Guidelines found during this Examination.
- d. United RI's utilization review processes shall include a documented process that offers providers an opportunity to request approval of a behavioral health service that has been determined by United RI to be inconsistent with United RI's formal criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances and safety and welfare of the patient. Such decisions shall be considered medical necessity decisions. The UR Agent clinical reviewer shall consider, address, and document all information submitted by the ordering provider in connection with this process as part of the medical necessity decision.
- e. The process for soliciting comments from Rhode Island behavioral health providers concerning proposed utilization review criteria shall be revised to improve the comment process in order to increase transparency. The process shall require United RI to reasonably and meaningfully consider and document all objections, comments and recommendations concerning the criteria. The process shall include implementation of the rules and regulations promulgated pursuant to R.I Gen. Laws § 27-18.9.
- f. Utilization review criteria shall include detailed, clinically appropriate, clinically based guidelines to ensure safe and effective treatment for patients whose behavioral health condition results in an inability to maintain basic self-care and the ability to safely transition to another treatment environment.
- g. United RI's general definition of medical necessity shall not include a discretionary clause, shall be used in a manner consistent with state and federal utilization review laws and regulations and shall not modify the elements of any specific Optum formal criteria applicable to different levels of care.

17. United RI shall revise its behavioral health utilization policies and procedures, in the manner set forth in (a) through (o), below. Each revised policy and procedure shall be subject to a component of a utilization review program training manual and training module. Compliance with the revised policies and procedures shall be monitored by this oversight policy.

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- a. Denial decisions shall be supported by, and not in conflict with, the facts, observations, clinical records, and other information as presented in the Case Record.
- b. Optum shall document a clinically appropriate and clinically based rationale when making a coverage determination for treatment at a lower level of care when the ordering provider's initial request was for a higher level of care.
- c. If the facts and circumstances presented suggest reason to believe that clinical information material to the utilization review decision is missing, United RI shall reasonably solicit such clinical information from the provider.
- d. The utilization review decision shall adequately consider in accordance with reasonable standards: (i) the patient's clinical condition, (ii) the treating provider's treatment recommendation and rationale for the request, and (iii) all relevant information offered or included in the record.
- e. When the material facts and clinical circumstances presented by the attending provider are not in dispute, the utilization review decision should not conflict with the treating provider's level of care and/or length of stay recommendation unless United RI documents clinical facts of the case to demonstrate the care requested is not medically necessary or has documentation in accordance with paragraph 17(f).
- f. There shall be clearly documented evidence to support a conclusion that the treating provider has voluntarily agreed to modify the treating provider's request so as to reduce the length of stay or lower the level of care initially requested. In the absence of such clearly documented evidence, the modified request shall be considered a denial, not an authorization.
- g. (This paragraph is intentionally left blank for formatting purposes).
- h. (This paragraph is intentionally left blank for formatting purposes).
- i. Until United RI fully addresses the safe transition of the patient, United RI shall not deny a request for coverage of a continued stay if there is no clinically appropriate treatment setting available for the patient upon discharge that would ensure the patient's health and safety, unless United RI has documentation in accordance with paragraph 17(f).

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- j. Until United RI fully addresses the safe transition of the patient, United RI shall not deny a request for coverage of a continued stay, in whole or in part based on the rationale that the patient is making insufficient progress, or the provider is not treating the patient aggressively enough, unless United RI has documentation in accordance with paragraph 17(f).
- k. A patient shall not be denied coverage for continued stay based on United RI's rationale that the level of care is "custodial" when the attending provider has demonstrated that there continues to be medically necessary treatment value unless United RI documents clinical facts of the case to demonstrate the care requested is not medically necessary or has documentation in accordance with paragraph 17(f).
- l. (This paragraph is intentionally left blank for formatting purposes).
- m. The utilization review process shall not be used to address quality of care issues. The revised policy shall describe alternative means to address quality of care issues observed during the utilization review process.
- n. The utilization review process shall require United RI to consider and document whether a potential utilization review denial might impede care, delay care, fail to ensure continuity of care, lead to an inappropriate transition of care, or to negatively impact the welfare and safety of the patient.
- o. Denial notifications shall avoid language that might unnecessarily adversely affect the patient, and/or language that may undermine the provider-patient relationship.

18. United RI shall revise its documentation policy and procedure with respect to its behavioral health utilization review records ("Case Records"). Compliance with the Case Record documentation policy shall be an explicit component of a utilization review program training manual and training modules. Compliance with the policy shall be monitored as part of United RI's compliance oversight activities. The revised documentation policy shall include the following requirements:

- a. Case Records shall include the date, time and detail of each event in the utilization review process.
- b. Case Records shall include the specifics of the initial provider request, and any modifications to the initial request.

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- c. Case Records shall document the content of all conversations or other communications with the treating provider or the treating provider's designee.
- d. Case Records shall document all clinical information offered by the provider to include the rationale for the provider's initial and any subsequent request for coverage of services.
- e. Case Records shall document the utilization review decision to include: (i) the patient's clinical condition, (ii) the treating provider's treatment recommendation and rationale for the request, and (iii) all relevant information offered or included in the record.
- f. Case Records shall be maintained in a manner to identify and report to OHIC evidence of compliance with state and federal laws and regulations.
- g. Case Records shall include evidence of an independent utilization review decision and rationale of the United RI's clinical reviewer as required by state and federal laws and regulations.
- h. Case Records shall include documentation by United RI's clinical reviewer of all material clinical information that was reviewed in making the medical necessity determination and in the case of denials shall also include documentation of the specific utilization review criteria not met.
- i. When United RI recommends a modification of the ordering provider's initial request, the Case Record shall document the clinically based rationale for recommending the modification over the ordering provider's initial request.
- j. The Case Record shall document the ordering provider's explicit communication of a voluntary agreement to modify the provider's initial request.
- k. Case Records shall be collected, organized, and maintained in a form readily accessible and reviewable by regulatory examiners for the purpose of assessing compliance.

19. United RI shall review, and as necessary revise, the scope of behavioral health services subject to prior authorization. United RI shall ensure that its utilization review program is conducted in a manner comparable to, and no more stringent than its utilization review program for medical surgical services. United RI shall demonstrate compliance with state and federal mental health parity law, regulations, and guidance through a plan-specific analysis of the methodologies and processes applied to determine the application of each NQTL to med/surg

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and MH/SUD benefits in each classification. This analysis shall focus on the comparability of processes and methodologies used to justify application of an NQTL to med/surg and MH/SUD benefits consistent with state and federal laws, regulations and guidance. United RI shall submit, in the proposed and final Plan of Correction the form, content, and plan year for data collection purposes of a utilization review parity analysis consistent with the following. If United RI believes that some elements of the following are not feasible or can be substituted with other parity information or analysis, United RI may explain its reasoning and suggest alternatives for the Commissioner's consideration as part of its proposed and final Plan of Correction:

- a. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) are subject to utilization review and: (i) describe the utilization program for each mental health, substance use disorder, and medical surgical benefit, (ii) state the number of requests processed for each mental health, substance use disorder, and medical surgical benefit, and (iii) state the number of denials, appeals, and denials on appeal for those requests processed for each mental health, substance use disorder, and medical surgical benefit.
- b. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) are not subject to utilization review and state the number of claims processed for each mental health, substance use disorder, and medical surgical benefit.
- c. For each mental health, substance use disorder, and medical surgical benefit identified in Paras. 19(a) and 19(b), above: (i) state the material reasons or other factors actually used or relied on in deciding whether or not utilization review would apply, (ii) identify and summarize the data and other information used to support the reasons or other factors, and (iii) document the decision process.
- d. For each mental health, substance use disorder, and medical surgical benefit subject to utilization review identified in Paras. 19(a) and (b), above, propose a methodology for determining whether utilization review for mental health and substance use disorder benefits are applied no more stringently than utilization review applied to medication surgical benefits. Such a methodology should: (i) use actual utilization review Case Records in comparing the degree of stringency, (ii) use independent providers to conduct the reviews, (iii) compare

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the time needed to complete utilization review requests for behavioral health services versus medical surgical services, (iv) compare the complexity of making behavioral health coverage requests versus medical surgical coverage requests and (iv) consider any other appropriate factors in determining the comparable rigorousness of the reviews.

Prescription drugs - findings.

20. During the time periods examined, United RI entered into a delegation contract with OptumRX to administer the utilization review function for behavioral health-related prescription drugs. Notwithstanding such delegation, and notwithstanding OptumRX's independent legal responsibilities, United RI is separately and entirely responsible for any failure of compliance by Optum with state and federal RI health insurance laws and regulations.

21. In accordance with the methodology described in Para. 3, above, the Examiners selected 183 prescription drug utilization review Case Records relating to requests for approval of prescription drugs used for the treatment of behavioral health conditions. Of those 183 prescription drug Case Records, 89 cases resulting in an authorization of the request were reviewed by the Examiners. Of those 89 prescription drug authorization cases, 6 were forwarded to the MGH Clinicians for review of clinically related issues. Of those 183 prescription drug Case Records, 76 were cases that resulted in a denial of the request and all were reviewed by the Examiners. Of those 76 prescription drug Case Records, 13 were forwarded to the MGH Clinicians for review of clinically related issues. Of those 183 prescription drug Case Records, 8 cases resulting in an appeal of an initial denial were reviewed by the Examiners. Of those 8-prescription drug appeal case, all 8 were forwarded to the MGH Clinicians for review of clinically related issues. All 183 prescription drug Case Records (authorizations and denials), were reviewed by the Examiners for non-clinical -related issues.

22. The Examiners find that the conduct, policies or procedures described in Paras. 23 through 29 constitute patterns or practices which violate the requirements of RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), the DOH Utilization Review Regulations, and/or the DOH Health Plan Certification Regulations. The Findings of Fact and Conclusions of Law set forth in Paras. 100 through 169 are incorporated by reference in this Summary of Prescription Drug Findings and Recommendations (Paras. 23 through 29).

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23. OptumRX used clinically inappropriate utilization review criteria approved by United RI to determine coverage for prescription drugs related to behavioral health conditions in violation of RIGL_§ 27-9.1-4 (3) and (4) and DOH Utilization Review Regulation § 3.2.20. For example:

- a. Medication assisted treatment.
 - i. The use of prior authorization for medication assisted treatment of opioid dependence disorders is clinically inappropriate.
 - ii. In one Case Record, Optum denied a prescriber's request for coverage of Suboxone for a patient with opioid dependence, because the prescriber did not disprove use of the medication for pain management purposes (on or about page 5 of Case Record). By denying coverage of a critical medication for a reason secondary to the patient's addiction, the patient was placed at risk of overdose and harm. In another Case Record, the prescriber had inadvertently noted a diagnosis code for this patient using ICD-9 code of 304.91 which is for unspecified drug dependency. OptumRX denied (on or about page 5 of Case Record) the request for coverage of Suboxone even though it was more likely than not the patient needed the medication for opioid dependence. The denial was later overturned but, meanwhile, filling the prescription for this essential and life-saving medication was delayed.
 - iii. The use of a more stringent prior authorization process for medication assisted treatment for opioid dependence disorders than for comparable medications for medical surgical conditions violates state and federal parity requirements.
 - iv. The opioid crisis facing Rhode Island and many other states demands, and has demanded for many years, an urgency by health care providers and health insurance companies that has not always been reflected in their response to the emergency. Furthermore, whatever value there is in imposing utilization review limitations on treatment for opioid dependency is far outweighed by the risk of harm or death to the patient, and negative impact on public health from failing to treated opioid dependent patients without delay.

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- v. The Examiners appreciate the willingness of United RI and the other Carriers to collaborate with the Office during the spring of 2017 to eliminate prior authorization requirements for medication-assisted treatment.
- b. The approval criteria used by OptumRX for Seroquel and Abilify failed to account for clinically appropriate off-label uses and doses. For example, in one Case Record a phone request was made by a prescriber for quetiapine (Seroquel) 25 mg X 30 to be taken at bedtime for a patient with the diagnosis of bipolar disease. OptumRX reviewer notes (on or about page 7 of Case Record) state "Per MDO call pt has bipolar but reason to exceed quantity limit does not meet criteria." A denial was issued as OptumRx stated that more than 42 pills/year is covered only if you are using this drug to treat OCD or adjunct to antidepressant therapy or if the patient needs a higher quantity to achieve dose not commercially available, to re-titrate or dose taper due to intolerance/instability of dose, adjust doses for hepatic insufficiency or adjust dose for use with CYP450 3A4 inhibitor. OptumRX denied a request for coverage of for low dose of a medication even though the low dose was a commonly prescribed off-label use by providers who typically treat patients with these diagnoses. The Examiners identified four additional Case Records to demonstrate this practice.
- c. The utilization review criteria used by OptumRX did not permit approval of Bupropion SR for patients with major depressive disorder, a commonly prescribed indication. For example, in one Case Record, the AP submits an urgent fax form request for Bupropion SR (150 mg generic for Zyban 150mg) for a patient with general anxiety disorder and major depression. The patient has been on this medication for over seven years. Case notes dated [date] (on or about page 6 of the Case Records) state "Not using for smoking cessation. I called the provider's office and unable to reach a staff member. I was unable to obtain any of the necessary information". The coverage request was denied because the medication was not being used for smoking cessation. Not only is this medication commonly used for treating depression, this patient had been stable on this medication for several years and the AP had documented failure on 3 other medications prior to the use of Bupropion SR.

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- d. The prior authorization criteria used by OptumRX failed to include an opportunity for the provider to support a clinically based exception to the criteria, given the particular patient's condition, treatment needs, and the safety and welfare of the patient. For example, in one Case Record summarized in Para. 23(b), there is no evidence that OptumRX provided an opportunity or made a reasonable effort to obtain clinical information to substantiate the need for an exception for this patient who was already on this medication as indicated on or about page 6 of the Case Record (reason for exceeding the OptumRX dosing requirement is "Maintenance"). The Examiners identified two additional Case Records to demonstrate this practice.

24. The prior authorization criteria applied by OptumRX was used in a clinically inappropriate manner in violation of RIGL§ 27-9.1-4(a)(3) and (4) and DOH Utilization Review Regulation § 3.2.20. For example:

- a. OptumRX applied incorrect facts to its utilization review decision. For example, in one Case Record the AP fax form request (on or about page 6) was for Brintillex 10 mg 4x per day for a patient with major depressive disorder. OptumRX electronic case notes found on or about page 3 indicate that the AP request was for 20 mg tablets once a day for a total of 30 pills which is inaccurate. The facts of this request were not accurately presented and therefore the approval was not based on facts. In this case, the AP did not receive coverage approval for what was requested on the fax form (the drug, the milligrams and the # of pills per day) and therefore this was a denial, not an authorization as presented by OptumRX.
- b. OptumRX used incorrect or non-existent criteria in denying a request for coverage. For example, in one Case Record the AP faxed a request for Lamictal XR 50 mg on [date]. The AP indicated that the patient had received a trial of the generic form of this medication and was intolerant to the generic. The OptumRX reviewer recognized the patient's intolerance to the generic, which was one of the criteria for approval, but a denial was nonetheless made based on the failure of the AP to report the patient's intolerance to the generic through FDA Adverse Event Reporting System (FAERS). There is no evidence to substantiate an OptumRX or UHC clinical criteria that relates to this denial rationale. The Examiners identified two additional Case Records to demonstrate this practice.

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- c. OptumRX routinely required prescribers to notify the FDA's Adverse Event Reporting System (Examiners note this FDA reporting is not mandatory for professional providers) as a condition for approval of some medications, when prescribers commonly do not notify the FDA unless a severe reaction is experienced. See Paras. 24(b) for one Case Record as evidence of this finding.
- d. Prior to making a denial, OptumRX failed to adequately consider all of the information offered by the prescriber in a manner to ensure the safety and welfare of the patient. The Examiners identified thirty-one Case Records to demonstrate this practice.

25. OptumRX failed to adequately consider the patient's need for continuity of care in violation of RIGL § 27-9.1-4(a)(3) and (4) and DOH Health Plan Certification Regulation § 3.2.3. The fact that a patient was being successfully treated by a particular medication, or a specific dose, frequently is not considered by OptumRX to be a reason to approve the medication. For example, in one Case Record, summarized in Para. 23(c), OptumRx denied coverage for this prescription for Bupropion notwithstanding the patient has been successfully treated on the medication for at least 8 years. The Examiners identified thirty-three additional Case Records to demonstrate this practice.

26. OptumRX engaged in additional unlawful utilization review practices in violation of RIGL § 27-9.1-4(a)(3) and (4) and DOH Utilization Review Regulation §§ 4, 5, and 6. For example:

- a. OptumRX did not routinely state in its approval notice whether the prescriber's request (including the dose and quantity of the request) had been approved or denied. For example, in one Case Record summarized in Para. 24(a), the approval notification letter states "We are pleased to inform you that your prescription for Brintellix has been approved for coverage up to the plan's supply limit for this medication. This medication is approved for coverage until [date] or until coverage for the medication is no longer available under the benefit plan or the medication becomes subject to a pharmacy benefit coverage requirement, such as supply limits or notification, whichever occurs first." There is no dose or quantity noted in this letter to indicate if the patient/beneficiary received what the prescriber requested. The Examiners identified two additional Case Records to demonstrate this practice.
- b. OptumRX used improper prior authorization Fax forms. For example:

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- i. OptumRX's Fax forms do not routinely solicit information from the prescribers concerning whether the prior authorization request is urgent. The OptumRX standard electronic format identifies this question for OptumRX Staff as follows, "Based on a fax or phone Request, is this an urgent request?" In the associated "Tech Note" following this question it states that this is an internal question only and directs the OptumRX staff to "not ask caller." This is a question that should be asked of all RX requests regardless of telephone or fax form transmission of such requests. While the fax forms do inform prescribers on how to make an urgent request separate from the fax form, that type of instruction is likely to lead to incomplete information and unnecessary delays, and such a barrier in the case of an urgent appeal is unreasonable. Most Case Records demonstrate this practice, including three Case Records specifically identified by the Examiners.
- ii. OptumRX's Fax forms failed to solicit essential information needed to reasonably process the utilization review request. For example, in one Case Record the AP used the OptumRX Medication Prior Authorization Form to request Quetiapine 25mg 3 tablets per day for a patient that had been on this medication and stable for 5 months. Documentation on or about page 7 of this Case Record and the associated denial notification letters state the denial is based on health plan criteria and further state that greater than 42 pills in one year are covered if the medication is being used for schizophrenia or bipolar disorders. Also, to use higher quantities must be for reasons that include increasing or decreasing the dose, taking a dose that is currently not available or to change dosing due to liver issues. Other reasons to cover could be that patient is taking a certain type of medication with quetiapine fumarate called CYP450 3A4 inhibitor. The electronic notes state further that higher quantities can also be for treating OCD and taking it with another medication to treat depression. UR reviewers claim that the patient did not meet any of these criteria. The fax form asks for the reason for the request noting the possibility that "chart notes will be requested if further documentation is

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necessary”, the name of the medication, the strength with directions for use, a diagnosis code and the date the patient started on this medication. The questions on the Optum fax form did not address the totality of information that is needed to adequately review the patient’s clinical status as it related to the denial. Most Case Records demonstrate this failure, including one Case Record specifically identified by the Examiners.

- iii. OptumRX's fax forms did not contain or reference the applicable approval criteria, and thereby did not provide adequate advance notice to prescribers of what must be demonstrated for approval of a request. For example, in one Case Record summarized in Para. 26(b)(ii), OptumRX did not communicate, in advance, what information would be necessary to obtain approval for this requested medication. Most Case Records demonstrate this failure.
 - iv. The Examiners identified sixteen additional Case Records to demonstrate the practice of deficient Fax forms supporting findings in Paras. 26(a) and (b) above.
- c. OptumRX failed to make reasonable efforts to solicit and obtain, by telephone or by other means, information necessary to reasonably and fairly process the prior authorization request. One Case Record identified fax request for 20 MG Vortioxetine (Brintellix) once per day for major depression. The fax form states the patient had tried and failed two other medications. The date of signature of the AP on the fax form is [date] and the provider notes that this is a second request (this fax receipt date is [date]). The notification letter found on or about page 10 of the Case Record states the denial decision is based on the patient not having tried and failed at least three other medications or that there is no documentation that the patient had been on the medication while being treated inpatient and stable on this medication. There are no questions asked on the fax form that match up with the criteria set by UHC (failing at least three medications) nor asked during a conversation which appeared to have taken place with the AP's office on [date] as noted on or about page 8 of this Case Record. Further, it states on the fax form (on or about page 9) that the patient chart notes will be

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- requested if further documentation is necessary. Given the reason for the denial and the limited information obtained by UHC, there was an inadequate effort to obtain the necessary information to make this denial decision. The Examiners identified ten additional Case Records to demonstrate this practice.
- d. OptumRX routinely did not request medical records of the patient when necessary, despite notifying prescribers that such requests would be made. In one Case Record summarized in Para. 26(c), no medical record was obtained as proposed by OptumRX given that additional information was, in fact, necessary.
 - e. OptumRX classified as authorizations cases that should have been classified as denials as shown, in one Case Record summarized in Para. 24(a). The Examiners identified five additional Case Records to demonstrate this practice.
 - f. OptumRX misrepresented the facts and circumstances of utilization review cases. For example, one Case Record was identified by the Examiners to demonstrate this practice.
 - g. OptumRX failed to state, in the Case Record, the principal reasons for denial specific to the patient and/or failed to address the prescriber's rationale for the request as shown in one Case Record summarized in Para. 26(b)(ii). The Examiners identified six additional Case Records the UR Agent clinical reviewer shall consider, address, and document all information submitted by the prescriber in connection with this process as part of the medical necessity decision to demonstrate this practice.
 - h. OptumRX failed to adequately consider the welfare and safety of the patient. For example, in one Case Record there was a fax request for Abilify 5 mg 1 ½ po qd for continued treatment for a patient with a diagnosis of major depression. Additional information on this fax form (on or about page 10) documents that the patient has been stabilized on this medication for over 2 years and that the dose was increased to 7.5 with good effect and good control substantiating a clinical indication for this dosing. The notification documents the decision to deny coverage was "based on the health plan criteria for Aripiprazole. More than 42 pills for one month are covered only if: "You require a higher quantity for dose titration." On or about page 5, the OptumRX electronic notes indicate that it is not known if the quantity of medication was being

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requested for titration purposes, yet the fax form is filled out indicating that it was not and on or about page 6 the documentation by UR staff recognized that this was not being used for titration. This information is inconsistent within the Case Record and the UR staff inconsistently and inappropriately presented only portions of what the provider presented on the fax form in making its decisions. Further, this member was stabilized on this medication and OptumRX did not take into consideration the welfare of the patient and the potential for destabilizing the patient in denying coverage for this medication. The Examiners identified six additional Case Records to demonstrate this practice.

- i. OptumRX failed to adequately consider all of the information offered by the prescriber, including the prescriber's rationale for the request as evidenced in one Case Record summarized in Para. 26(g). The Examiners identified twenty-five additional Case Records to demonstrate this practice.
- j. OptumRX failed to evidence that a thorough, independent review of the prescriber's request was conducted by the OptumRX clinical reviewer. For example, one Case Record presents a fax form for Suboxone 8mg/2mg 60 tablets po bid. Start date for the medication is the date of the request [date]. A diagnosis code on this fax form (ICD-9 code of 304.91) is unspecified drug dependency. The documentation does accurately state that the AP did not specify what specific drug the patient was dependent on and that the provider is appropriately certified to prescribe and treat with Suboxone. The OptumRX staff states that this could mean that the dependence could be "...tobacco, opioid...". There was apparently an outreach attempt and once again the UR staff was "...unable to reach a staff member." However, the Case Record contains no evidence of reasonable attempts or dates or times of calls. This UR staff's documentation does not rationally assess this AP request. Notable is that the AP is a certified suboxone provider obligated to the federal government to use Suboxone in the manner intended. This case shows a lack of effort on the part of the UR Agent and is inaccurate in the notification letters when stating that "Suboxone film is denied. Your plan's pharmacy criteria for Suboxone film require the following: (1) You are being treated for opioid dependence; AND (2) the medication is not being used for pain management." There is no evidence that

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the OptumRX reviewing provider considered the impact to this compromised patient of not obtaining this necessary medication in a timely manner to treat the patient's dependency. Also, the denial rationale did not change beginning with the OptumRX staff and continuing through the OptumRX clinical reviewer. The Examiners identified forty-three additional Case Records to demonstrate this practice.

- k. OptumRX failed to utilize a process to address clinically appropriate uses of, and doses for off-label medications not falling within standard approval criteria to assure the safety and welfare of the patient. Most Case Records reflecting a prescriber's request for off-label use of medications demonstrated this failure, including, for example, four Case Records specifically identified by the Examiners.
- l. OptumRX routinely required patients to make written authorizations for the prescriber to conduct an appeal on the patient's behalf. For example, one Case Record evidences a denial for Quetiapine. This denial was appealed after the prescriber submitted a signed "Appointment of Representative Statement" form (see on or about page 5 of Case Record). OptumRX should not have required such appointment forms to be completed for a provider to appeal. The Examiners identified one additional Case Record to demonstrate this routine OptumRX practice.

27. As a result of the patterns and practices identified in Paras. 20 through 26 above, OptumRX potentially delayed and/or impeded patient care in violation of RIGL § 27-9.1-4(a)(3) and (4) and DOH Utilization Review § 3.2.12. The Examiners identified eight additional Case Records to demonstrate this practice.

28. Inadequate documentation. OptumRX's utilization review documentation practices were grossly inadequate in that that they failed to consistently meet the documentation requirements of RI Insurance Regulation 67 and DOH Utilization Review Regulation § 4.1. Due to the lack of information provided in the Case Records reviewed by the Examiners, the Examiners may have been unable to identify other examples of unlawful utilization review practices which may have occurred. Further examination of Case Records will need to occur after documentation standards and procedures have improved. Examples of inadequate documentation practices include the following:

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- a. OptumRX failed to adequately document essential information related to the utilization review event. See evidence in one Case Record summarized in Para. 23(a). The Examiners identified six additional Case Records to demonstrate this practice.
- b. OptumRX failed to accurately document whether the medication or dose requested was approved. See evidence in one Case Record summarized in Para. 24(a). Though all Case Records demonstrate this failure, the Examiners specifically identified five additional Case Records to demonstrate this practice.
- c. OptumRX failed to include in the Case Record the fax form sent in by the prescriber, and other information offered by the subscriber. See evidence in one Case Record summarized in Para. 23(b). The Examiners identified one additional Case Record to demonstrate this practice.
- d. OptumRX failed to accurately document the events of the utilization review case. See evidence in one Case Record summarized in in Para. 26(g). The Examiners identified one additional Case Record to demonstrate this practice.
- e. OptumRX failed to document the prescriber's initial request as evidenced in one Case Record summarized in Para. 24(a). Though all Case Records demonstrate this failure, seventeen additional Case Records specifically identified by the Examiners demonstrate this practice.
- f. OptumRX failed to document the date and content of prescriber communications as evidenced in one Case Record where the prescriber requested duloxetine 30 mg. The documentation does not clearly present what the provider originally requested, as this was a phone call, and OptumRX merely documents on or about page 4 that the quantity per day is 2 which appears to be stated on or about page 5. Additional information on or about page 5, implies per the Message Code: ADDLQTY and a phone number for the AP. Then it states "Please Review" followed by standard language for plan limits-doses, quantities and supply limits. In this case the letters are written in a manner that states "We are pleased to inform you that the additional supply of Duloxetine hcl requested by your physician has been approved up to the plan's supply limit for this medication" and then goes on to attach to these "approval" letters to the prescriber and patient appeal rights, thereby indicating a denial was made at

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some point. Consequently, it is unknown what was originally requested, what the supply limit is or why an appeal is being offered if the coverage provided was an approval of the prescriber's request. While indications point to a conclusion that this was a denial or a modification/agreement to change an initial AP request, there is insufficient information to validate what actually occurred given the lack of documentation of the AP communication.

The Examiners identified three additional Case Records to demonstrate this practice.

- g. OptumRX failed to document the prescriber's voluntary agreement to modify the prescriber's request as evidenced in one Case Record summarized in Para. 24(a). The Examiners identified one additional Case Record to demonstrate this practice.
- h. OptumRX failed to document consideration by the OptumRX reviewer of all of the information offered by the prescriber as evidenced in one Case Record summarized in Para. 26(b)(v).
- i. OptumRX failed to include accurate information concerning continuation therapy in the Case Records as evidenced in one Case Record described in Para. 23(c). The Examiners identified one additional Case Record to demonstrate this practice.
- j. OptumRX failed to document the dates and sequences of required events in the utilization review process as evidenced in one Case Record summarized in Para. 26(b)(v). The Examiners identified one additional Case Record to demonstrate this practice.
- k. The Examiners specifically identified forty-nine Case Records to demonstrate inadequate documentation, or failure to solicit necessary information and findings presented in a-j above.

29. OptumRX's utilization review program for medications used for behavioral health conditions was applied in a more stringent manner than was the case with medications for medical-surgical conditions. Six Case Records specifically identified by the Examiners demonstrate this practice.

Prescription drugs - recommendations.

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30. United RI shall implement the following necessary and appropriate Recommendations to remediate the violations described in Paras. 20 through 29 and 35 through 41. On or before July 31, 2020, United RI shall file a proposed Plan of Correction to implement each of the following Recommendations, for the Commissioner's consideration. On or before August 31, 2020, United RI shall file a final Plan of Correction approved by the Commissioner to implement each of the following Recommendations.

31. United RI shall provide effective, independent oversight of OptumRX's policies and procedures, and its administration of United RI's utilization review programs, to ensure full compliance with state and federal laws, and to discontinue the patterns and practices of non-compliance documented in this Report. This oversight program that is initiated shall be submitted as part of the proposed and final Plan of Correction.

32. United RI shall revise its prescription drug utilization review criteria in the manner set forth in (a) through (c), below.

- a. The utilization review process shall include a process that offers prescribers an opportunity to request approval of a medication (or of a quantity, supply or dose of a prescription drug) inconsistent with the formal criteria and/or formulary, based on the unique or unusual nature of the patient's clinical condition or circumstances and the safety and welfare of the patient. Such decisions shall be considered medical necessity decisions. The UR Agent's clinical reviewer shall consider, address, and document all information submitted by the prescriber in connection with this process as part of the medical necessity decision.
- b. The process for soliciting comments from Rhode Island behavioral health providers concerning proposed utilization review criteria shall be revised to improve the comment process in order to increase transparency. The process shall require United RI to reasonably and meaningfully consider all objections, comments and recommendations concerning the criteria, prior to the effective date of the adoption or revision of criteria. The process shall include implementation of the rules and regulations promulgated pursuant to R.I Gen. Laws § 27-18.9.
- c. United RI shall revise its utilization review criteria as part of its adverse benefit determination process and/or as part of its internal appeal process for Seroquel, Abilify, and Bupropion according to Para. 32(a) above.

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33. United RI shall revise its prescription drug utilization review policies and procedures for medications typically prescribed, as set forth in (a) through (m), below. Each revised policy and procedure shall be subject to an explicit component of a utilization review program training manual and training module. Compliance with the policies and procedures shall be monitored by this oversight policy.

- a. The "trial" period for step therapy criteria shall be based on generally accepted medical standards, shall be evidence-based, and shall allow for a patient to bypass the trial period if the prescriber indicates that there is or was a contraindication to the alternative medication or the patient has/had previously used the alternative medication.
- b. United RI shall fully consider and address the need for continuity and transition of care when:
 - i. Step therapy or "fail first" procedures are being applied and;
 - ii. Requests are made for approval of a medication (or for a quantity, supply, or dose of a medication) in cases where the patient is being treated successfully with the medication requested (or is being treated successfully at the requested quantity, supply or dose of the medication), or if the prescription is being renewed.
- c. United RI shall revise its policies and procedures as part of its proposed and final Plan of Correction to account for the patient's need for continuity and transition of care when: (1) the patient has been prescribed the medication as a member of a different health plan and/or formulary issued by United RI, (2) the patient has been prescribed the medication as a member of a health plan issued by a different carrier, (3) the patient has been prescribed a medication that is no longer on the formulary due to a United RI issued formulary change, and (4) the patient has been prescribed medication using samples supplied to the prescriber by a pharmaceutical company. For scenario number four herein, United RI shall implement a transition fill program that allows the member to remain on the prescribed sample medication for a period of time before converting to a formulary alternative. The member may remain on the prescribed sample only when clinically appropriate and medically necessary and provided the continuity of care, welfare and safety of the patient is ensured.

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- d. United RI shall explicitly consider all information that suggests that the request for a medication (for a particular prescription drug, or for a quantity, supply or dose of the prescription drug) is for continuation therapy.
- e. United RI shall clearly state the principal reason for denial of the request, including the specific criteria not met, and the facts used to determine that the specific criteria were not met.
- f. The utilization review process shall explicitly consider whether a potential utilization review denial might impede care, delay care, fail to ensure continuity of care, or lead to an inappropriate transition of care.
- g. United RI's clinical reviewers shall conduct a thorough, independent review of the prescriber's request. United RI clinical reviewers shall consider all of the information offered by the prescriber, including the rationale in support of the approval request. United RI shall include , in its proposed and final Plan of Correction, standards and procedures for how it will ensure that: (1) the United RI's clinical reviewers do not "rubber-stamp", or give undue weight to the recommendations, suggestions, notes or comments related to disposition by the previous reviewers or decision-making staff, and (2) the United RI's clinical reviewer explains the decision with sufficient detail to understand why the decision was made and, if applicable, specifically how the prescriber's facts and rationale were considered.
- h. United RI shall state in its approval decisions what medication is approved, and what quantity, supply or doses of the medication is approved.
- i. Fax forms, utilization review websites, and requests received by telephone shall conform to the following requirements:
 - i. Drug specific prior authorization forms and protocols shall contain the specific clinical questions and information requests for the prescriber to respond to in order to obtain coverage approval.
 - ii. The request forms and protocols shall reflect a coordinated and efficient process to address all types of utilization review, including prior authorization, step therapy, and quantity limits that does not lend itself to delays in access to medically necessary medications.

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- iii. The request forms and protocols shall explicitly ask the prescriber whether the request is urgent.
- iv. The request forms and protocols shall ensure that once the prescriber has demonstrated that the request is for continuation therapy, United RI shall not deny coverage for the medication until it has determined, in a documented consult with the prescriber, that the patient can be safely and effectively transitioned to another covered medication.
- v. United RI shall develop a process to identify out of date fax forms, consolidate forms where possible, and effectively communicate with providers which fax forms should be used to request prior authorization.
- j. United RI shall revise its standards to ensure that reasonable efforts are made to solicit and obtain, by telephone, email, or otherwise, all information necessary to fairly and equitably process the request. If the facts and circumstances presented suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such clinical information shall be effectively solicited from the prescriber and the prescriber shall be allowed a reasonable period of time to respond.
- k. United RI shall request medical records of the patient when necessary to fairly and equitably process the request.
- l. United RI shall classify as a denial any utilization review decision that does not authorize the prescription drug requested, or does not authorize the quantity, supply, or dose of the prescription drug requested.
- m. United RI shall not require a patient to authorize its provider in writing to conduct an appeal on the patient's behalf.

34. United RI shall revise its documentation policy for utilization review records ("Case Records") for prescription drugs. Compliance with the Case Record documentation policy shall be subject to an explicit component of a utilization review program training manual and training modules. Compliance with the policy shall be monitored by an oversight policy. The revised documentation policy shall include the following requirements.

- a. Case Records shall include the date, time and detail of each event in the utilization review process.
- b. Case Records shall include:

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- i. The specifics of the initial prescriber request, including the rationale for the prescriber's request;
 - ii. The quantity, supply or dose of the medication requested;
 - iii. Any voluntary agreement to modify the request;
 - iv. All information submitted by the prescriber in connection with the request;
and
 - v. Information to determine if the request is for continuation therapy.
- c. Case Records shall document all conversations or other communications with the prescriber, including the date, time and content of the communications.
 - d. Case Records shall include prescriber fax forms, and all website request information offered by the prescriber, if used by the prescriber.
 - e. Case Records shall include United RI's clinical reviewer documentation that all material clinical information was reviewed by the clinical reviewer and shall include documentation of the utilization review criteria not met, and the reviewer's rationale for rejecting or disagreeing with the requesting prescriber's request, clinical judgment or recommendation.
 - f. If a request is pended for insufficient information, the Case Record shall document (1) what specific information is needed, (2) communications or attempted communications with the provider, and (3) the provider's response to the communication(s).
 - g. Case Records shall be collected, organized, and maintained in a form and manner such that the Commissioner can readily ascertain compliance with state and federal laws and regulations, and implementation of these recommendations and the final Plan of Correction.

Oversight deficiencies – findings.

35. During the time periods examined, United RI delegated administration of its utilization review program for behavioral health services to Optum Inc., through its operating division United Behavioral Health. During the time periods examined, United RI delegated administration of its utilization review program for prescription drugs for behavioral health conditions to Optum Inc., through its operating division OptumRX. Furthermore, the Examiners' review of Case Records demonstrates that OptumRX, in turn, delegated to a fourth party, MCMC, the function of reviewing prescriber appeals from initial denials. United RI remained legally responsible for

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administering its utilization review programs in a reasonable and fair manner, and for complying with state and federal laws and regulations. To fulfill these responsibilities in compliance with RI law, United RI needed to ensure that it had an effective oversight program of United Behavioral Health and OptumRX as well as a formal agreement in place with its delegates describing the delegated function(s) and oversight program in accordance with RIGL § 27-18-8(b), §§ 27-9.1-4(a)(3) and (4), and DOH Health Plan Certification Regulation §§ 1.6 and 2.6. For the reasons set forth in Paras. 36 and 38 below, the Examiners find that United RI exhibited a significant failure in its obligation to maintain adequate oversight of Optum's utilization review programs in violation of Rhode Island law.

36. In the case of the sub-delegation to MCMC by OptumRX of United RI's function of reviewing prescriber appeals from initial denials there is no evidence suggesting that United RI approved this further delegation, nor is there evidence that United RI complied with Rhode Island law requiring United RI's effective oversight of MCMC's performance of United RI's appeal review responsibilities through a formal agreement describing the delegated function(s) and oversight program. Moreover, instead of maintaining an effective oversight program of United Behavioral Health and OptumRX, United RI delegated its oversight responsibilities to other national United affiliates. During the course of this Examination the Examiners found no persuasive evidence that United RI engaged in active, meaningful, and effective oversight of the other national United affiliates to which the oversight responsibility was delegated. As demonstrated by the Findings of this Report, those other United affiliates did not conduct effective oversight of United Behavioral Health and OptumRX. Given the significant disparity in financial size and strength between United RI on the one hand, and United Behavioral Health and OptumRX on the other hand, it is unreasonable to expect United RI to be able to conduct effective oversight of the delegated entities without significant changes to the oversight program in place during the examination time period.

37. For the year ending 2017, UnitedHealthcare Insurance Company, one of the United RI companies, stated net income of \$2.7 billion, only a small portion of which was derived from RI business. For the year ending 2017, UnitedHealthcare of New England, Inc., the other United RI company, stated net revenue of \$23.6 million. In contrast, UnitedHealthcare Group stated 2017 revenue of \$201 billion, and Optum (as used in this Para. and Para. 38, "Optum" means Optum, Inc. and OptumRX) posted revenue of \$91.2 billion. Optum and its parent UnitedHealthcare Group have far greater economic and institutional power and influence over the operation of

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United RI than does United RI itself. In addition, from a corporate governance perspective Optum reports to UnitedHealth Group, not United RI. Likewise, United RI reports to UnitedHealth Group, rather than operating independently. Based on the financials of the relevant companies, the corporate structure of the relevant companies, and the lack of active oversight by United RI, the Examiners find that the delegation agreement between United RI and Optum is not an arms-length, real, and effective agreement. Rather, it is a pro forma agreement that masks the unfettered independence of Optum, and United RI's lack of control in or authority over Optum's performance of the utilization review process conducted in Rhode Island. Neither UnitedHealth Group nor Optum were entities subject to the direct regulation of the Commissioner in 2014-2015, although with statutory amendments in 2017 the Commissioner currently has direct jurisdiction over Optum in terms of health plan certification and utilization review.

38. In an environment where Optum was subject to no effective control or oversight by United RI, Optum's failure to comply with state and federal laws and regulations, is substantial and noteworthy in both scope and severity. In terms of scope, of 141 behavioral health Case Records analyzed by the Examiners, over 721 specific violations were found, and 6 violations applied to all of the 99,499 insured benefit plans and covered lives in 2015. Of 183 prescription drug Case Records analyzed by the Examiners, over 272 specific violations were found, 2 violations applied to all of the 99,499 insured benefit plans and covered lives in 2015, and 3 violations applied to all 183 Case Records reviewed by the Examiners. In terms of severity, the Case Records analyzed by the Examiners demonstrated serious and significant harm to members suffering from mental health or substance use disorders. Of particular concern to the Examiners is that Optum's grossly inadequate documentation practices mean that the Examiners undoubtedly under-counted and under-identified the number, type and severity of Optum's violations. The Examiners conclude that not only did United RI fail to conduct adequate oversight of Optum, but any substitute oversight that may have been performed by national affiliates of United Health Group also failed to conduct adequate and effective oversight of Optum.

39. The Examiners find that United RI exhibited a significant failure in its obligation to maintain adequate oversight of Optum's utilization review programs.

Oversight deficiencies - recommendations.

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40. United RI shall revise and maintain effective, independent oversight of Optum and OptumRX's policies and procedures, and its administration of United RI's utilization review programs, to ensure full compliance with state and federal laws. This oversight program shall include, at a minimum, the following:

- a. An oversight process to oversee the development and implementation of United RI's and United RI's delegated entities' (such as Optum and OptumRX) plan to correct the non-compliance documented in this Report;
- b. Identification and specification in the oversight program of how entities or departments to which United RI delegates any of its utilization review responsibilities (such as Optum and OptumRX) will be overseen in terms of regular oversight of relevant contracts, meaningful auditing of utilization review activities and regular reporting to OHIC to ensure initial and continued compliance with each element of United RI's final Plan of Correction resulting from this Examination;
- c. Effective, oversight of any sub-delegate administering portions of the utilization review program;
- d. Submission of an oversight program as part of its proposed and final Plan of Correction; and
- e. Submission of periodic audit reports in form, content and frequency as determined by the Commissioner.

Obligation to facilitate the examination - findings.

41. Health insurance carriers have an obligation to facilitate examinations called for by the Commissioner, and to aid the Examiners in the conduct of the examination in accordance with RIGL § 27-13.1-4(b). United RI failed to comply with its obligation to assist in and facilitate the Examination. For example:

- a. Responses to the Examiners' requests for information were controlled and carried out not by United RI, but rather by Optum (as used in this Para. "Optum" means Optum Inc. and OptumRX). United RI staff had no apparent role in the examination activities of Optum. In essence, United RI abdicated its obligation to facilitate and assist in the examination to Optum.
- b. Many times, responses to the Examiners' requests were delayed. Many times, the Examiners had to repeat or remind United RI of the requests. United RI's

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reason for the delays sometimes suggested that other internal projects had a higher priority than the Examination.

- c. Many times, incorrect or incomplete responses were submitted, either because Optum appeared to misunderstand the Examiners' requests, or because insufficient effort or expertise was applied to the requests. Instead of seeking clarification from the Examiners, Optum provided incorrect or incomplete responses.
- d. Documents were submitted in a haphazard manner, without any explanation or guide as to which documents, and which provisions in the documents, were intended to be responsive to the Examiners' requests for information. Without such an explanation or guidance, the responses were in many cases un-useable, and therefore unresponsive.
- e. The Examiners requested policies and procedures in effect in 2014 and 2015. Instead, Optum sometimes submitted policies and procedures in effect at the time of the response to the request, or the documents submitted did not identify whether they were in effect in 2014 or 2015.
- f. When the Examiners requested United RI to provide Optum Case Record data, the responses were significantly incorrect or delayed, and Optum sometimes submitted un-useable data. This finding is especially applicable to OptumRX's response for Case Record data. The Examiners needed to make two requests for prescription drug Case Records because the response to the first request did not contain enough information to properly review the Case Records. In some cases, the denial Case Records indicated that an appeal was filed, but the appeal Case Records sent to the Examiners by OptumRX did not contain Case Records for the appeals of those denials. The Examiners find that an undetermined number of appeals were made during the period examined that were not included in the appeal Case Records sent by OptumRX, thereby resulting in the under-counting of potential violations and impeding the course of the Examination. In other instances, a denial Case Record was only submitted in the OptumRX response to the Examiners' second request for Case Records, or multiple Case Records were submitted for the same denial. Other carriers

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subject to this Examination performed significantly better than United RI and Optum in facilitating and assisting the Examiners.

- g. In summary, Optum's responses were frequently late, incomplete, incorrect, or unresponsive to the Examiners' requests. As a result, time and effort by all parties was wasted, and the work of the Examiners was impeded.

Obligation to facilitate the examination – recommendation.

42. United RI shall evaluate its performance in and compliance with the examination process. United RI shall issue a report of the steps it has taken since 2016 and the steps it recommends be taken to address the shortcomings set forth in the report's findings and to ensure prompt and effective compliance with future market conduct examinations. United RI shall submit this report to the Commissioner on or before the submission date for the proposed Plan of Correction .

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Order

Wherefore, it is hereby ORDERED:

- A. The Commissioner hereby adopts the Examination Report and each Recommendation set forth in the Examination Report and orders United RI to implement each Recommendation set forth in the Examination Report.
- B. On or before July 31, 2020, or such other date as ordered by the Commissioner, United RI shall file a proposed Plan of Correction to implement each of the recommendations ordered by the Commissioner.
- C. On or before August 31, 2020, or such other date as ordered by the Commissioner, United RI shall file a final Plan of Correction, approved by the Commissioner, to implement each of the recommendations ordered by the Commissioner.
- D. United RI shall implement the Plan of Correction, within the time frames set forth in the approved Plan of Correction.
- E. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate to address the Report's findings, and to implement the Report's recommendations, and the Commissioner's orders. Such further actions may include but not be limited to validation studies conducted by the Office to verify compliance with these Orders. United RI shall pay the costs of any such further actions or supplemental orders.
- F. United RI shall make a penalty payment of \$350,000 on or before April 15, 2020. The payment shall be made to General Treasurer, State of Rhode Island.
- G. In lieu of further penalty related to the findings of this Market Conduct Examination, United RI shall make a behavioral health system infrastructure payment in the amount of \$2.85 million by or before April 15, 2020. The payment shall be made to a non-profit Rhode Island organization agreed to by the Commissioner, under the terms agreed to by the Commissioner. Payment shall be used to improve the behavioral health system, including improving preventative care and timely access to needed care and treatment

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for individuals with mental health and substance use disorder conditions. The behavioral health infrastructure payment shall be separate from, and in addition to United RI's costs of implementing this Report's Recommendations and Orders.

Dated at Cranston, Rhode Island this 20th day of March, 2020.



Marie Ganim, Commissioner

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THIS ORDER CONSTITUTES A FINAL ADMINISTRATIVE DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS ORDER MAY BE APPEALED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT, CHAPTER 35 OF TITLE 42 WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.

Consent of UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc.

I. United RI understands and agrees that this Order constitutes valid obligations of United RI, legally enforceable by the Commissioner.

II. United RI waives its right to judicial review with respect to the above-referenced matter; provided, however, United RI shall have a right to a hearing on any charge or allegation brought by OHIC that United RI failed to comply with, or violated any of its obligations under this Order, and United RI shall have the right to appeal any adverse determination resulting from such charge or allegation.

III. United RI acknowledges and agrees that it consents to the legal obligations imposed by this Order, and that it does so knowingly, voluntarily and unconditionally.

IV. Notwithstanding the foregoing, this consent does not constitute an admission of any statement of fact or conclusions of law contained in the Examination Report or Order.

UnitedHealthcare Insurance Company

By:  _____

Date: March 19, 2020

Title: President

UnitedHealthcare of New England, Inc.

By: Stephen J. Farrell _____

Date: March 18, 2020

Title: President



Stephen J. Farrell
Chief Executive Officer
475 Kilvert Street
Warwick, RI 02886

March 19, 2020

Marie Ganim, PhD
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69, First Floor
Cranston, RI 02920

Re: In re: Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

Dear Commissioner Ganim:

UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. (together "UnitedHealthcare") appreciate the opportunity to submit this response to the Office of Health Insurance Commissioner's market conduct examination report and order (the "Report").

UnitedHealthcare's goal in the Commonwealth is and always has been the safety and well-being of its Rhode Island members. In that same spirit, we take very seriously the findings included in the Report. As stated in our official response to the Report, since this the market conduct exam began, UnitedHealthcare has changed its utilization review guidelines for both behavioral health and substance use disorders to evidence-based, industry-developed, third-party guidelines. UnitedHealthcare also actively trains clinicians responsible for making utilization review determinations on the use of these guidelines, and we conduct periodic audits of those clinicians and staff to ensure that these guidelines are being followed. UnitedHealthcare has similarly reevaluated its prescription-drug practices and processes, continues to base its clinical criteria on evidence, and is striving to continually improve its services.

While we are proud of the improvements we have made as the result of these and other business practice changes, we maintain that UnitedHealthcare complied with both Rhode Island and federal law as written during years 2014 through 2016, the period covered by the Report. Notwithstanding our disagreement with OHIC on this point, UnitedHealthcare agrees to continue to improve its services to Rhode Island members and to follow the recommendations set out in the agreed upon Order to assist our members in receiving the right care, at the right time, in the right setting.

UnitedHealthcare commits going forward that it will continue to offer quality coverage to its members—especially those impacted by behavioral health and substance use disorders—in Rhode Island and beyond. UnitedHealthcare is an industry leader in addressing the opiate crisis by increasing access to evidence based treatment. We have expanded the availability of medication assisted treatment by adding additional office based opiate treatment providers and programs. In recent years, we have also supported both the National Alliance on Mental Illness and the Providence Center, Rhode Island’s leading mental health and addiction provider. UnitedHealthcare remains committed to these and other efforts to assist some of Rhode Island’s most vulnerable populations.

We look forward to working with OHIC to develop improved means for ensuring that quality care continues to be available to its Rhode Island members, especially those needing behavioral health or substance use disorder treatment. To that end, we will begin immediately preparing a Plan of Correction that is consistent with the terms of the Report and Order. In addition, UnitedHealthcare will make a contribution to the Rhode Island Foundation as part of its goal to invest in important Rhode Island community programs that address critical issues facing those living in the Ocean State.

Sincerely,

A handwritten signature in black ink, appearing to read 'S. Farrell', written in a cursive style.

Stephen J. Farrell
Chief Executive Officer