AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

ARC Issue Brief: *Wit v. United Behavioral Health*

Ruling highlights pervasive violations denying patients adequate care for mental illness and substance use disorder

Background

Judge Joseph Spero of the United States District Court for the Northern District of California issued a detailed and scathing rebuke to United Behavioral Health (UBH) for placing the payer's financial interests over the safety and well-being of patients from 2011-2017 across four states: Connecticut, Illinois, Rhode Island and Texas. The Court found UBH liable for breach of its fiduciary duty and liable for the plaintiffs' denial of benefits claim. The findings of fact and conclusions of law were issued February 28, 2019.

The class action was brought on behalf of patients who were denied coverage by UBH for residential treatment for serious mental illness and substance use disorder. Coverage also was denied by UBH for outpatient mental health treatment. Five of the most important takeaways from the Court's findings include:

1. The Court found that UBH's self-created guidelines dictating what would be covered for mental health illness and substance use disorders did not meet generally accepted standards of care in the commercial and self-insured health insurance markets;

2. The Court found that UBH committed facial violations of state law in four states for not providing patients the standard of care;

3. The Court found that the generally accepted standard of care was defined by guidelines developed by medical societies, including the American Society of Addiction Medicine (ASAM) criteria;

4. The Court found that patients' benefit contracts stipulated consistency with the generally accepted standard of care and that UBH could not alter that requirement through the adoption and application of medical necessity criteria that didn't meet that standard; and

5. The Court found that UBH's actions were essentially a mitigation strategy in response to the federal Mental Health Parity and Addiction Equity Act.

> **"[The Court finds that during the class period UBH violated the laws of Illinois, Connecticut, Rhode Island, and Texas by failing to apply criteria that were in compliance with the laws of those states for making coverage determinations relating to substance use disorders treatment."**

For more information

The full decision is available here: https://cand.uscourts.gov/filelibrary/3631/C14-2346-JCS_Redacted-FF-and-CL.pdf. For more information about ways in which this decision may be helpful to medical society advocacy, please read below and contact Daniel Blaney-Koen, JD, ARC Senior Legislative Attorney at (312) 464-4954 or daniel.blaney-koen@ama-assn.org.

UBH's coverage and denial decisions were motivated by financial factors

In a detailed takedown of UBH's practices, the Court found that guidelines used by UBH to deny care recommended by a patient's physician did not represent the standard of care. The court found that UBH's decisions repeatedly focused on coverage only for acute symptoms rather than more comprehensive treatment. In other words, if an acute care episode was no longer present, long-term treatment often was denied. The Court also severely criticized and found UBH's experts lacked credibility, in part, because they "were simply offering post hoc rationalizations for Guidelines that transparently fail to provide for the effective treatment of co-occurring conditions."

UBH's actions, moreover, were contrary to explicit state law requiring UBH to follow the generally accepted standard of care. The Court found that UBH's medical experts "had serious credibility problems," including that "a significant portion of their testimony … was evasive—and even deceptive." Some of UBH's witnesses claimed that "benefit expense" was not a factor when UBH developed its care guidelines, but the Court found that "The *only* reason UBH declined to adopt the ASAM Criteria was that its Finance Department wouldn't sign off on the change," and that "UBH's Finance Department had veto power with respect to the Guidelines and used it to prohibit even a change in the Guidelines that all of its clinicians had recommended."

The decision makes clear the systematic efforts that UBH undertook to deny care to potentially tens of thousands of patients over the course of several years. Whether the actions of UBH also have occurred in the coverage decisions of other behavioral health management companies or payers is a question that the AMA believes should be addressed by policymakers. There are multiple areas where further advocacy may be relevant for a medical society.

Medical society guidelines are the standard of care

Guidelines developed by the nation's medical societies may be the true star of the ruling. The Court found that medical society-developed guidelines were authoritative sources that reflected generally accepted standards of care. This includes:

1) American Society of Addiction Medicine Criteria ("ASAM Criteria");

2) American Association of Community Psychiatrist's ("AACP") Level of Care Utilization System ("LOCUS");

3) Child and Adolescent Level of Care Utilization System ("CALOCUS") developed by AACP and the American Academy of Child and Adolescent Psychiatry ("AACAP"), and the Child and Adolescent Service Intensity Instrument ("CASII"), which was developed by AACAP in 2001 as a refinement of CALOCUS; and

4) Medicare benefit policy manual from the Centers for Medicare and Medicaid Services ("CMS Manual").

Additional sources the Court found that "reflect generally accepted standards of care" include:

1) APA Practice Guidelines for the Treatment of Patients with Substance Use Disorders, Second Edition

2) APA Practice Guidelines for the Treatment of Patients with Major Depressive Disorder; and

3) AACAP's Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers.

Why should policymakers pay close attention to this decision

- If a state is using one or more of the medical society guidelines noted above, and UBH is doing business in that state, UBH is arguably violating the standard of care as well as its fiduciary duties to its enrollees. UBH also may be violating state law.

- If a state has, through statute or regulation, explicitly adopted one or more of the medical society guidelines noted above, and UBH is doing business in that state, UBH may be in facial violation of state law as the Court found that the UBH guidelines are sub-standard and not reflective of the standard of care as in the medical society-developed guidelines.

- This decision only focused on UBH, but it reached plans in the commercial and self-insured markets. To the extent that other behavioral health management companies (or payers) use their own guidelines to evaluate claims, it raises the question whether those entities' guidelines are 1. Meeting the standard of care; and 2. Complying with state law.

- There should be no question that UBH's motivations were financial, that the use of its own guidelines was motivated primarily to meet utilization management requirements, and decisions to not adopt or accurately apply the ASAM Criteria was to save money.

Support for comprehensive care can help guide further medical society advocacy

In finding that UBH violated state and federal laws and denied its enrollees the standard of care, the Court made numerous findings in support of comprehensive care that also can help guide further advocacy, including providing a roadmap for state regulators to evaluate whether other payer and behavioral health management company policies are following the standard of care. For example, the Court found:

- "[e]ffective treatment requires treatment of the chronic, underlying condition."

- "Because co-occurring disorders can aggravate each other, treating any of them effectively requires a comprehensive, coordinated approach to all conditions."

- "In order to treat patients with mental health or substance use disorders effectively, it is important for providers to 'match' them to the appropriate level of care."

- "the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care in addressing a patient's overall condition, including underlying and co-occurring conditions."

- "it is a generally accepted standard of care that where there is uncertainty as to the likely effectiveness of different proposed levels of care, practitioners treating patients for mental health and substance use disorders should exercise caution by selecting the higher level of service intensity."

- "One of the ways practitioners take into account the developmental level of a child or adolescent in making treatment decisions is by relaxing the threshold requirements for admission and continued service at a given level of care."

- "Throughout the Class Period, UBH failed to adopt separate level-of-care criteria tailored to the unique needs of children and adolescents. Nor do the Guidelines instruct decision-makers to apply the criteria contained in the Guidelines differently when the member is a child or adolescent."

Coverage for "acute" symptoms is not the same as comprehensive, effective care

Throughout the decision, the Court highlights that UBH was found to have only focused on "coverage of services to treat 'acute' symptoms…rather than treatment of the member's underlying condition." That is, the Court found that "UBH knowingly and purposefully drafted its Guidelines to limit coverage to acute signs and symptoms."

Thus, while UBH consistently denied coverage for higher levels of care, it also did not necessarily approve coverage for lower levels of care, either, because there may not be "acute" symptoms present. And even though lower levels of care may not be effective, UBH repeatedly determined that it was as "safe" as a higher level of care because of the absence of acute symptoms.

Therefore, if a payer or behavioral health management company is taking similar actions, those decisions arguably are not only violating the medical standard of care, but like the patients who brought the action in *Wit*, patients in other states may currently be experiencing harm due to coverage denials based on the payer or behavioral health management company guideline that prefers financial interests over safe and effective patient care.

Medical societies can help policymakers clearly understand that the standard of care for mental illness and substance use disorders focuses on ensuring patient safety at every level of care, but also that every level of care must be effective. The Court was clear that both prongs must be met to meet the standard of care.

UBH omitted certain facts, relied too heavily on accreditation

ASAM Criteria played a very large role throughout the Court's decision, in part, because the four states specifically adopted them as the standard of care. Yet, "[t]he most glaring inconsistency between UBH Guidelines and the ASAM Criteria relates to coverage of residential treatment at levels 3.1, 3.3 and 3.5. UBH Guidelines simply do not provide criteria for coverage of services at these levels." The Court further found that "[i]n its post-trial brief, UBH essentially conceded that its Guidelines do not provide for coverage of residential treatment at ASAM levels 3.1, 3.3 or 3.5. Instead, UBH offers a hodge-podge of excuses for this omission, none of which is convincing."

Another key point that the Court noted was the role of accreditation. The AMA has argued to the National Association of Insurance Commissioners and others that accreditation should not take the place of regulatory oversight. Notably, the Court found that the accreditation *process* was satisfied by UBH, but that did not prevent UBH from preferring its financial interests over that of patient protections when developing the content of its medical necessity standards.

"[B]y a preponderance of the evidence, that in every version of the [UBH] Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members' underlying conditions. While the particular form this focus on acuity takes varies somewhat between the versions, in each version of the Guidelines at issue in this case the defect is pervasive and results in a significantly narrower scope of coverage than is consistent with generally accepted standards of care."