DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

February 9, 2026

RY 2023 – UnitedHealthcare of Texas, Inc. – Texas – HIOS ID #40220

Christina Stecki
Associate Director, Regulatory Affairs
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Re: Final Determination Letter – Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitation (NQTL) Comparative Analysis Review – Provider reimbursement for outpatient, in-network services.

Dear Ms. Stecki,

The Centers for Medicare & Medicaid Services (CMS), on behalf of the U.S. Department of Health and Human Services, has completed its review of the Corrective Action Plan (CAP) and additional comparative analysis submitted to address the instances of non-compliance noted in the MHPAEA NQTL Analysis Review (Review).

The purpose of the Review was to assess UnitedHealthcare of Texas, Inc.'s (Issuer) compliance with the following requirements under Title XXVII of the Public Health Service Act (PHS Act) and its implementing regulations:

> Section 2726 of the PHS Act and implementing regulations at 45 CFR §§ 146.136 and 147.160[1] - Parity In Mental Health And Substance Use Disorder Benefits (MHPAEA and its implementing regulations).

The Review covered provider reimbursement for outpatient, in-network services for the 2023 plan year (hereinafter referred to as "the NQTL").

CMS conducted this Review pursuant to section 2726(a)(8)(A) and (B) of the PHS Act, as added by section 203 of Title II of Division BB of the Consolidated Appropriations Act, 2021.[2] CMS contracted with Examination Resources, LLC to assist CMS with conducting this Review.

[1] In this document, references to 45 C.F.R. §§ 146.136 and 147.160 refer to the regulations applicable during the 2023 plan year.
[2] Pub. L. 116-260 (Dec. 27, 2020).

On August 8, 2025, CMS provided an Initial Determination Letter of non-compliance to the Issuer and directed the Issuer to submit a CAP and additional comparative analysis to CMS to demonstrate compliance with MHPAEA and its implementing regulations. In CMS' Initial Determination Letter, we identified the following instances of non-compliance with section 2726 of the PHS Act, all of which have been addressed by the Issuer's corrective actions and revised comparative analysis.

I. Failure to Provide Sufficient Information and Supporting Documentation, in Violation of Section 2726(a)(8)(A) of the PHS Act.

1. Failure to provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL, as written and in operation.

i. Failure to provide sufficient information and supporting documentation regarding the factors used to determine mental health and substance use disorder (MH/SUD) provider and medical/surgical (M/S) provider reimbursement rates.

In its February 15, 2023 initial submission, the Issuer identified provider type, services/procedures, and market dynamics as factors for setting provider reimbursement rates.[3] However, the submission appeared to be incomplete and contained inconsistent factors, processes, and terminology.[4] For example, the Issuer's submission identified other items that appeared to be different factors than those outlined by the Issuer in its narrative.[4] The Issuer's submission also appeared to identify the use of different processes for negotiating reimbursement rates for MH/SUD providers and M/S providers, including differing terminology such as "conditions" for rate negotiation "exceptions" for MH/SUD providers as compared to factors impacting overall "rate consideration" and "reimbursement negotiation" for M/S providers.[5] As a result, CMS determined that the Issuer failed to provide sufficient information about the factors used in the design and application of the NQTL to MH/SUD benefits and M/S benefits, as outlined in the Initial Determination Letter.

In its September 22, 2025 CAP submission, the Issuer provided a revised comparative analysis (hereinafter referred to as the "2025 comparative analysis") listing the factors used to set reimbursement rates for MH/SUD providers and M/S providers: CMS rates, provider services, network adequacy, provider type, and geographic location.[5] The Issuer stated that these *"same factors are considered in the reimbursement rate processes for both MH/SUD and medical/surgical services."*[6] The 2025 comparative analysis provides detailed information including factor definitions, corresponding evidentiary standards and sources, and explanations

[3] INN Reimbursement_Prof Svcs_NQTL_02152023, pg. 2.
[4] See UHC of TX_RY23_Initial Determination Letter_PR OP INN_20250808, pgs. 3-4; Contracting Practitioner and Group Contracting Eligibility and Negotiation Process, pg. 2; Contract Negotiations Prof_Services_SOP (1), pgs. 1-2.
[5] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pgs. 7-9.
[6] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 5

as to how each factor is applied in establishing provider reimbursement rates.[7] The Issuer clarified that several items in its supporting documents are not factors but rather part of the *"universe of information that UHC may collect when beginning rate modeling,"* while *"several of these items function as sources for the factors and are referenced within the Updated Comparative Analysis as such."*[8] In regard to its factors, the Issuer explained certain references to items listed in its submission for M/S provider negotiations while updating its comparative analysis for additional clarity.[9,10] The Issuer also clarified that its use of the terms "exceptions" and "conditions" in its submission for MH/SUD provider negotiations, stating that the terminology *"all describe[s] the same underlying concepts"* pertaining to establishing provider reimbursement rates.[11] Additionally, the Issuer provided all documentation requested in the Initial Determination Letter.[12,13,14]

CMS agrees that the Issuer's corrective action addressed the identified insufficient information.

ii. Failure to provide sufficient information and supporting documentation for the financial incentive factors used to determine MH/SUD provider reimbursement rates and M/S provider reimbursement rates.

In its July 10, 2023 supplemental submission, the Issuer provided a policy that identified the use of various "performance-based" financial incentives, including performance bonuses, capitation, and bundled payments, provided to MH/SUD providers and M/S providers.[15] A separate policy indicated that these incentives influence rate decisions for M/S providers.[16] CMS requested that the Issuer provide the financial incentive factors considered when establishing and renegotiating reimbursement rates for MH/SUD providers and M/S providers.[17] In its November 20, 2023 secondary supplemental submission, the Issuer stated that financial incentives are not used when establishing or renegotiating reimbursement rates for either provider group, without reconciling the apparent inconsistencies.[18] Therefore, it was unclear whether and how any performance and/or financial incentives are considered in establishing rates and reimbursements for MH/SUD providers and M/S providers, as outlined in the Initial Determination Letter.

In its September 22, 2025 CAP submission, the Issuer clarified that the incentive programs are not offered during contract or rate negotiations but are available only to existing provider

[7] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pgs. 7-17
[8] 2025-09-22 Response to CMS Texas Initial Determination Letter, pgs. 5-6.
[9] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 6.
[10] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pgs. 7-17.
[11] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 7.
[12] NC18a_Contract Template Guidelines_Version_Confidential & FOIA Exempt.
[13] Optum Prac_Grp Ctrctg Elig_Neg Process_Confidential & FOIA Exempt.
[14] UBH Par Agr Template Drafting Tool_Confidential & FOIA Exempt_.
[15] EXTX23HM0075963_001-UHC-Gold-A-Value-0-Deductible-Unlimited-0-Virtual-Urgent-Care-+-0-Primary-Care-Visits-0-T1-Preferred-Rx-2023, pgs. 101-102.
[16] Contract Negotiations Prof_Services_SOP (1), pg. 2.
[17] UHC-Provider Reimbursement_Second Insufficient Data Request_20231103 Final, Request Item #1.A.5.
[18] See TX HIOS 40220 Prov Reimb Insuff Data Resp 2_Final_112023, pg. 2; EXTX23HM0075963_001-UHC-Gold-A-Value-0-Deductible-Unlimited-0-Virtual-Urgent-Care-+-0-Primary-Care-Visits-0-T1-Preferred-Rx-2023, pgs. 101-102; Contract Negotiations Prof_Services_SOP (1), pgs. 1-2.

groups.[19] In the 2025 comparative analysis, the Issuer confirmed that it has incentive programs for both MH/SUD provider groups and M/S provider groups, and stated *"Both offer incentives for promoting cost-effective quality care and documenting and evaluating member needs."*[20] Additionally, the 2025 comparative analysis includes an updated list of factors which does not include "performance-based incentives" as a factor in establishing provider reimbursement rates.[21] The Issuer also reiterated that *"the incentive programs […] are not considered in the development of standard fee schedules or negotiation of fee for service rates. Providers may become eligible for these incentive programs during their contract term separate from the standard rate negotiation process."*[22]

CMS agrees that the Issuer's corrective action addressed the identified insufficient information.

2. Failure to provide sufficient information and supporting documentation regarding the processes, strategies, evidentiary standards, and other factors used to apply the NQTL, as written and in operation.

i. Failure to provide sufficient information demonstrating the financial incentive payment programs for MH/SUD providers are comparable to, and applied no more stringently than, the financial incentive payment programs for M/S providers.

In its July 10, 2023 supplemental submission, the Issuer identified financial incentives and contractual arrangements (including bonus payments and capitation agreements) for "network providers" tied to provider quality, member satisfaction, and cost-effectiveness.[23] CMS requested information on any variations in incentives between MH/SUD providers and M/S providers.[24] In its November 20, 2023 secondary supplemental submission, the Issuer stated that MH/SUD incentives were offered to facilities via a bonus program while M/S incentives were paid directly to outpatient primary care providers, and asserted that the programs are comparable and not more stringent for MH/SUD providers.[25] However, CMS determined that the Issuer failed to demonstrate that financial incentive program processes provided to MH/SUD providers were comparable to, and applied no more stringently than, those for M/S providers, as outlined in the Initial Determination Letter.

In its September 22, 2025 CAP submission, the Issuer provided additional information on its financial incentive programs.[26,27] The Issuer described the *"value-based"* program available to MH/SUD *"provider groups"* and stated that, like its M/S programs, the program is available

[19] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pg. 21.
[20] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pg. 21.
[21] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pgs. 7-9.
[22] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 10.
[23] EXTX23HM0075963_001-UHC-Gold-A-Value-0-Deductible-Unlimited-0-Virtual-Urgent-Care-+-0-Primary-Care-Visits-0-T1-Preferred-Rx-2023, pgs. 101-102.
[24] UHC-Provider Reimbursement_Second Insufficient Data Request_20231103 Final, Request Item #1.A.
[25] TX HIOS 40220 Prov Reimb Insuff Data Resp 2_Final_112023, pgs. 1, 2, 14, 15.
[26] 2025-09-22 Response to CMS Texas Initial Determination Letter, pgs. 11-12.
[27] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pg. 21.

when there is *"sufficient membership for evaluation of the quality metrics."*[28,29] The Issuer added that MH/SUD providers are eligible for an enhanced fee schedule upon meeting certain metrics which are applied after any reimbursement negotiations.[30,31] For M/S providers, the Issuer offers bonus payments also tied to quality metrics such as diagnosing and documenting medical conditions.[32] The Issuer analyzed the comparability and stringency of these programs, concluding that the MH/SUD program is comparable to the M/S programs as they all relate to the professional services provided, require sufficient membership for measurement, and incentivize quality, evaluation, and documentation.[33] The Issuer also stated that that the programs were developed using the same underlying considerations, with any differences reflecting how services are delivered.[34] Additionally, the Issuer found that bonus payments and enhanced fee schedules are *"comparable methods of enhancing compensation,"* and noted that the MH/SUD fee schedule enhancements can be more desirable because they provide additional compensation across services.[35] The Issuer also explained that many primary care providers also treat MH/SUD diagnoses, and that the primary care incentive programs affect both M/S and MH/SUD service types.[36] The Issuer also provided supporting documentation for the referenced financial incentive programs.[37]

CMS agrees that the Issuer's corrective action addressed the identified insufficient information.

ii. Failure to provide sufficient information demonstrating MH/SUD provider reimbursement rate durations are comparable to and no more stringently applied than M/S provider reimbursement rate durations.

In its February 15, 2023 initial submission, the Issuer indicated that MH/SUD provider reimbursement rates are negotiated for one-year terms and M/S provider reimbursement rates are negotiated for three-year terms, based on the length of provider contracts.[38] CMS requested the factors and evidentiary standards used to establish different durations for provider reimbursement rates.[39] In its July 10, 2023 supplemental submission, the Issuer stated that the durations were "*established preMHPAEA*" and that contract rates renew automatically.[40] CMS again requested the factors and evidentiary standards used to establish different provider reimbursement rate durations, as well as an explanation of how the variation complies with MHPAEA.[41] CMS determined that the Issuer failed to provide sufficient information regarding the factors and evidentiary standards used to establish different contract term lengths, nor did the Issuer demonstrate that MH/SUD contract terms impacting the duration of reimbursement rates

[28] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 11.
[29] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pg. 21.
[30] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 11.
[31] 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pg. 21.
[32] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 12.
[33] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 12.
[34] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 11.
[35] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 12.
[36] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 12.
[37] Express_Quality_Value_Based_Program_Flyer_Confidential & FOIA Exempt_; 2025 I-PCPi Quick Reference Guide_Confidential & FOIA Exempt_; 2025 ICAIP Quick Reference Guide_Confidential & FOIA Exempt_.
[38] INN Reimb_Comparison and No More Stringent Analysis, pg. 3.
[39] Insufficient Data Request_UHC_Provider Reimbursement_Final (dated June 16, 2023), Request Item #4.A.
[40] TX HIOS 40220 Provider Reimb Insufficient Data Response_Final_071023, pg. 19.
[41] UHC-Provider Reimbursement_Second Insufficient Data Request_20231103 Final, Request Item #3.A.

agreed upon under the provider contract are comparable to, and applied no more stringently than, the M/S contract terms, as outlined in the Initial Determination Letter.

In its September 22, 2025 CAP submission, the Issuer reiterated that its *"historical practice"* of shorter contract terms for MH/SUD providers results in less stringency and supplied supporting data.[42] The Issuer stated that contract terms are negotiable and that any MH/SUD provider or M/S provider may request longer or shorter terms.[43] The Issuer again noted that any one-year MH/SUD contracts automatically renew, and that most network providers have renewed.[44] The Issuer also reasserted that the duration discrepancy *"favors MH/SUD providers"* because there is *"often [a] renegotiations of rates"* upon the end of each term, as well as an ability for the provider to terminate the contract.[45] After providing its 2025 comparative analysis as to the current contract durations, as a *"good faith effort to acknowledge CMS' concern"* the Issuer also updated its MH/SUD contract template to offer three initial term options—one, two, or three years—allowing MH/SUD providers to choose their preferred initial term.[46] The Issuer submitted its updated Optum Participation Agreement Template showing fillable fields for the multiple term options, as well as associated template guidance.[47]

CMS agrees that the Issuer's corrective action addressed the identified insufficient information.

II. Conclusion

CMS' findings detailed in this letter pertain only to the NQTL under review and do not bind CMS (or any other government agency or entity) in any subsequent or further review of other plan provisions or their application for compliance with governing law, including MHPAEA and its implementing regulations. If additional information is provided to CMS regarding this NQTL or Issuer, CMS reserves the right to conduct an additional review for compliance with MHPAEA or other applicable PHS Act requirements.[48]

CMS' findings pertain only to the specific plans to which the NQTL under review applies and are offered by the Issuer and do not apply to any other plan or issuer, including other plans or coverage for which the Issuer acts as an Administrator. However, these findings should be shared with affiliated entities, and steps should be taken as appropriate to ensure compliance with applicable requirements.

CMS will include a summary of the comparative analysis and the results of CMS' review in its annual report to Congress pursuant to section 2726(a)(8)(B)(iv) of the PHS Act.

[42] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 13.
[43] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 13.
[44] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 13.
[45] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 13.
[46] 2025-09-22 Response to CMS Texas Initial Determination Letter, pg. 13; See also 2025-09-22 Texas NQTL Analysis INN Reimbursement Professional Services, pg. 19.
[47] UBH Par Agr Template Drafting Tool_Confidential & FOIA Exempt_, pg. 12.
[48] See section 2726(a)(8)(B)(i) of the PHS Act. See also 45 C.F.R. § 150.303.

Sincerely,

Mary M. Nugent -S

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cc: Texas Department of Insurance