ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU

In the Matter of

Assurance No. 26-007

Investigation by LETITIA JAMES,
Attorney General of the State of New York, of

Carelon Behavioral Health, Inc.
and Carelon Behavioral Health IPA, Inc.,

Respondents.

ASSURANCE OF DISCONTINUANCE

The Office of the Attorney General of the State of New York ("OAG") commenced an investigation pursuant to New York Executive Law § 63(12) into the business practices of Carelon Behavioral Health, Inc. and Carelon Behavioral Health IPA, Inc. (collectively, "Respondents" or "Carelon"). OAG's investigation, which originated with its statewide secret shopper survey of thirteen health plans ("Secret Shopper Study"), concerns the accuracy of Respondents' behavioral health participating provider directory, the adequacy of their behavioral health provider networks, and their compliance with behavioral health parity laws.[1] This Assurance of Discontinuance ("Assurance") contains the findings of OAG's investigation and the relief agreed to by OAG and Respondents (collectively, the "Parties"), whether acting through their respective directors, officers, employees, representatives, agents, delegated entities, affiliates, or subsidiaries.

[1] Office of the New York State Attorney General Letitia James, Inaccurate and inadequate: Health plans' mental health provider network directories (Dec. 7. 2023), https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf.

FINDINGS

Carelon

1. Carelon is a managed behavioral health organization ("MBHO") that has operated in New York State for approximately 20 years and currently administers behavioral health benefits for approximately four million New Yorkers, including members of plans offered by EmblemHealth, Inc. ("Emblem"), Anthem Blue Cross Blue Shield ("Anthem," formerly known as Empire Blue Cross Blue Shield), Independent Health, VNS Health, Hamaspik, Village Care Max, Amida Care, Elderplan, and the Empire Plan (New York State Health Insurance Plan), which is the health benefit plan for New York State and local governmental employees. Carelon previously administered behavioral health benefits for MVP health plan members.

2. Carelon Behavioral Health, Inc. is licensed under New York Insurance Law § 2101 as an independent adjuster by the New York State Department of Financial Services ("DFS"), and as a utilization review agent by the New York Department of Health. Carelon Behavioral Health, Inc. files utilization review reports with DFS. Carelon's principal offices are located in Boston, Massachusetts.

3. In 2015, after a multiyear investigation, OAG executed an Assurance of Discontinuance with Carelon Behavioral Health, Inc. (the "2015 AOD"), which is still in effect and requires Carelon Behavioral Health, Inc. to, among other things: (a) maintain an online provider directory and update it in a timely manner to reflect the addition or termination of a provider from the network or a change in a physician's hospital affiliation; (b) ensure that its provider network contains an adequate number of behavioral health providers to meet the treatment needs of members; and (c) comply with New York and federal behavioral health parity

laws.[2]

The Behavioral Health Crisis In New York State

4. Millions of New Yorkers live with behavioral health disorders. As used in this Assurance, "behavioral health" includes mental health disorders, substance use disorders, and autism. In 2023 and 2024, 21.9% of adults in New York State had any mental illness within the past year, and 17.3% of people 12 or older had a substance use disorder within the past year.[3] The COVID-19 pandemic dramatically increased the need for behavioral health services in New York.[4]

5. Access to behavioral health treatment remains out of reach for many. More than half of insured adults who do not get needed behavioral health treatment cite lack of coverage by their health plans as the reason.[5] In 2022, almost 500,000 New York children aged 3 through 17 had a diagnosed behavioral health condition (depression, anxiety problems, or behavioral or conduct problems).[6] Of those children, 196,000 (40 percent) did not receive treatment or counseling.[7]

6. Consumers depend on their health insurance to access and afford behavioral health treatment for themselves and their dependents. To find in-network treatment and to shop

[2] https://ag.ny.gov/press-release/2015/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental; https://ag.ny.gov/sites/default/files/settlements-agreements/ValueOptionsAOD-FullyExecuted.pdf.
[3] United States Substance Abuse and Mental Health Services Administration (SAMHSA), 2023-2024 National Survey on Drug Use and Health (NSDUH), https://www.samhsa.gov/data/sites/default/files/reports/rpt56957/2024-nsduh-sae-tables-percent-csvs/2024-nsduh-sae-tables-percent.pdf.
[4] *See* N.Y. State Health Found., *Mental Health Impact of the Coronavirus Pandemic in New York State* (2021), https://nyshealthfoundation.org/wp-content/uploads/2021/02/mental-health-impact-coronavirus-pandemic-new-york-state.pdf; NYC Dep't of Health and Mental Hygiene, *Impacts of COVID-19 on Mental Health in New York City*, 2021 (2021), https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf.
[5] Kaiser Family Found. (KFF), *Proposed Mental Health Parity Rule Signals New Focus on Outcome Data as Tool to Assess Compliance* (Sept. 29, 2023), https://www.kff.org/mental-health/issue-brief/proposed-mental-health-parity-rule- signals-new-focus-on-outcome-data-as-tool-to-assess-compliance/.
[6] Child and Adolescent Health Measurement Initiative, *2022 National Survey of Children's Health*, https://www.childhealthdata.org/browse/survey/results?q=10029&r=34.
[7] *Id.*

for insurance, consumers look to provider directories maintained by health plans and MBHOs like Carelon. But consumers—in particular those with behavioral health conditions—may experience challenges when using these directories, including providers not accepting new patients, long wait times to see providers, and inaccurate or out-of-date provider information.

7. Secret shopper surveys, in which callers simulate the experience of consumers calling providers in the online network directory of a health plan or MBHO, are an effective tool to test directory accuracy and identify gaps in network adequacy. Numerous secret shopper studies conducted during the past eight years have indicated that inaccuracies in health plans' provider directory listings for behavioral health providers exist, including incorrect information about network status, location, and availability to accept new patients.[8] In July 2024, a study published in the Journal of the American Medical Association showed that only 18 percent of mental health clinicians listed as in-network for Medicaid plans were reachable, accepted Medicaid, and could provide a new patient appointment.[9] These are referred to as "ghost networks"—i.e., providers who are listed in a provider directory as being in-network but are not taking new patients or are no longer in a plan's network. Other tools serve a similar purpose as secret shopper surveys, including examining claims data to assess whether consumers actually access treatment.

OAG'S INVESTIGATION OF CARELON

Respondents' Online Participating Provider Directory

8. Respondents develop and administer networks composed of various types of

[8] Kaiser Family Found. (KFF), *Proposed Mental Health Parity Rule Signals New Focus on Outcome Data as Tool to Assess Compliance* (Sept. 29, 2023), https://www.kff.org/mental-health/issue-brief/proposed-mental-health-parity-rule- signals-new-focus-on-outcome-data-as-tool-to-assess-compliance/.
[9] Diksha Brahmbhatt & William Schpero, *Access to Psychiatric Appointments for Medicaid Enrollees in 4 Large US Cities*, *JAMA*, 332(8):668–669 (2024), https://jamanetwork.com/journals/jama/fullarticle/2821639.

behavioral health providers and facilities in New York ("Participating Providers"). The Participating Providers accept negotiated rates—plus the applicable member co-payment, coinsurance, and/or deductible—as payment in full for covered services rendered to members of health plans for which Respondents administer the behavioral health benefit ("Members").

9. Respondents receive demographic, specialization, appointment availability, and other information about Participating Providers from such providers, and/or CAQH (a third-party provider credentialing and data repository that provides data and daily updates to customers, including Respondents). Respondents also receive information about Participating Providers from client health plans and Members. Respondents make such information available to Members, providers, and consumers through provider directories on their public website https://plan.carelonbehavioralhealth.com/find-a-provider/ ("Online Participating Provider Directory"). The websites of some of Respondents' health plan clients, including Emblem and Empire Plan, contain links that redirect to Carelon's Online Participating Provider Directory. Other health plan clients of Respondents, such as Anthem, maintain their own provider directory, which includes information provided by Respondents.

10. Respondents' Online Participating Provider Directory contains listings for Participating Providers (including facilities) that include the following information, provided by the Participating Provider and/or CAQH: name, addresses, telephone number(s), and in the case of physicians and other applicable providers, specialty area, hospital affiliations and any applicable board certification, and whether they are accepting new patients.

11. Respondents' Online Participating Provider Directory is available to Members and other consumers who seek information about Respondents' Participating Provider network when selecting their health plans.

Respondents' Directory Accuracy Policies and Process

12. Respondents' policy titled "Provider Database and Provider Directory" ("Carelon's Directory Policy") states that upon receiving notification of inaccurate practitioner or provider data, Carelon investigates the inaccuracy and verifies the accuracy of the information or updates provider information in its Online Participating Provider Directory within two business days. Further, in February 2023, Carelon represented to Emblem that Carelon "ensures provider data directory updates are made expeditiously" and "[f]or 2022, there was a one-day or less [turnaround time] for provider data demographic updates displayed in the provider directory."

13. A related Carelon policy, "Provider Directory Attestation Outreach," requires Respondents on a quarterly basis to remind all Participating Providers to attest or confirm their directory information. The policy also requires Respondents to remove Participating Providers from their Online Provider Directory when their attestations or confirmations are not current.

14. Carelon failed to send the verification reminders to every provider on a regular schedule, as required by their policies and federal law. For those providers who did receive a verification reminder, Carelon failed to consistently remove providers who did not respond.

15. Carelon made a business decision to remove Participating Providers from their Online Participating Provider Directory only if such providers did not verify their information for more than one year. But in several instances, Carelon did not remove providers from its directory who did not verify for longer periods.

16. Carelon's Directory Policy states that CAQH is the primary source for provider demographic information for Carelon's directory database. Providers that participate with CAQH are required to update and attest their information through CAQH.

17. Respondents, however, are aware that CAQH provider data can be unreliable. Data given to Respondents in 2025 indicated that 92% of the Online Provider Directory entries for 124 sampled New York providers, based on CAQH data, stated inaccurately or without evidence that providers were accepting new patients.

18. Other than the verification reminders, Respondents' main ongoing method of ensuring the accuracy of Online Participating Provider Directory listings is to send emails and other written communications and make phone calls to small samples of providers (with a two-time exception where a larger pool was sampled), as part of telephonic and digital directory audits and surveys, which consistently show widespread inaccuracies.

19. When this limiting sampling reveals errors in the Online Participating Provider Directory, Respondents do not uniformly make corrections.

20. Respondents represented to Emblem in February 2023 that they analyze Participating Providers with no claims activity over the past twelve months and have a process to remove such providers from their Online Participating Provider Directory. But Carelon has not, in fact, removed providers with no claims activity.

21. Carelon's "scorecards" for New York health plans whose Members it serves routinely show "High Risk" in red for network issues for Emblem, including broad concerns about directory accuracy and provider accessibility, perceived challenges securing an appointment with providers, and high-volume network providers likely to leave due to low provider reimbursement rates. Further, Carelon senior management is alerted to serious concerns from its New York health plan clients regarding problems with Respondents' directory accuracy and network adequacy.

Respondents' Network Adequacy Policies and Process

22. Respondents' "Network Design, Access and Availability Standards" policy requires their provider network to meet or exceed the following availability standards for behavioral health appointment waiting times:

a. Emergencies: Member must be seen immediately.

b. Non-life threatening emergent: member must be offered the opportunity to be seen within six hours of the request.

c. Urgent: Member must be offered the opportunity to be seen within 48 hours of the request.

d. Initial visit for routine care: Member must be offered the opportunity to be seen within ten (10) business days.

Respondents' "standard of performance" is that their network has 95 percent or greater availability across all licensure types.

23. Respondents are aware that Emblem's "Monitoring Access & Appointment Availability" policy sets forth requirements for assessing compliance with appointment wait time standards, as measured through telephone surveys. The policy deems the following telephone survey results to be "non-compliant" with the appointment availability standards: no answer after three calls, line busy on three attempts, put on hold for more than 10 minutes in three attempts, disconnected phone, telephone number changed but no forwarding number given, practitioner no longer at number, practitioner no longer participating, and practitioner not accepting new patients.

24. Despite having what appear on paper to be robust policies, Respondents have not consistently monitored network adequacy for behavioral health services. Respondents do not—

and cannot—measure actual access to providers.

25. This inaction continues even though Carelon knows there is a lack of Participating Providers in its New York network who can treat Members with mental health and substance use disorders in certain rural areas, and children and adolescents.

OAG's Secret Shopper Study

26. Using a methodology commonly used in academic studies published in peer reviewed journals, OAG conducted a "simulated patient" secret shopper study of behavioral health Participating Providers listed in Respondents' Online Participating Provider Directory for the health plan Emblem, between March 14 and April 27, 2023, and published the results on December 7, 2023.[10] OAG called 44 Participating Providers in New York City listed in Respondents' Online Participating Provider Directory for Emblem as accepting new patients, including psychiatrists, nurse practitioners, doctoral-level psychologists, and Licensed Clinical Social Workers.

27. OAG called providers posing as a relative of an Emblem Member with a mental health need, with the goal of securing an appointment. For two-thirds of the calls, staff used Scenario A (a fictional adult patient), stating the family member is depressed and their primary care physician suggested they see a mental health provider. For one-third of the calls, staff used Scenario B (a fictional child patient), stating they are the parent of a 14-year-old who has begun having problems in school. When callers reached a voicemail, they left a message with a request for a call back. When the listed phone number was incorrect but callers reached a person who could direct them to another number, the caller followed those instructions and attempted to

[10] Office of the New York State Attorney General (Dec. 7. 2023), *Inaccurate and inadequate: Health plans' mental health provider network directories*, https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf, at 17-23.

reach the listed provider.

28. Of the 44 Participating Providers listed as accepting new patients in Respondents' Online Participating Provider Directory for Emblem whom OAG attempted to contact, the Secret Shopper Study found that 16 (36 percent) advised they were not accepting new patients, 11 (25 percent) were not practicing, and five (11 percent) were non-working numbers, incorrect numbers, or unreturned calls. Staff could make appointments with only eight (18 percent) of the listings, either in-person or via telehealth. The Study concluded that 82 percent of the listed providers staff attempted to contact were therefore "ghosts," because, for example, they were unreachable, or advised they were not accepting new patients, or not in-network—despite being listed in Respondents' directory for Emblem as in-network and accepting new patients. The following chart shows detailed results of the Study:

Plan: EmblemHealth | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	28	9	3	3	11%	89%
Scenario B (child)	16	9	5	2	31%	69%
EmblemHealth totals	**44**	**18**	**8**	**5**	**18%**	**82%**

29. Of the 44 Participating Providers OAG contacted, Respondents' data show that they failed to verify the information of 16 of those 44 providers within at least one quarter of the prior year—more than one-third. Respondents' claims data show that of those 44 providers, seven treated no Emblem Members in the prior year, and 20 (almost half) treated four Emblem Members or less.

30. Respondents have not corrected certain listings of providers whom OAG contacted. For example, in 2023, Respondents' Online Participating Provider Directory for Emblem listed a provider as accepting new patients and practicing child psychiatry. When OAG called the doctor's office to book an appointment for a child, the receptionist said that the

provider works in a nursing home, does not accept outpatient clients, and only sees patients over age 18. Yet until late September and October 2025 (when the provider's listings for some locations were removed), he was still listed as accepting new patients and practicing child psychiatry, even though he submitted no claims to Respondents for Emblem members from 2019 through 2024, and his provider verification file indicates that he lives in Florida and sees patients at eight locations in four different states (Florida, New York, Pennsylvania, and California), in practices whose names include the word "senior."

Other New York State Secret Shopper Surveys

31. In secret shopper surveys, the New York State Department of Health ("DOH") also found serious deficiencies in Respondents' Online Participating Provider Directory for Emblem. In 2023, a DOH secret shopper survey of Emblem's Essential Plan providers showed that of 30 behavioral health providers surveyed, the access rate was 13 percent.

Respondents' Secret Shopper Surveys

32. Carelon's own secret shopper surveys of behavioral health providers in the Online Participating Provider Directory for Emblem have produced results similar to OAG's and DOH's findings.

33. For example, in January and February 2025, Respondents called 600 behavioral health Participating Providers for Emblem plans seeking to schedule appointments, to "simulate the experience of a member seeking behavioral health services by a practitioner." Respondents represented to Emblem in a February 2025 report that only 62 percent of providers Carelon called who responded to the question were accepting new patients and only 46 percent had appointment availability within ten days. Even worse, in calculating these percentages, Respondents excluded providers whom they could not reach, even though such providers should

have been included. Had Respondents properly calculated the percentages by including unsuccessful calls in the result calculations, the overall appointment availability would have been 22 percent, and the ten-day appointment availability rate would have been 10 percent.

34. These results show that Respondents do not come close to meeting the access and availability standards set forth in their own policies for Emblem members.

35. Carelon did not share with Emblem its internal summary of secret shopper surveys of Participating Providers for Emblem plans, which confirms an eight percent success rate in calls attempting to schedule appointments with those providers—and that Respondents have a "ghost network," with members experiencing frustration due to unavailable providers, out-of-network providers incorrectly included in the directory, wrong phone numbers, and providers not accepting new patients.

36. Thousands of behavioral health providers listed in Respondents' Online Participating Provider Directory for Emblem do not treat Emblem Members. During a six-year period from 2019 through 2024, 6,475 of Respondents' behavioral health Participating Providers for Emblem Members did not file a single behavioral health claim for treatment of an Emblem Member; 4,495 filed no claims at all. In 2023, 87 percent of Respondents' behavioral health Participating Providers for Emblem Members were unavailable—filing zero claims as reflected in audited claims data provided to Emblem by Carelon:

Provider Type	Listed	Accessed	Unavailable	Total
Psychiatrist	881	160	721	881
Psychologist	977	114	863	977
Licensed Social Worker	2124	317	1807	2124
Mental Health Counselor	578	46	532	578
Licensed Behavior Analyst	489	0	489	489
Other Mental Health Provider	579	110	469	579
All Providers (Total)	5628	747	4881	5628

Complaints by Respondents' Members Regarding Access to Behavioral Health Treatment

37. From 2018 through 2024, Emblem Members lodged at least 360 complaints with Respondents relating to directory inaccuracy or inability to secure behavioral health treatment with Participating Providers.

38. Carelon has a practice of deeming complaints unsubstantiated, even when Members unsuccessfully tried to reach providers whose numbers Carelon had given them. For example, a Member contacted Respondents because they could not locate a Participating Provider for their spouse. The Member reported that they called at least eight Participating Providers listed in Respondents' Online Participating Provider Directory for Emblem seeking an appointment for their spouse to see a psychiatrist, but each call was unsuccessful because the provider did not participate with Emblem, was not accepting new patients, or had an incorrect number or place of business. Carelon then gave the spouse a list of approximately twenty-five (25) Participating Providers listed in Respondents' Online Participating Provider Directory for Emblem, and the spouse called each of them without any success in securing an appointment for the Member. Carelon then reached out to an additional thirty-eight (38) Participating Providers listed in their Online Participating Provider Directory, but could not secure an appointment for the Member's spouse with any of them. Nevertheless, Carelon sent the Member a complaint determination letter stating the complaint was unsubstantiated because the Member did not send the names of specific providers they called within ten days of the date of the complaint acknowledgement letter.

39. Another Emblem Member filed a complaint with OAG after Carelon failed to respond adequately to her complaint regarding her difficulty finding an in-network psychiatrist for her 14-year-old son, who suffered from major depression and attention-deficit disorder. As

set forth in OAG's Secret Shopper Study, Carelon "gave her a list of eight in-network providers, but none accepted new patients[.]" Respondents sent the same list of providers to OAG, suggesting they were available in-network providers, despite the fact that the Member's out-of-network provider had filed a written grievance with Respondents a month earlier, stating that he called ***the same providers***, who told him they could not treat the Member. After several months and OAG's intervention, Respondents entered into a single-case agreement with an out-of-network psychiatrist.

The Harms Caused by Inaccurate Provider Directories

40. Inaccurate provider directories may cause consumers seeking health care to expend additional time and resources combing through website listings and calling providers' offices to secure an appointment with an in-network provider. Ghost networks can exacerbate behavioral health conditions, creating additional anxiety and feelings of hopelessness for patients who may delay or forego care altogether due to the difficulty of accessing services, the cost, or both.[11]

41. Surveys consistently show that lack of adequate insurance coverage is a major reason why consumers with behavioral health conditions go without treatment. According to a

[11] John E. Dicken, Gov't Accountability Off., GAO-22-104597, Mental Health Care; Access Challenges for Covered Consumers and Relevant Federal Efforts 12 (2022) ("2022 GAO Report"), at 17, https://www.gao.gov/assets/gao-22-104597.pdf; *Barriers to Mental Health Care: Improving Provider Director Accuracy to Reduce the Prevalence of Ghost Networks*¸ U.S. Senate Committee on Finance 2–3 (May 3, 2023) (written testimony of Mary Giliberti, Chief Public Policy Officer, Mental Health America), https://www.finance.senate.gov/imo/media/doc/Mary%20Giliberti-written%20testimony%205-1.pdf; *id.* at 2 (testimony of Robert L. Trestman, PhD, MD On Behalf of the American Psychiatric Association), https://www.finance.senate.gov/imo/media/doc/Robert%20Trestman%20APA%20testimony%20050123%20FINAL.pdf [hereinafter Trestman Testimony]. *See also* Simon F. Haeder et al., *A Knotty Problem: Consumer Access and the Regulation of Provider Networks*, 44 J. Health Pol. Pol'y L. 937, 938-39 (2019) [hereinafter Haeder et al., *A Knotty Problem*], https://read.dukeupress.edu/jhppl/article-abstract/44/6/937/139734/A-Knotty-Problem-Consumer-Access-and-the?redirectedFrom=fulltext; Simon F. Haeder et al., *Going the Extra Mile? How Provider Network Design Increases Consumer Travel Distance, Particularly for Rural Consumers*, J. Health Pol. Pol'y L. 1107, 1127 (2020) [hereinafter Haeder et al., *Going the Extra Mile?*], https://pubmed.ncbi.nlm.nih.gov/32464649/; Jinkyung Kim et al., *Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care*, 44 Health Serv. Rsch. 145, 156-57 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669622/.

2022 survey conducted by The Harris Poll, 43 percent of Americans who needed mental health or substance-use-related care in the past year did not receive it, compared to only 21 percent of those who needed primary care.[12] Notably, 43 percent of those who did not receive necessary mental health care in the past year cited insurance-related issues as the barrier and 37 percent reported that cost-related issues prevented them from accessing care.[13]

42. Inaccurate provider directories—and the resultant inability to find in-network providers—lead many consumers to seek out-of-network care.[14] A study analyzing health insurance claims data showed much greater out-of-network provider use for behavioral health and physical health services.[15] In New York in 2017, outpatient behavioral health office visits were 10 times more likely than medical/surgical inpatient stays and primary care visits to be out-of-network.[16]

43. Many consumers who use out-of-network providers are confronted with surprise bills. In other words, they did not initially know that a provider was out-of-network. In a national survey conducted in 2018, the majority of respondents who had used a mental health provider directory encountered inaccuracies, and as a result of those inaccuracies, were twice as likely as recipients of general medical services to be treated by an out-of-network provider and four times more likely to receive an unexpected outpatient out-of-network bill.[17]

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[12] Nat'l Council for Mental Wellbeing, 2022 Access to Care Survey Results, at 4 (May 11, 2022), https://www.thenationalcouncil.org/resources/2022-access-to-care-survey-results/.
[13] *Id.* at 9, 20.
[14] 2022 GAO Report, at 17.
[15] Stoddard Davenport et al., Milliman Research Report, Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement 6 (2019), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/importedfiles/ektron/AddictionandmentalhealthvsphysicalhealthWideningdisparitiesinnetworkuseandproviderreimbursement.pdf.
[16] *Id*. at 65.
[17] Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39 Health Affs. 975, 978–80 (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

44. Higher out-of-network utilization results in higher costs for consumers. A study of psychotherapy costs between 2007 and 2017 found that out-of-network prices dramatically increased for both adults (from $123.30 to $148.64) and children (from $119.83 to $139.18), even as in-network prices and cost sharing declined.[18] Consumers who lack out-of-network benefits must pay the entire cost of treatment, which is a strong deterrent to seeking care.

45. The harms related to the lack of adequate behavioral health service providers in New York State fall disproportionately on populations that are already marginalized in the health care system.

Disparities between Administration of Behavioral Health Services and Medical/Surgical Services

46. Carelon states in its Provider Handbook, which is available on its public website, that it "manages mental health and substance use disorder services of benefit plans sponsored and/or administered, in whole or in part, by companies and organizations contracted with Carelon in compliance with applicable laws, rules, and regulations, including without limitation the Federal Mental Health Parity and Addictions Equity Act, Affordable Care Act, state parity laws, and regulations."[19]

47. Carelon also states on its public website, as required by the 2015 AOD, that for fully funded and state and local governmental health plans in New York it "administers, subject to medical necessity, benefits for inpatient and outpatient behavioral health care, which are at least equal to and no more restrictive than medical/surgical benefits under the plan[.]"[20]

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[18] Nicole M. Benson & Zirui Song, *Prices and Cost Sharing for Psychotherapy In Network Versus Out Of Network In The United States*, 39 Health Affs. 1210, 1212–1213 (July 2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01468. The prices are adjusted to 2016 US dollars.

[19] Carelon Behavioral Health Provider Handbook, https://www.carelonbehavioralhealth.com/content/dam/digital/carelon/pdf/Carelon%20Behavioral%20Health%20Provider%20Handbook.pdf, at 9.

[20] Carelon Mental Health Parity Disclosures, https://plan.carelonbehavioralhealth.com/members/mental-health-parity-disclosures/.

48. Despite its public commitments, including in the 2015 AOD, Carelon continues to exhibit a lack of compliance with behavioral health parity laws. For example, there are notable disparities in "in-network exceptions" granted to Members who are seeking behavioral health services and those seeking medical/surgical care. In-network exceptions allow Members to see out-of-network providers at in-network cost sharing due to difficulties finding Participating Providers. Exceptions were granted for behavioral health services at a far greater rate than medical/surgical services in at least one of Carleon's client health plans. In 2022, Respondents' GHI business had 195 Members with in-network exceptions for behavioral health services, but only eight for medical/surgical services, despite having many times more Members receiving medical/surgical services than mental health services. In the second quarter of 2024, Respondents' HIP business had 442 in-network exceptions for behavioral health services but only 19 for medical/surgical services, despite having many times more Members receiving medical/surgical services than mental health services. Such disparities suggest, as has been shown nationally, that Members have difficulties finding Participating Providers at a far greater rate for behavioral health treatment than for medical/surgical treatment. Compounding the harm, Respondents did not ensure Members paid only in-network cost sharing when they had to see out-of-network providers due to inability to secure an appointment with an appropriate in-network provider, despite being required to do so.

49. Further, Carelon has not conducted an analysis of provider reimbursement for New York health plans it services, for purposes of assessing compliance with behavioral health parity laws. Respondents are aware that reimbursement rates for behavioral health services are low, acknowledging in an internal email that "besides Medicaid we just run extremely conservative on all our rate negotiations and honestly in many situation at [sic] for professional

may be underpaying in the aggregate and creating access issues."

LEGAL REQUIREMENTS

Directory Accuracy Requirements

50. New York law requires provider directories to include a listing, by specialty, of the name, address, and telephone number of all participating providers, noting whether each provider is accepting new patients. N.Y. Ins. Law §§ 3217-a(a)(17) and 4324(a)(17); N.Y. Pub. Health Law § 4408(1)(r). For mental health and substance use disorder treatment providers, the directories must include any affiliations with participating facilities certified or authorized by the Office of Mental Health ("OMH") or the Office of Addiction Services and Supports ("OASAS"), and any restrictions regarding the availability of the individual provider's services. The provider directory must reside on a website and be updated within 15 days of the addition or termination of a provider from a health plan network or a change in a physician's hospital affiliations.

51. New York law requires that if a health plan member receives a bill for out-of-network services resulting from inaccurate network status information, the member can be charged only their in-network cost sharing, regardless of whether the member's coverage includes out-of-network services. N.Y. Ins. L. §§ 3217-b(n) and 4325(o); N.Y. Pub. Health L. § 4406-c(12); 11 N.Y.C.R.R. § 52.77(a).

52. New York regulations require that "every MCO [managed care organization] shall maintain and update, on a quarterly basis, a listing by specialty of the names, addresses and telephone numbers of all participating providers, including facilities, and in the case of physicians, board certification. Where the MCO contracts with behavioral health facilities rather than directly with behavioral health providers, the provider types available at the facilities must be included in the listing." 10 N.Y.C.R.R. § 98-1.16(i).

53. The federal No Surprises Act requires all private health plans to maintain accurate online provider directories, verify their directories at least every 90 days, and post any changes within two business days. 42 U.S.C. § 300gg-115(a). Plans must apply in-network cost sharing for covered services provided by providers inaccurately listed as in-network. 42 U.S.C. § 300gg-115(b).

Network Adequacy Requirements

54. New York law requires each commercial health plan to "ensure that the[ir] network is adequate to meet the health and mental health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract." N.Y. Ins. Law § 3241(a)(1).

55. New York health plans must provide referrals to non-participating providers at in-network cost sharing for members who are unable to access an appropriate participating provider. N.Y. Ins L. §§ 4804(a) and 4910(b)(4).

56. Each qualified health plan ("QHP") sold on the New York State of Health Marketplace must maintain a network "that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay." 45 C.F.R. § 156.230(a)(1)(ii).

Behavioral Health Parity Requirements

57. The Mental Health Parity and Addiction Equity Act ("MHPAEA") prohibits health plans from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than the treatment limitations they apply to medical/surgical benefits. 42 U.S.C. § 300gg-26. "Treatment limitations" include nonquantitative treatment limitations ("NQTLs"), "which otherwise limit the scope or duration of benefits for treatment

under a plan or coverage." NQTLs include "[s]tandards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage." 45 C.F.R. § 146.136(c)(4)(ii). A plan may not impose an NQTL on mental health or substance use disorder benefits unless, "as written and in operation," the NQTL is "comparable to" and "applied no more stringently" than to medical/surgical benefits. 45 C.F.R. § 146.136(c)(4)(i)(A). For example, if a health plan takes steps to ensure it has an adequate number of in-network medical/surgical providers, the plan must take comparable steps to ensure an adequate number of in-network mental health and substance use disorder providers. Plans must also "perform and document comparative analyses of the design and application of NQTLs." 42 U.S.C. § 300gg-26(a)(8)(A).

58. New York's behavioral health parity law (originally enacted as "Timothy's Law") incorporates the requirements of MHPAEA. N.Y. Ins. L. §§ 3216(i)(31), (i)(35); §§ 3221(l)(5), (7); §§ 4303(g), (l).

Obligations to Provide Accurate, Non-Misleading Information

59. New York General Business Law § 349(a) prohibits "unfair, deceptive, or abusive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service" in New York State.

60. New York General Business Law § 350 prohibits false advertising "in the conduct of any business, trade or commerce or in the furnishing of any service" in New York.

61. New York Insurance Law § 2601(a) prohibits unfair claim settlement practices,

including, but not limited to, knowingly misrepresenting to claimants pertinent facts relating to coverage.

62. New York Insurance Law § 4226 prohibits misrepresentations and misleading statements by insurers.

63. OAG finds that Respondents' actions and omissions are in violation of: New York Executive Law § 63(12); Insurance Law §§ 2601(a), 3217-a(a)(17), 4324(a)(17), 3241(a)(1), 3216(i)(31) & (35), 3221(l)(5) & (7), 4303(g) & (l), and 4226; Public Health Law § 4408(1)(r); General Business Law §§ 349(a) and 350; 10 N.Y.C.R.R. § 98-1.16(i); 42 U.S.C. §§ 300gg-115(a) and 300gg-26; and 45 C.F.R. §§ 146.136(c) and 156.230(a)(1)(ii).

64. OAG finds that Respondents violated provisions of the 2015 AOD.

65. Respondents neither admit nor deny OAG's Findings, Paragraphs 1 through 49, above.

66. OAG finds the relief and agreements contained in this Assurance appropriate and in the public interest. THEREFORE, OAG is willing to accept this Assurance pursuant to Executive Law § 63(15), in lieu of commencing a statutory proceeding for violations of Executive Law § 63(12) based on the conduct described above during the period of January 1, 2020, through present.

IT IS HEREBY UNDERSTOOD AND AGREED, by and between the Parties:

RELIEF

Entities Bound By Assurance

67. This Assurance binds Carelon Behavioral Health, Inc. and Carelon Behavioral Health IPA, Inc., as well as their principals, officers, successors, and assigns.

Compliance with the Law

68. Respondents shall not engage, or attempt to engage, in conduct in violation of any applicable laws and regulations, including but not limited to New York Executive Law § 63(12); Insurance Law §§ 2601(a), 3217-a(a)(17), 4324(a)(17), 3241(a)(1), 3216(i)(31) & (35), 3221(l)(5) & (7), 4303(g) & (l), and 4226; Public Health Law § 4408(1)(r); General Business Law §§ 349(a) and 350; 10 N.Y.C.R.R. 98-1.16(i); 42 U.S.C. § 300gg-115(a) and 300gg-26; and 45 C.F.R. §§ 146.136(c) and 156.230(a)(1)(ii), and expressly agree and acknowledge that any such conduct is a violation of the Assurance, and that OAG thereafter may commence the civil action or proceeding contemplated in Paragraph 66, in addition to any other appropriate investigation, action, or proceeding.

PROGRAMMATIC RELIEF

69. Respondents will begin to implement the relief described in Paragraphs 71 through 97 below immediately upon the full execution of this Assurance.

70. For avoidance of any doubt, the relief described in Paragraphs 71 through 97 below apply to all commercial health plans, New York State or local governmental employee health plans, Essential Plan products, Qualified Health Plans, Medicaid managed care plans, and Child Health Plus plans for which Respondents administer behavioral health benefits. The relief described in Paragraphs 71 through 97 below does not apply to self-funded plans governed by ERISA. For avoidance of doubt, the relief described in Paragraphs 71 through 97 applies to fully insured plans governed by ERISA.

71. For those health plans for which Respondents are delegated responsibility by their client health plan for maintaining an Online Participating Provider Directory (a "Directory Delegated Plan")—which include Emblem, NYSHIP (Empire Plan), IHA, Hamaspik, Village Care Max, Amida Care, Elderplan, and VNS—Respondents shall maintain an Online

Participating Provider Directory that includes an accurate listing for each Participating Provider ("Participating Provider Information") that shall include:

a. name, address, telephone number, licensure, and digital contact information;

b. whether the provider or facility is accepting new patients;

c. for mental health and substance use disorder providers, any affiliations with participating facilities certified or authorized by OMH or OASAS;

d. any restrictions regarding the availability of the individual provider or facility's services, including but not limited to any limits on the ages of patients that the provider treats or the type of specific behavioral health conditions that the provider treats;

e. languages other than English spoken by the Participating Provider; and

f. for physicians, board certification and any affiliations with participating hospitals.

72. For Directory Delegated Plans, Respondents shall on all Online Participating Provider Directories include a clear and conspicuous link next to each Participating Provider listing through which Members, Participating Providers, and members of the public can report inaccurate information contained in such directories. Respondents shall monitor reports of inaccurate directory information on a continuous basis.

73. For Directory Delegated Plans, Respondents shall, as of the Effective Date of this Assurance:

a. correct the Online Participating Provider Directory within two (2) business days after learning of, or receiving information regarding, the beginning or termination of network agreements, and/or changes to the Participating Provider Information set forth in Paragraph 71 above.

b. within two (2) business days after Respondents learn that a provider is not accepting new patients, add a notation in the Online Participating Provider Directory that such provider is not accepting new patients, subject to the provisions of Paragraph 75, including but not limited to the claims analysis.

74. For Directory Delegated Plans, Respondents shall create and maintain a "Behavioral Health Participating Provider Directory Deletion/Addition Report," which shall include, for behavioral health providers who are removed from or added to the Online Participating Provider Directory, the following information: name, office address, date of removal or addition, reason for removal or addition, and if applicable, date on which their participation in the applicable plan's networks ended. As used in this Assurance, a "Behavioral Health Provider" is a New York-licensed or certified individual (psychiatrist, psychiatric nurse practitioner, master social worker, clinical social worker, psychologist, mental health counselor, creative arts therapist, marriage and family therapist, psychoanalyst, or credentialed alcoholism and substance abuse counselor) who treats behavioral health conditions, or a hospital, institution, facility, clinic, program, or agency licensed by OMH or OASAS. Within sixty (60) days after the Effective Date, Respondents shall submit to OAG the first Behavioral Health Participating Provider Directory Deletion/Addition Report for such plan, which shall include the results of the review process described in Paragraph 75(a)(ii)(3) below. Respondents shall submit to OAG the next Behavioral Health Participating Provider Directory Deletion/Addition Report for the applicable plan six (6) months after the Effective Date, and subsequent reports at six-month intervals.

75. ***Verification Process***. Within thirty (30) days after the Effective Date, Respondents shall submit to OAG for approval a written policy and procedure containing the provisions set

forth in this Paragraph, establishing an Online Participating Provider Directory verification process for Directory Delegated Plans and for health plans for which Respondents are delegated responsibility by their client health plan for verifying the accuracy of Participating Provider Information (a "Verification Delegated Plan"), which includes NYSHIP, Emblem, Anthem, Independent Health, Amida Care, VNS Health, Elderplan, Village Care Max, and Hamaspik ("Verification Process"). Respondents shall implement Paragraph 75(a)(ii)(3) within sixty (60) days after the Effective Date except for Emblem plans administered by Respondents, for which the requirement is thirty (30) days. Respondents shall implement the other provisions of the Verification Process within thirty (30) days after OAG approval. The Verification Process shall include the following:

a. Every ninety (90) days (a "Verification Cycle"), Respondents shall:

i. Outreach each credentialed behavioral health Participating Provider by electronic means, fax, or through U.S. mail (for those that opt out of electronic communications) to request they verify the accuracy of information included in their directory listing. Electronic means shall include, but not be limited to, a pop-up message triggered upon login to provider websites maintained by Respondents, which is linked to a directory information accuracy verification form.

ii. Stratify Participating Providers into three groups:

1. Providers who remain in the directory. These include providers who verified the accuracy of their directory information ***and*** do not fall within subsections (2) and (3) below.

2. Providers who remain in the directory but require further investigation.

Regardless of whether a Participating Provider attests to the accuracy of their directory information, Respondents shall investigate the accuracy of the Participating Provider Information, including at least two follow-up contacts with providers—the second of which shall be via telephone—to confirm their continued participation in Respondents' provider network, in the following situations:

a. Providers who have not submitted a claim within the last ninety (90) days. If Respondents do not timely confirm such providers' continued participation in the applicable provider network(s), Respondents shall remove such providers from the Online Participating Provider Directories.

b. Providers with deactivated, invalid, missing or HHS OIG Exclusion-listed NPIs.

c. Providers listed as practicing at five or more unaffiliated locations.

d. Unlikely specialty combinations. For example, Participating Providers who practice at hospitals but are listed as treating outpatients, including providers under whose NPI's no outpatient claims have been submitted. If a Participating Provider practices at a hospital but does not treat outpatients, their Participating Provider Directory listing shall so indicate in a clear and conspicuous manner.

3. Providers who must be removed from the directory. Within sixty (60) days after the Effective Date (except for Emblem plans administered by Respondents, for which the requirement is thirty (30) days), Respondents

shall complete a review of their most recent provider verification information and, within fifteen (15) days after such review, remove Participating Providers: (i) who did not respond to Respondents' most recent verification request; and/or (ii) for whom Respondents have information, including but not limited to a response to a verification request or other communication to Respondents, that they are no longer providing services or no longer participating with Respondents, or not accepting new patients. Thereafter, Respondents shall remove Participating Providers who do not verify their directory information within fifteen (15) days after a Verification Cycle, or within two (2) business days from when Respondents receive information, including but not limited to a response to a verification request or other communication to Respondents, that they are no longer providing services, or no longer participating with Respondents, regardless of a Verification Cycle. If a Provider does not verify their directory information within fifteen (15) days after a Verification Cycle, but in the past ninety (90) days has submitted to Respondents claims, request for authorization, and/or medical records, such Provider may remain in the directory but with a notation that they are not accepting new patients, and Respondents shall perform diligence to ensure the directory information for the Provider is accurate and take all reasonable steps to secure a verification as soon as possible. If Respondents cannot verify such Providers' directory information, they shall remove such Providers from the applicable Online Participating

Provider Directories.

iii. Conduct rolling outreach such that each Participating Provider verifies the accuracy of their information every ninety (90) days. In other words, the provider's verification resets the 90-day cycle.

iv. Maintain documentation of all efforts undertaken in the Verification Process for each Participating Provider listed in an Online Participating Provider Directory, which shall accurately reflect the dates on which each provider's Participating Provider status and Participating Provider Information were verified. If Respondents use telephone communications to verify Participating Provider status and Participating Provider Information as part of their Verification Process, it shall record any and all telephone calls.

v. Conduct educational outreach to professional associations to emphasize the importance of provider cooperation in Respondents' Verification Process.

76. ***Response Protocol***. Within thirty (30) days after the Effective Date, Respondents shall submit to OAG for approval a written policy and procedure containing the provisions set forth in this Paragraph, establishing a protocol for processing requests for information, complaints, grievances, and appeals from Members and others acting on their behalf (including family members and providers) relating to access to Participating Providers for plans for which Respondents are delegated such functions (G&A Delegated Plans) ("Response Protocol"). These plans include Emblem, NYSHIP, IHA, and Amida Care. Respondents shall implement the Response Protocol within thirty (30) days after OAG approval. The Response Protocol shall include the following:

a. For Members with G&A Delegated Plans who seek assistance from Respondents

with finding or making an appointment with a Participating Provider and/or request information regarding whether a provider is in-network, Respondents shall reply to the Member to indicate whether the provider is a Participating Provider as soon as practicable and in no case later than one (1) business day after such communication is received by Respondents. Respondents shall communicate with the Member in the manner (e.g., electronic, print, telephonic) as requested by the Member, or if no such request, via the same means as the Member used in the initial contact. If telephonic means are used and Respondents are unable to reach the Member by telephone, Respondents shall use a secondary means to reach the Member. Respondents shall retain such communication in such Member's file for at least two (2) years following such response.

b. The Response Protocol shall include, and Respondents shall comply with, the following provisions:

   i. Provide notice to Members with G&A Delegated Plans in all complaint, grievance, and appeal acknowledgment and determination letters, adverse determination letters, explanations of benefits, and similar types of communications drafted or sent by Respondents, regarding their rights under the 2025 New York network adequacy and access regulations, 11 NYCRR § 38.0, 10 NYCRR § 98.0, including their rights to file complaints related to inability to access services with a behavioral health provider ("Access Complaints") and receive out-of-network exceptions. For purposes of this Assurance, in addition to statutory or regulatory meanings, a "Complaint" shall include any communication in which a Member expresses any form of

dissatisfaction ("Member Dissatisfaction"), including but not limited to difficulty locating a behavioral health provider, concerns about behavioral health providers, and/or frustration with any Carelon process. "Member Dissatisfaction" includes but is not limited to any expression of frustration, anger, or disappointment, in tone or in words to the effect of "unhappy," "discuss with your supervisor," "someone else review," "have been waiting," "keep calling," "disappointed," "violate," "fed up," "too long," "confusing," "awful," "suffering," and "sensitive." For avoidance of doubt, to lodge a Complaint a Member need not use the actual word "Complaint" or other specific words or phrases. If a Carelon representative is unsure whether a Member wishes to lodge a Complaint, such representative must treat the Member's communication as a Complaint.

ii. Consider any Access Complaint related to access to behavioral health services to be presumptively valid.

iii. Waive the three-day waiting period under 11 NYCRR § 38.0 and 10 NYCRR § 98.0 for Access Complaints in urgent cases. In this AOD, an "urgent case" is defined as an acute condition or a condition that may become an emergency if not treated.

iv. Before providing referrals or names of providers to Members, Respondents must contact such providers—via telephone or other means that may be approved by the OAG—and confirm in real time that they accept new patients and can treat the Member.

v. Respondents shall not state or suggest to Members that responsibility for

accurate directories rests with providers.

vi. If a Member lodges a Complaint, grievance, or appeal regarding surprise bills with Respondents, Respondents must inform the Member about the requirements under New York law (11 NYCRR § 52.77) and federal law (42 U.S.C. § 300gg-115(b)) that Members be held harmless (responsible only for in-network cost-sharing) when given inaccurate network status information.

vii. If a Member lodges a Complaint, grievance, or appeal with Respondents stating they called a provider after receiving a provider's information from Respondents and the information given about the provider's in-network status or ability to see new patients was inaccurate, Respondents must hold the Member harmless (responsible only for in-network cost-sharing) unless Respondents can prove with documentary evidence that it did not provide inaccurate information.

viii. If a Member lodges a Complaint, grievance, or appeal about a vendor or telehealth entity that contracts with Respondents (e.g., Valera, TalkSpace, etc.), Respondents must immediately escalate and resolve the Complaint, grievance, or appeal within three (3) business days, except in the case of expedited appeals under New York Insurance Law § 4904, in which case the appeal must be determined within two (2) business days, or twenty-four (24) hours for inpatient substance use disorder treatment.

ix. Respondents shall coordinate with the G&A Delegated Plans to resolve any Complaint, grievance, or appeal that such health plan believes concerns

behavioral health benefits.

x. Respondents must consider any Complaint, grievance, or appeal relating to access to care under urgent time frames if the Complaint, grievance, or appeal indicates it could be urgent.

xi. Respondents must follow up with a Member who lodges a Complaint, grievance, or appeal about provider availability, to confirm the Member has made an appointment, by sending to the Member at least one communication by email or other means of contact requested by the Member, and making at least one phone call to the Member.

xii. Respondents must comply with the New York Continuity of Care law, N.Y. Ins. L. §§ 3217-d(c), 4306-c(c), 4804(e) & (f), and N.Y. Pub. Health L. § 4403(6)(e) & (f)), with respect to Members who lodge a Complaint, grievance, or appeal about their provider leaving Respondents' network.

77. ***Incorrect Directory Information Protocol.*** Within thirty (30) days after the Effective Date, Respondents shall submit to OAG for approval an Incorrect Directory Information Protocol for communications with Members, including Members of Directory Delegated Plans and G&A Delegated Plans containing the provisions set forth in this Paragraph. Respondents shall implement the Incorrect Directory Information Protocol within thirty (30) days after OAG approval. The Incorrect Directory Information Protocol shall include the following:

a. If Respondents provide inaccurate network status information to a Member, as defined below, Respondents must hold the Member harmless (responsible only for in-network cost-sharing).

b. Respondents shall be deemed to provide inaccurate network status information if

Respondents:

i. indicate in their Online Participating Provider Directory that a non-participating provider is participating in Respondents' networks;

ii. indicate, through their Response Protocol, that a non-participating provider is participating in Respondents' networks;

iii. indicate incorrectly that a provider is accepting new patients; and/or

iv. fail to provide information regarding a specific provider's participating status within one (1) business day of a request from a Member.

c. The Incorrect Directory Information Protocol shall include, and Respondents shall comply with, the following provisions:

i. If a Member lodges a Complaint, grievance, or appeal stating they contacted providers (including those given by Respondents), but such providers were not available or did not answer or respond, Respondents must deem such Complaint, grievance, or appeal substantiated unless Respondents timely prove otherwise, and hold the Member harmless, as defined above.

ii. If a Member lodges a Complaint, grievance, or appeal stating they called a provider Respondents provided but does not supply the name(s) of such provider(s), Respondents must search their files for all communications with such Member and cannot shift the burden to such Member to supply Respondents with information they already have.

iii. Respondents must remove providers they cannot reach from their Provider Directories, and from databases used to supply information to Members.

iv. Respondents cannot tell Members that Respondents lack jurisdiction over out-

of-network providers.

78. ***Appointment Waiting Times.*** Respondents shall ensure that Members are able to obtain appointments with behavioral health providers within the following time frames ("Access Time Frames"):

a. For commercial and state and local employee health plan Members:

i. Emergency care: Member must be seen immediately.

ii. Urgent care: Member must be seen within twenty-four (24) hours.

iii. Initial appointment with an outpatient facility or clinic, or a health care professional not employed or contracted with an outpatient facility or clinic: Ten (10) business days.

iv. Appointment following a discharge from a hospital or an emergency room visit: Seven (7) calendar days.

b. For Medicaid Members:

i. Emergency care: immediately upon presentation.

ii. Inpatient services: immediately upon presentation.

iii. Urgently needed services: twenty-four (24) hours.

iv. Non-urgent care: Seven (7) calendar days.

79. ***In-Network Exceptions.*** Within thirty (30) days of the Effective Date, Respondents shall submit for OAG approval a written policy and procedure that establishes a protocol for Members and others acting on their behalf, including but not limited to family members and providers, to request in-network exceptions when Members cannot obtain an appointment with an appropriate provider within Access Time Frames set forth in Paragraph 78 above (the "In- Network Exception Protocol"). Pursuant to such in-network exceptions, Members

shall be held harmless (responsible only for in-network cost-sharing). The In-Network Exception Protocol shall include the following:

a. For Members who say they were unable to secure a timely appointment with a Participating Provider, Respondents shall have three (3) business days—except for emergent and urgent cases—from receipt of the Member communication to locate a Participating Provider that can treat the Member's behavioral health condition and is able to meet the appointment wait times set forth in Paragraph 78 above. If no appropriate Participating Provider is identified, Respondents shall allow the Member to see a non- participating provider and hold the Member harmless (responsible only for in- network cost-sharing), regardless of whether Respondents are able to enter into a single-case agreement with a provider.

b. For its health plan clients that use FAIRHealth data as a benchmark for out-of-network reimbursement, Respondents shall use FAIRHealth out-of-network rates, and not in-network rates, as the benchmark for negotiation of rates under single-case agreements.

80. ***Audits***. Respondents shall:

a. At least once per quarter, conduct behavioral health Participating Provider secret shopper surveys using the methodology set forth in OAG's December 2023 report titled "Inaccurate and Inadequate," and make the results publicly available.

b. For any audit or survey of Participating Provider directory accuracy or provider access and availability, including but not limited to digital audits and secret shopper surveys, include in calculations of rates of directory accuracy and provider access and availability all attempted contacts, including those that: (i) do

not result in offers of appointments that satisfy the appointment availability standards set forth in this Assurance; or (ii) result in no response or answer, a wrong number or email, a disconnected number, or an unreturned call or voicemail.

81. ***Complaint Monitoring System***. Within thirty (30) days of the Effective Date, Respondents shall establish a Participating Provider Directory/Network Access Complaint Monitoring System for G&A Delegated Plans ("Complaint Monitoring System"). Respondents shall:

a. log and track by date all Complaints, grievances, or appeals relating to the subject matter of this Assurance, including but not limited to inaccurate Online Participating Provider Directory listings, network access issues, and requests for in-network exceptions made to or through Respondents' regulatory affairs group, executive/concierge Complaint process or the like, customer service lines, and Complaint, grievance, and appeal processes.

b. document how each Complaint, grievance, and appeal was handled and resolved.

c. provide to OAG every six (6) months following the Effective Date of this Assurance a report listing the information contained in (a) and (b) ("Complaint Report").

82. ***Behavioral Health Participating Provider Recruitment and Retention Plan***. Within ninety (90) days of the Effective Date, to improve access to behavioral health services, Respondents shall create and submit to OAG a behavioral health provider recruitment and retention plan ("Behavioral Health Provider Recruitment and Retention Plan"), which shall include a detailed description of the mechanisms through which Respondents will work to

expand their network of behavioral health providers. The Behavioral Health Provider Recruitment and Retention Plan shall include, at a minimum, specific proposals for: (a) outreach to New York-licensed behavioral health providers who are not currently Participating Providers, including psychiatrists, psychiatric nurse practitioners, master social workers, clinical social workers, psychologists, mental health counselors, creative arts therapists, marriage and family therapists, psychoanalysts, and credentialed alcoholism and substance abuse counselors; (b) periodically reviewing existing provider fee schedules and network needs for Behavioral Health Participating Providers; (c) reducing administrative burdens on providers; (d) estimating expected utilization of behavioral health services based on anticipated Member enrollment and health care needs of the Member population; (e) an analysis of the number and types of behavioral health care providers required to furnish covered behavioral health services, the number and types of providers actively providing behavioral health services within Respondents' network, and the number and types of providers accepting new patients; (f) an analysis of the collection and monitoring of data on provider-to-enrollee ratios, travel time and distance to participating providers, percentage of participating providers accepting new patients, and appointment wait times; and (g) investigating the role of telehealth in providing access to behavioral health services.

83. ***Training***. Respondents shall develop a written training protocol regarding the provisions in Paragraphs 71 through 82 above for all personnel involved in: administering Respondents' Online Provider Directory; ensuring directory accuracy; ensuring network adequacy; assisting plans for which Respondents administer behavioral health benefits in ensuring behavioral health parity; handling Member Complaints, grievances, and appeals relating to directory accuracy and/or network adequacy; and/or provider relations ("Relevant Personnel"),

regardless of whether they are employed by Respondents or third parties, or are independent contractors. Respondents shall submit a written training protocol to OAG within thirty (30) days of OAG approval of the written policies and procedures described in Paragraphs 71 through 82.

a. Respondents shall train all Relevant Personnel based on the written materials. Key Relevant Personnel (as designated by Respondents and approved by OAG) shall be trained on the materials within three (3) months of OAG approval of such materials, and all other Relevant Personnel shall be trained within six (6) months of OAG approval of such materials. Thereafter, new Relevant Personnel will be trained within thirty (30) days of commencing their duties. Training will continue on an annual basis and must be provided to all Relevant Personnel no less than one time per year until three years after the Effective Date.

b. Respondents shall create and maintain records regarding all training conducted pursuant to this Paragraph, including records of attendance. Such records shall be reviewed by the Independent Monitor as part of its audits (as set forth below), and provided to OAG no more than fourteen (14) days after a demand for such records is made.

84. Respondents shall make new and meaningful investments in implementing the following initiatives and, during the period in which the Independent Monitor functions (see Paragraphs 85 through 89 below), shall report annually to OAG a summary of the investments made:

a. Recruiting additional psychiatrists and psychiatric nurse practitioners who treat children and adolescents into Respondents' provider networks, through outreach efforts to: hospitals; clinics; professional associations; medical fellowship, residency

and internship programs; medical schools; universities and colleges; behavioral health advocacy organizations; and other community resources.

b. Providing assistance to Members in navigating Respondents' Online Provider Directories and locating behavioral health providers who can timely treat them in a convenient setting. This shall include hiring additional staff for customer service, and Complaints, grievances and appeals.

c. Providing assistance to providers in navigating Respondents' directory information verification process. This shall include additional staff for provider relations.

d. Conducting outreach to Members regarding mental health services spanning the continuum of care that are available in their communities and covered by Respondents.

MONITORING AND OVERSIGHT BY INDEPENDENT MONITOR

85. Within thirty (30) days of the Effective Date, Respondents will designate a person or entity, subject to reasonable approval by OAG, with experience in directory accuracy and network adequacy processes, provider networks, behavioral health parity, and health insurance claims processes, to serve as an independent monitor ("Independent Monitor"), who will submit to OAG bi-annual reports detailing Respondents' compliance with the requirements set forth in this Assurance, Paragraphs 71 through 83 (each, a "Compliance Report"). The first such Compliance Report shall be submitted to OAG nine (9) months after the Effective Date (the "First Compliance Report"). Subsequently, Respondents shall submit Compliance Reports every six (6) months, continuing until three (3) years after the First Compliance Report, subject to the provisions of Paragraph 89 below. In any case where the circumstances warrant, OAG may require an interim Compliance Report upon thirty (30) days' notice.

86. Within thirty (30) days after the OAG approves the Independent Monitor, Respondents shall make all necessary information available to the Independent Monitor, including but not limited to the Online Participating Provider Directory, network adequacy information, provider network information, and health claims data systems.

87. The Compliance Reports shall: (a) assess Respondents' compliance with the programmatic relief set forth above in Paragraphs 71 through 83; (b) describe the Independent Monitor's performance of the analyses set forth below in Paragraphs 90 through 96; and (c) report on administration of the restitution process set forth below in Paragraph 97. Each Compliance Report shall include: detailed results of the Independent Monitor's reviews, including relevant statistics; the Complaint Report (described above in Paragraph 81); the Behavioral Health Participating Provider Directory Deletion/Addition Report (described above in Paragraph 74); and a description and schedule of any corrective measures taken by Respondents or planned to be taken by Respondents.

88. If, after the Independent Monitor has submitted at least (4) four Compliance Reports to OAG, Respondents demonstrate substantial compliance with the terms of this Assurance, and OAG agrees that Respondents are substantially compliant with the terms of this Assurance, the Independent Monitor shall cease to function. For avoidance of doubt, OAG retains its right to begin a new investigation.

89. If, after Respondents have submitted four Compliance Reports, OAG determines that Respondents are not substantially compliant with the terms of this Assurance, the Independent Monitor will continue to function and OAG shall produce a report setting forth Respondents' non-compliance with the terms of this Assurance and proposed steps for Respondents to come into compliance. Following such OAG report, the Independent Monitor, in

consultation with OAG, shall develop a plan of corrective action for Respondents to achieve compliance with the terms of this Assurance. Thereafter, the Independent Monitor's role shall terminate upon the conclusion of a six-month reporting cycle that shall occur after OAG deems that Respondents are in substantial compliance with the terms of this Assurance. Respondents can exercise an option to replace the Independent Monitor if necessary, with OAG's consent, not to be unreasonably withheld.

90. ***Verification process review.*** The Independent Monitor shall:

a. take a statistically valid random sampling of Participating Providers who were subject to Respondents' Verification Process (the "Verified Providers");

b. compare the Participating Provider Information of the Verified Providers that is contained in Respondents' Online Participating Provider Directory with current source documentation obtained through Respondents' Verification Processes and other quality control processes. The Independent Monitor may consult Respondents' documentation, including claims data, applicable scripts, email notices, other correspondences and telephonic recordings, as well as independent data sources used in the Verification Process described in Paragraph 75;

c. determine the percentage of those Verified Providers whose Participating Provider Information is accurately listed in Respondents' Online Participating Provider Directory (the "Accuracy Percentage"); and

d. if Respondents' Accuracy Percentage falls below the requirements set forth under federal and New York laws and regulations, the Independent Monitor shall develop and present to OAG an appropriate remedial action plan, including additional protocols, monitoring and/or retraining.

91. ***Access review***. The Independent Monitor shall:

a. survey two statistically significant samples of Participating Providers (the "Access Sample") to determine their next available appointment. There shall be one sample for Participating Providers in Respondents' networks for commercial plans, and a second sample for Participating Providers in Respondent's networks for Medicaid, Essential Plan, and Child Health Plus plans;

b. determine the percentage of the Access Sample who have an available appointment within the Access Time Frames set forth in Paragraph 78 above (the "Access Percentage");

c. if Respondents' Access Percentage falls below the regulatory requirements set forth under federal and New York laws and regulations, as indicated by OAG, develop and present to Respondents and OAG an appropriate remedial action plan, including additional monitoring, recruiting, and/or retraining; and

d. assess whether Respondents have approved in-network exceptions for all Members who were unable to access an appropriate Participating Provider within the wait times set forth in Paragraph 78, in accordance with Paragraph 79(a).

92. ***Out-of-network utilization review***. Respondents shall request from their client plans the following medical/surgical data, and if the client plans provide such data, Respondents shall include the data in its analysis. The Independent Monitor shall analyze Respondents' claims data to calculate:

a. by applicable rate code and provider type, the percentage of Members submitting claims for outpatient behavioral health treatment with out-of-network providers vs. in- network providers;

b. by applicable rate code and provider type, the percentage of Members submitting claims for outpatient medical/surgical treatment with out-of-network providers vs. in- network providers; and

c. the differences, if any, between (a) and (b).

93. ***Provider reimbursement review***. Respondents shall request from their client plans the following medical/surgical data, and if the client plans provide such data, Respondents shall include the data in its analysis. The Independent Monitor shall analyze a statistically valid random sampling of Respondents' claims data to calculate:

a. by applicable rate code and provider type, reimbursement rates for behavioral health Participating Providers;

b. by applicable rate code and provider type, reimbursement rates for medical/surgical participating providers; and

c. the differences, if any, between (a) and (b).

94. ***Network breadth review***. Respondents shall request from their client plans the following medical/surgical data, and if the client plans provide such data, Respondents shall include the data in its analysis. The Independent Monitor shall calculate:

a. the percentage of all behavioral health providers in Respondents' service area who are Participating Providers;

b. the percentage of all medical/surgical providers in Respondents' service area who are Participating Providers; and

c. The differences, if any, between (a) and (b).

95. ***Cultural competence review***. The Independent Monitor shall measure:

a. The percentage of Participating Providers who can communicate with patients in

languages other than English, based on a provider attestation; and

b. The percentage of Participating Providers who have received cultural competence training, based on a provider attestation.

96. ***Consumer complaint review***. The Independent Monitor shall analyze Respondents' Complaint Reports and available related data to:

a. determine patterns of Complaints, grievances, and appeals regarding directory inaccuracy and network inadequacy for G&A Delegated Plans;

b. determine opportunities for improvement, if any, in Respondents' responses to Complaints, grievances, and appeals for G&A Delegated Plans; and

c. evaluate the sufficiency of Respondents' Complaint, grievance, and appeal mechanisms for G&A Delegated Plans.

RESTITUTION

97. Respondents shall fully cooperate with Emblem and the Independent Monitor for Assurance of Discontinuance No. 24-009 regarding implementation of the restitution process set forth in Paragraph 104 therein. For their other Directory Delegated Plans and G&A Delegated Plans, Respondents shall implement a restitution process, with eligibility and payment determinations to be adjudicated by the Independent Monitor, as follows:

a. For the period beginning January 1, 2020, through the Effective Date (the "Restitution Period"), Respondents shall provide for restitution as set forth below to all Members with whom Respondents communicate, including Members of Directory Delegated Plans and G&A Delegated Plans, who are not Members of self-funded plans governed by ERISA who fall into one or more of the following categories, and who have not received restitution under another AOD or otherwise

("Eligible Members"):

i. Eligible Members who paid amounts in excess of any applicable in-network co-payment, coinsurance, or deductible for behavioral health services rendered by non-participating providers who were incorrectly listed as participating providers in Respondents' Online Participating Provider Directory at the time they received services ("Listed Non-Par Providers"). Listed Non-Par Providers shall include, but not be limited to, those providers who had terminated or disputed their participation status, or had not verified their participation status, but continued to be listed as participating providers. Such claims shall be referred to as "Directory Claims."

ii. Eligible Members who paid amounts in excess of any applicable in-network co-payment, coinsurance, or deductible for behavioral health services rendered by non-participating providers after being unable to secure an appointment with an appropriate in-network behavioral health provider. Such claims shall be referred to as "Network Claims."

iii. Respondents shall provide notice, in a form approved by OAG, on their member website regarding Eligible Members' ability to submit Directory Claims and Network Claims.

b. Directory Claims.

i. Respondents shall make available to the Independent Monitor records sufficient to enable them to identify and review Directory Claims received during the Restitution Period.

ii. The Independent Monitor shall identify all Directory Claims and

within sixty (60) days from the date that all Directory Claims are identified, Respondents shall issue restitution to each Eligible Member with a Directory Claim for amounts paid in excess of any applicable in-network co-payment, coinsurance, or deductible plus interest in the amount of 12 percent from the date of payment until the date restitution is issued, unless the Eligible Member has been reimbursed for such Claim by another source. The Independent Monitor is permitted to request additional time to identify specific Directory Claims if needed.

iii. Eligible Members shall be entitled to submit additional Directory Claims to the Independent Monitor for services rendered during the Restitution Period by the Listed Non-Par Providers, which the Independent Monitor shall review to determine if such claims are valid Directory Claims.

c. Network Claims.

i. Within thirty (30) days of the Effective Date, Respondents shall submit to OAG for approval a form of notice ("Notice") stating that Members may be eligible to submit Directory Claims and Network Claims. Respondents shall mail the Notice to all current and former Eligible Members who: (i) have previously submitted claims for behavioral health services rendered by non-participating providers; (ii) and/or are current or former Eligible Members of NYSHIP (New York State Health Insurance Program), fully insured Commercial, Essential Plan, and

Qualified Health Plan (QHP) plans who have do not have out-of-network benefits. Respondents shall also post the Notice on their public website. The Notice shall include:

1. a statement that all Eligible Members are entitled to submit restitution claims for services rendered by non-participating providers during the Restitution Period, after being unable to secure an appointment with an appropriate in-network behavioral health provider.
2. the procedures and timeframes for submitting a claim for restitution. Eligible Members will have one hundred (100) days to submit claims from the date Respondents mail the Notices (the "Claim Deadline"), except for Eligible Members who receive restitution for Directory Claims, who will have a one-time sixty (60) day period to submit additional Directory Claims after Respondents mail the restitution payments.
3. A statement that Eligible Members may also submit Directory Claims for services rendered during the Restitution Period by the Listed Non-Par Providers.

ii. The Independent Monitor shall send the Notice to all Members within forty-five (45) days of OAG's approval of the Notice. Respondents shall also post the Notice in clear and conspicuous locations on their public and Member websites.

iii. The Independent Monitor shall evaluate each Network Claim to determine if the Eligible Member received services from a non-

participating provider after being unable to secure an appointment with an appropriate in-network behavioral health provider despite undertaking efforts to secure an appointment with an appropriate in-network behavioral health provider (a "Valid Network Claim").

iv. For Each Valid Network Claim, the Independent Monitor shall calculate the amounts paid in excess of any applicable in-network co- payment, coinsurance, or deductible plus interest in the amount of 12 percent from the date of payment until the date restitution is expected to be paid (each a "Valid Network Claim Amount"). Within thirty (30) days after the Claim Deadline, the Independent Monitor shall calculate the aggregate total of all Valid Network Claim Amounts.

v. If the aggregate total of all Valid Network Claim Amounts is equal to or less than $8,000,000, within twenty (20) days of the Independent Monitor's delivery to Respondents and OAG of a calculation showing that the aggregate total of all Valid Network Claim Amounts is equal to or less than $8,000,000, Respondents shall arrange for restitution to be paid to the Eligible Member for such Eligible Member's Valid Network Claim Amount.

vi. If the aggregate total of all Valid Network Claim Amounts is greater than $8,000,000, the Independent Monitor shall calculate each Eligible Member's pro-rata reimbursement for their Valid Network Claim Amount ("Pro-Rata Valid Network Claim Amount). Each Eligible Member's Pro-Rata Valid Network Claim Amount shall be calculated as

follows: Eligible Member's Valid Network Claim Amount / aggregate total of all Valid Network Claim Amounts x $8,000,000.

vii. Within twenty (20) days of the Independent Monitor's delivery to Respondents and OAG of the calculation of each Eligible Member's Pro-Rata Valid Network Claim Amount, Respondents shall arrange for restitution to be paid to the Eligible Member for such Eligible Member's Pro-Rata Valid Network Claim Amount.

d. Within three (3) months of completion of restitution payments, the Independent Monitor shall submit to OAG a report documenting all Eligible Members who submitted claims for restitution, those to whom restitution was paid, those whose claims were denied, the provider's name and office address, dates services rendered, restitution amount and date paid, and reason for denial, if applicable.

GENERAL PROVISIONS

98. Acceptance of this Assurance by OAG is not an approval or endorsement by OAG of any of Respondents' policies practices or procedures, and Respondents shall make no representation to the contrary.

99. Compliance with Other Obligations. In the event that Respondents reasonably believe that the performance of their obligations under any provision of this Assurance would conflict with any federal or state law or regulation that may be enacted or adopted after the Effective Date of this Assurance such that compliance with both this Assurance and such provision of law or regulation is not possible, Respondents shall notify OAG promptly and the Parties shall meet and confer at their earliest convenience to attempt to resolve such alleged

conflict.

100. Respondents expressly agree and acknowledge that a default in the performance of any obligation under this Assurance is a violation of the Assurance against the defaulting Respondents, and that OAG thereafter may commence the civil action or proceeding contemplated in Paragraph 66, in addition to any other appropriate investigation, action, or proceeding, and that evidence that the Assurance has been violated shall constitute prima facie proof of the statutory violations described in Paragraph 63, pursuant to Executive Law § 63(15).

Ongoing Cooperation

101. Respondents agree to cooperate with all ongoing requests by OAG for information related to this investigation and to ensure compliance with this Assurance.

Penalties, Fees, Costs

102. Respondents shall pay to the State of New York $2,000,000 (two million) dollars in penalties, fees, and costs. Payment shall be made in full by wire transfer within thirty (30) business days of the Effective Date of this Assurance. OAG shall provide transfer information to Respondents.

103. The Parties agree that it would be difficult to value the damages caused by default in the performance of any obligation under this Paragraph, and therefore agree that Respondents shall pay to the State of New York a stipulated penalty of $20,000 for each and every such material default in the performance of any obligation under this Paragraph occurring after the Effective Date of the Assurance.

Subsequent Proceedings

104. Respondents expressly agree and acknowledge that OAG may initiate a subsequent investigation, civil action, or proceeding to enforce this Assurance, for violations of

the Assurance, or if the Assurance is voided pursuant to Paragraph 110 below, and agree and acknowledge that in such event:

a. any statute of limitations or other time-related defenses are tolled from and after the Effective Date of this Assurance;

b. OAG may use statements, documents or other materials produced or provided by Respondents prior to or after the Effective Date of this Assurance;

c. any civil action or proceeding must be adjudicated by the courts of the State of New York, and that Respondents irrevocably and unconditionally waive any objection based upon personal jurisdiction, inconvenient forum, or venue; and

d. evidence of a violation of this Assurance shall constitute prima facie proof of a violation of the applicable law pursuant to Executive Law § 63(15).

105. If a court of competent jurisdiction determines that Respondents have violated the Assurance, Respondents shall pay to OAG the reasonable cost, if any, of obtaining such determination and of enforcing this Assurance, including without limitation legal fees, expenses, and court costs.

Effects of Assurance

106. All terms and conditions of this Assurance shall continue in full force and effect on any successor, assignee, or transferee of Respondents. Respondents shall include in any such successor, assignment or transfer agreement a provision that binds the successor, assignee or transferee to the terms of the Assurance. No party may assign, delegate, or otherwise transfer any of its rights or obligations under this Assurance without the prior written consent of OAG, which shall not be unreasonably withheld.

107. Nothing contained herein shall be construed as to deprive any person of any

private right under the law.

108. Any failure by OAG to insist upon the strict performance by Respondents of any of the provisions of this Assurance shall not be deemed a waiver of any of the provisions hereof, and OAG, notwithstanding that failure, shall have the right thereafter to insist upon the strict performance of any and all of the provisions of this Assurance to be performed by Respondents.

Communications

109. All notices, reports, requests, and other communications pursuant to this Assurance must reference Assurance No. 24-009, and shall be in writing and shall, unless expressly provided otherwise herein, be given by hand delivery; express courier; or electronic mail at an address designated in writing by the recipient, followed by postage prepaid mail, and shall be addressed as follows:

If to Respondents, to: Matthew Zayotti, Matthew.Zayotti@carelon.com.

If to OAG, to: Michael D. Reisman, or in his absence, to the person holding the title of Bureau Chief, Health Care Bureau.

Any changes in the person to whom communications should be specifically directed shall be made in writing in advance of the change.

Representations and Warranties

110. OAG has agreed to the terms of this Assurance based on, among other things, the representations made to OAG by Respondents and their counsel and OAG's own factual investigation as set forth in Findings, Paragraphs 1 through 49 above. Respondents represent and warrant that neither they nor their counsel have made any material representations to OAG that are inaccurate or misleading. If any material representations by Respondents or their counsel are later found to be inaccurate or misleading, this Assurance is voidable by OAG in its sole discretion.

111. No representation, inducement, promise, understanding, condition, or warranty not set forth in this Assurance has been made to or relied upon by Respondents in agreeing to this Assurance.

112. Respondents represent and warrant, through the signatures below, that the terms and conditions of this Assurance are duly approved. Respondents further represent and warrant that Carelon Behavioral Health, Inc. and Carelon Behavioral Health IPA, Inc., by Dr. Patrick Fox, as the signatory to this Assurance, is a duly authorized officer acting at the direction of the Boards of Directors of Carelon Behavioral Health, Inc. and Carelon Behavioral Health IPA, Inc.

General Principles

113. Unless a term limit for compliance is otherwise specified within this Assurance, Respondents' obligations under this Assurance are enduring.

114. Nothing in this Assurance shall relieve Respondents of other obligations imposed by any applicable state or federal law or regulation or other applicable law.

115. Respondents shall not in any manner discriminate or retaliate against any health care providers who cooperated or are perceived to have cooperated with the investigation of this matter or any future investigation related to enforcing this agreement.

116. Respondents agree not to take any action or to make or permit to be made any public statement denying, directly or indirectly, any finding in the Assurance or creating the impression that the Assurance is without legal or factual basis. This Paragraph shall not (a) preclude Respondents from acknowledging that, by entering the Assurance, it did not admit to the OAG's Findings and entered the Assurance to avoid the time and expense of litigation, (b) affect Respondents' testimonial obligations, or (c) affect Respondents' right to take legal or factual positions in response to, or defense of, any inquiry, audit, litigation or other proceedings,

including, without limitation, any inquiry or action brought by an individual, entity, or governmental authority other than the OAG.

117. Nothing contained herein shall be construed to limit the remedies available to OAG in the event that Respondents violate the Assurance after its effective date.

118. This Assurance may not be amended except by an instrument in writing signed on behalf of the Parties to this Assurance.

119. In the event that any one or more of the provisions contained in this Assurance shall for any reason be held by a court of competent jurisdiction to be invalid, illegal, or unenforceable in any respect, in the sole discretion of OAG, such invalidity, illegality, or unenforceability shall not affect any other provision of this Assurance.

120. Respondents acknowledge that they have entered this Assurance freely and voluntarily and upon due deliberation with the advice of counsel.

121. This Assurance shall be governed by the laws of the State of New York without regard to any conflict of laws principles. The Assurance and all its terms shall be construed as if mutually drafted with no presumption of any type against any party that may be found to have been the drafter.

122. This Assurance may be executed in multiple counterparts by the parties hereto. All counterparts so executed shall constitute one agreement binding upon all parties, notwithstanding that all parties are not signatories to the original or the same counterpart. Each counterpart shall be deemed an original to this Assurance, all of which shall constitute one agreement to be valid as of the Effective Date of this Assurance. For purposes of this Assurance, copies of signatures shall be treated the same as originals. Documents executed, scanned and transmitted electronically and electronic signatures shall be deemed original signatures for

purposes of this Assurance and all matters related thereto, with such scanned and electronic signatures having the same legal effect as original signatures.

123. The Effective Date of this Assurance shall be November 10, 2026.

LETITIA JAMES
Attorney General of the State of New York
28 Liberty Street
New York, NY 10005

By: 

Michael D. Reisman
Assistant Attorney General
Health Care Bureau

Carelon Behavioral Health, Inc. and Carelon Behavioral Health IPA, Inc.

By: 

Dr. Patrick Fox
President