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

July 31, 2023

Community Health Choice of Texas – Texas – HIOS # 27248

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Re: Final Determination Letter - Finding of Non-Compliance - Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitation (NQTL) Comparative Analysis Review – Prior authorization treatment limitations for outpatient, in-network services.

Dear Ms. Wright, Ms. Campbell, and Mr. Beene:

This letter is being sent to inform you that a review of the Corrective Action Plan (CAP) submitted on October 30, 2021 and September 30, 2022 to address the instances of non-compliance noted in the MHPAEA NQTL Analysis Review (Review) is complete. This letter also identifies, as applicable, additional remediation and corrective action the Centers for Medicare & Medicaid Services (CMS) identified as necessary to fully address the instances of non-compliance.

The purpose of the Review was to assess Community Health Choice of Texas' (Issuer) compliance with the following requirements under Title XXVII of the Public Health Service Act (PHS Act) and its implementing regulations for the specific NQTL comparative analysis reviewed:

> PHS Act § 2726, 45 C.F.R. §§ 146.136 and 147.160 – Parity In Mental Health And Substance Use Disorder Benefits.

The Review covered prior authorization treatment limitations for outpatient, in-network services for the 2021 plan year (hereinafter referred to as "the NQTL").

CMS conducted this Review pursuant to PHS Act § 2726(a)(8)(A) and (B), as added by Section 203 of Title II of Division BB of the Consolidated Appropriations Act, 2021.[1] CMS contracted with Examination Resources, LLC to assist CMS with conducting this Review.

On September 16, 2021, CMS provided an initial determination letter of non-compliance to the Issuer and requested a CAP and additional comparative analysis to demonstrate compliance. After reviewing the Issuer's October 30, 2021 and September 30, 2022 CAP submissions and additional comparative analysis, CMS is finalizing the determination of non-compliance with MHPAEA in the following areas noted in the September 16, 2021 initial determination letter and discussed below:

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

PHS Act § 2726(a)(8)(A) requires that the Issuer "make available […] upon request, the comparative analyses and the following information: […] (ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits. (iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits. […] (v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section." CMS identified violations of this provision in the following instances:

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

   The Issuer identified in its supplemental response dated July 14, 2021 that five factors that are considered when determining which outpatient, in-network mental health and substance use disorder (MH/SUD) services and medical/surgical (M/S) services are subject to the NQTL (MHPAEA NQTL Comparative Analysis Review 7-14-21, pg. 5). These factors were:

   - Data analysis to detect over - and under - utilization of services and variability of services;
   - Clinical review of information to ensure adherence to evidence-based medicine;
   - Clinical review of information for safety concerns to ensure appropriate use of medications or services to ensure that they do not interfere with other types of medications or potentially worsening existing conditions;
   - Ensure administering clinician has the appropriate training; and

[1] Pub. L. 116-260 (Dec. 27, 2020).

- Clinical review of information to ensure drugs and/or devices are not used for clinical treatment outside those approved by the FDA or supported medical evidence.

In the initial determination letter dated September 16, 2021, CMS requested that the Issuer provide information regarding the quantitative thresholds for each factor identified, including how these factors are defined, established, or measured. In its CAP response submitted on October 30, 2021, in response to CMS' initial determination request, the Issuer stated:

> *For MH/SUD – psychotherapy has a quantitative threshold of no authorization required until after 30 visits in a year. This quantitative threshold is noted on the Texas EHB Benchmark Summary for 25 visits per year. CHC threshold is more lenient with 30 visits before prior authorization is required For MS – obstetric ultrasounds – authorization required for greater than 2 in a year. This threshold was established based on OB/GYN medical specialist recommendation* (MHPAEA NQTL Comparative Analysis Review 7-14-21, pg. 6).

The Issuer did not provide information regarding the quantitative thresholds for each factor identified, including how these factors are defined, established, or measured. Specifically, the Issuer did not define the factor "Data analysis to detect over-and-under utilization of services and variability of services," including how it is measured or assessed. In addition, while the Issuer identified three factors that include the phrase "Clinical review of information," it is unclear which individuals are involved in conducting the clinical reviews of information, including their qualifications and applicable clinical specialties.

The Issuer identified two additional, different factors that are used to determine which services are subject to the NQTL in its CAP response submitted on September 30, 2022. The factors were adherence to evidence-based medicine and cost (CHC PA OP INN MHPAEA NQTL Comparative Analysis_Final 9-30-2022, pg. 16). Pertaining to the sources and evidence used for each of these factors, the Issuer stated:

> *Adherence to Evidence-based Medicine: This factor is evaluated with reference to InterQual Criteria and the consensus-based independent clinical judgment of the [Medical Care Management Committee] MCMC. Cost: Benefits for durable medical equipment are considered "high cost" if they exceed $500* (CHC PA OP INN MHPAEA NQTL Comparative Analysis_Final 9-30-2022, pg. 16).

The Issuer's explanation of how the cost factor pertains to durable medical equipment, a single M/S benefit, is an insufficient description of this factor . It is unclear how the Issuer established the $500 threshold for the utilized factor of "cost," including the sources and evidence used in establishing this threshold. Additionally, by providing only a single example, the Issuer did not sufficiently explain how the cost factor is applied to prior authorizations for outpatient, in-network MH/SUD services and to M/S services more broadly. The Issuer did not provide information regarding how these thresholds are

measured for each MH/SUD service and M/S service subject to the NQTL, and how they were established for the NQTL. Similarly, it is unclear how "evidence-based medicine" is defined and measured, as well as how the independent clinical judgement of the MCMC is established.

Overall, it is unclear which factors are used in the design and application of the NQTL, including the applicable quantitative measures used for the factors. It is also unclear which factors apply to each MH/SUD service and M/S service due to the lack of clarity surrounding the factors that are utilized. As such, the Issuer failed to provide sufficient information regarding the application of the factors considered in the design and application of the NQTL, as written and in operation, in violation of PHS Act § 2726(a)(8)(A)(ii) and (iii).

Therefore, CMS directs the Issuer to take the following corrective actions to address this finding of non-compliance by MM, DD, 2023:

- Provide a complete list of factors utilized to determine which MH/SUD services and M/S services are subject to prior authorization. This list should identify which factors apply to each MH/SUD service and M/S service;
- Provide concise definitions for each factor identified above;
- To the extent the Issuer defines any of the factors in a quantitative manner, identify and provide quantitative measures or thresholds of each factor identified above. Provide supporting information regarding the methodology and sources used in establishing the quantitative measure or threshold and affirmatively state if quantitative thresholds are used; and
- Provide the qualifications and applicable clinical specialties of the decision makers and experts pertaining to the "clinical review" factors, if still applicable.

2. **Failure to provide a sufficient reasoned discussion of findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified and their stringency, as written and in operation.**

The Issuer provided in its CAP response submitted September 30, 2022, prior authorization approval and denial rates for MH/SUD outpatient, in-network services and M/S outpatient, in-network services. The Issuer stated, "*The data demonstrates that the prior authorization approval and denial rates for MH/SUD outpatient, in-network services are comparable to, and no more stringent than, the prior authorization approval and denial rates for M/S outpatient, in-network services"* (CHC PA OP INN MHPAEA NQTL Comparative Analysis_Final 9-30-2022, pg. 17). However, the data metrics provided by the Issuer in its CAP response submitted September 30, 2022, indicated a higher prior authorization approval rate and a lower prior authorization denial rate for MH/SUD services as compared to M/S services.

The Issuer further stated, *"This [prior authorization approval and denial] analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the prior authorization requirement to outpatient, in-network MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than*

the processes, strategies, evidentiary standards, and other factors used to apply the prior authorization requirement to outpatient, in-network M/S benefits" (CHC PA OP INN MHPAEA NQTL Comparative Analysis_Final 9-30-2022). Despite this statement, the Issuer did not provide information regarding how all other written requirements, such as how the processes, strategies, evidentiary standards, and factors utilized are comparable and no more stringently applied to MH/SUD services as compared to M/S services, as written and in operation. Prior authorization approval and denial rates account for one process used to apply the NQTL and do not serve as evidence of comparability or relative stringency of the other processes, strategies, evidentiary standards, and other factors used to apply the NQTL. For example, the Issuer did not provide any metrics on timeliness (turn-around-time) or appeals data for prior authorization decisions. Therefore, the prior authorization approval and denial rates alone do not sufficiently demonstrate how all processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD services are comparable to and no more stringently applied than to M/S services.

As such, the Issuer failed to provide a sufficient reasoned discussion of findings and conclusions as to the comparability and relative stringency of the processes, strategies, evidentiary standards, factors, and sources identified, as written and in operation, in violation of PHS Act § 2726(a)(8)(A)(v).

Therefore, CMS directs the Issuer to take the following corrective actions to address this finding of non-compliance by MM, DD, 2023:

- Provide a complete stringency assessment demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied to MH/SUD outpatient in-network benefits compared to outpatient, in-network M/S benefits. The stringency assessment should demonstrate that the written processes used to apply the NQTL are no more stringently applied in operation. The assessment should include, at a minimum, an assessment of the following metrics:
    - Outpatient, in-network prior authorization appeal data for MH/SUD benefits and M/S benefits, including the total number of appeals submitted, the number of appeals for which the denial was upheld, and the number of overturned appeals; and
    - Outpatient, in-network prior authorization decision timeliness for MH/SUD benefits and M/S benefits.
- Include the results and analysis of the completed stringency assessment in a reasoned discussion of the findings or conclusions regarding the comparability and stringency of the NQTL and its associated processes, strategies, evidentiary standards, and other factors.

II. Next Steps.

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Issuer must, within seven business days of the date of this letter, notify all individuals enrolled under a plan subject to this NQTL that it is

not compliant with the requirements under MHPAEA. Please provide a copy of the letter, with the date(s) the letter was sent, and a list of recipients by [insert date].

If the Issuer fails to complete the identified corrective actions, provide appropriate notice to its enrollees, or provide documentation of these actions to CMS by the specified dates, CMS may pursue further enforcement action, including the imposition of civil money penalties pursuant to 45 C.F.R. § 150.301.

CMS' findings detailed in this letter pertain only to the NQTL under Review and do not bind CMS in any subsequent or further review of other plan provisions or their application for compliance with governing law, including MHPAEA. If additional information is provided to CMS regarding this NQTL or plan, CMS reserves the right to conduct an additional review for compliance with MHPAEA or other applicable PHS Act requirements.[2]

CMS' findings pertain only to the specific plans to which the NQTL under Review applies and are offered by the Issuer and do not apply to any other plan or issuer, including other plans or coverage for which the Issuer acts as an Administrator.

CMS will include a summary of the comparative analysis, results of this Review, determination of non-compliance, and the identity of the Issuer in its annual report to Congress pursuant to PHS Act § 2726(a)(8)(B)(iv).

Sincerely,

Jeffrey C. Wu -S

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Date: 2024.06.14 09:37:30 -04'00'

Jeff Wu
Deputy Director for Policy
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

cc: Texas Department of Insurance

[2] See PHS Act § 2726(a)(8)(B)(i). See also 45 C.F.R. § 150.303.