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

The Centers for Medicare & Medicaid Services (CMS) has concluded that State of Nebraska's WellNebraska Plans is not in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), as codified at Public Health Service Act (PHS Act) § 2726 (42 U.S.C. § 300gg-26). The Plan must, by September 4, 2024, notify all individuals enrolled under a plan subject to this non-quantitative treatment limitation (NQTL) that it is not compliant with the requirements of MHPAEA and its implementing regulations. Please provide a copy of the letter, with the date(s) the letter was sent, and a list of recipients to CMS by September 4, 2024.

August 23, 2024

State of Nebraska – Nebraska

Christy Osentowski
Administrator Employee Wellness & Benefits
Christy.osentowski@nebraska.gov

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 for inpatient, in-network services.

Dear Ms. Osentowski:

This letter informs you that a review of the Corrective Action Plan (CAP) and additional comparative analysis submitted on August 10, 2023, to address the instances of non-compliance noted in the MHPAEA NQTL Analysis Review (Review) is complete. This letter also identifies, as applicable, additional corrective actions that are necessary to address the instances of non-compliance identified in the June 26, 2023 initial determination letter.

The purpose of the Review was to assess State of Nebraska's WellNebraska Plans' (Plan) compliance with the following requirements under Title XXVII of the Public Health Service Act (PHS Act) and its implementing regulations:

> PHS Act § 2726, 45 C.F.R. § 146.136 - Parity In Mental Health And Substance Use Disorder Benefits (MHPAEA and its implementing regulations).

The Review covered prior authorization requirements for inpatient, in-network services for the Plan for the plan year covering July 2021 – June 2022 (hereinafter referred to as "the NQTL").

CMS conducted this Review on behalf of the Secretary of Health and Human Services 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.

After reviewing the CAP and additional comparative analysis provided, CMS is finalizing the initial determination that the Plan violated PHS Act § 2726 by failing to provide a sufficient comparative analysis as required under PHS Act § 2726(a)(8)(A).

This final determination letter identifies the ways that the Plan's CAP and additional comparative analysis fail to comply with PHS Act § 2726. This letter also specifies additional corrective actions for the Plan to address the findings of non-compliance.

On June 26, 2023, CMS provided an initial determination letter of non-compliance to the Plan and directed the Plan to submit a CAP and additional comparative analysis to CMS to demonstrate compliance with MHPAEA and its implementing regulations. After reviewing the Plan's August 10, 2023 CAP submission, additional comparative analysis, and response to the CAP follow-up email sent on February 21, 2024, CMS is finalizing the initial determination of non-compliance with MHPAEA for the following areas noted in the June 26, 2023 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 Plan "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. […] (iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder 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 NQTLs to medical or surgical benefits in the benefits classification." CMS identified violations of this provision in the following instances:

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

The Plan provided a chart labeled "factor grid" in its June 24, 2022 initial submission illustrating the factors applied to determine the imposition of a prior authorization requirement on inpatient, in-network mental health and substance use disorder (MH/SUD) benefits and inpatient, in-

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

network medical/surgical (M/S) benefits.[2] The Plan identified "clinical appropriateness" and "value" as factors applied to both MH/SUD benefits and M/S benefits, but also noted: *"[a]dditional factors may be used as the basis for subjecting other M/S benefits to prior authorization requirements."*[3],[4] The Plan did not explain how the factors are applied, such as whether one or both factors must be met to establish a prior authorization requirement. Further, the Plan's comparative analysis "factor grid" seemed to suggest that both factors are applied to all MH/SUD benefits requiring prior authorization, while M/S benefits requiring prior authorization are subject to both factors, one factor, or neither of the factors.[5] The Plan stated in its supplemental submission that both the "value" and "clinical appropriateness" factors are applied to both MH/SUD benefits and M/S benefits, but again did not sufficiently explain how the factors are defined or applied in operation.[6]

The Plan's "factor grid" included a "comparability check" tab that defined clinical appropriateness as "*those inpatient services that as determined by internal medical experts, are in accordance with [] objective, evidence-based clinical criteria and nationally recognized guidelines."*[7] The provided definition failed to explain how the Plan's internal medical experts determine whether MH/SUD services or M/S services "are in accordance" with "clinical criteria and nationally recognized guidelines." No specifics of the review process were provided including, but not limited to, any thresholds or other evidentiary standards utilized in determining clinical appropriateness. The "factor grid" also stated,

> *Value Identified: defined as the value of subjecting the services to prior authorization exceeds the administrative costs by at least 1:1. The process includes a review of utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value.*[8]

The Plan did not provide an explanation as to how this process determines whether there is an opportunity to "improve quality" or "reduce unnecessary costs" or sufficient detail on how the Plan calculates the "administrative costs" relative to the "value" of subjecting a service to prior authorization. Further, this factor appears to have a disproportionate impact on MH/SUD services. For example, all four MH/SUD services subject to prior authorization meet the "value" factor compared to only nine of 21 M/S services.[9] This appears to result in nearly all inpatient MH/SUD services being subject to a prior authorization requirement. The Plan did not provide an explanation for this variation or discuss how it impacts MH/SUD services versus M/S services in operation.

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[2] Copy of Benefits by Prior Auth Factor Grid – WellNebraska.
[3] Copy of Benefits by Prior Auth Factor Grid – WellNebraska, tab NQTL Prior Auth Inpatient, cells D2, F2.
[4] Copy of Benefits by Prior Auth Factor Grid – WellNebraska, tab NQTL Prior Auth Inpatient, cell A32.
[5] Copy of Benefits by Prior Auth Factor Grid – WellNebraska, tab NQTL Prior Auth Inpatient.
[6] UHC Response – State of Nebraska 8.19.22 INN, pgs. 4-6, 16.
[7] Copy of Benefits by Prior Auth Factor Grid – WellNebraska, tab NQTL Prior Auth Inpatient, cell E2.
[8] Copy of Benefits by Prior Auth Factor Grid – WellNebraska, tab Introduction, cell A4.
[9] Copy of Benefits by Prior Auth Factor Grid – WellNebraska, tab NQTL Prior Auth Inpatient.

CMS noted the Plan's failure to provide sufficient information and supporting documentation, including the plan terms and policies used to apply the NQTL, in the initial determination letter. CMS further stated, "*[a] conclusory statement of broadly stated processes, strategies, standards, or other factors, without specific supporting evidence and detailed explanations, is not sufficient*."[10] The Plan subsequently provided as part of its CAP response a revised "factor grid" to correspond with its updated narrative while clarifying that *"either factor"* triggers a prior authorization requirement and stating *"the Plan is not aware of any other factors"* for M/S services.[11, 12] However, the Plan again provided insufficient information as to how these factors are applied, stating *"[t]he factor of clinical appropriateness is met if evidence-based clinical criteria exist"* prior to *"approving creation of a new prior authorization requirement."*[13] The Plan did not provide information or evidence as to why the mere existence of such criteria triggers a prior authorization requirement and how this impacts MH/SUD services versus M/S services. The Plan also did not provide any supporting documentation, such as policies and procedures, outlining how the Plan applies the factors to impose prior authorization requirements.

Therefore, the Plan failed to provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL for MH/SUD benefits and M/S benefits as written and in operation, in violation of PHS Act § 2726(a)(8)(A)(ii).

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

The Plan did not sufficiently describe the process for prior authorization requests or include supporting policies and procedures in its initial submission.[1] CMS requested the Plan provide a narrative detailing the process of reviewing, approving, or denying a prior authorization request, including applicable decision timeframe standards, and copies of any policies or procedures related to the prior authorization determination process.[15] The Plan provided a narrative outlining the process for reviewing and approving or denying prior authorization requests but failed to provide supporting policies and procedures for non-urgent inpatient MH/SUD services in its supplemental submission. The Plan stated in its CAP response: "*We have confirmed and provided the timeframes regarding prior authorizations for inpatient services and updated the NQTL analysis accordingly*".[16] However, the Plan failed to provide applicable policy and procedure documentation verifying that the timeframe standards listed are applicable to inpatient services. The supporting documentation previously provided by the Plan listed a prior authorization decision timeframe standard for non-urgent outpatient services but did not list a timeframe standard for non-urgent inpatient services.[17]

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[10] State of NE_Initial Determination Letter_PA IP INN_FINAL, pgs. 9-10.
[11] 1 - Benefits by Prior Auth Factor Grid – WellNebraska.
[12] 8.10.23 – UHC Response Grid (Prior Auth IP INN) – State of Nebraska, pg. 1, 5.
[13] 8.10.23 – UHC Response Grid (Prior Auth IP INN) – State of Nebraska, pg. 15.
[14] Prior Auth INN IP NQTL_WellNebraska.
[15] Request Item #3.I.
[16] 8.10.23 – UHC Response Grid (Prior Auth IP INN) – State of Nebraska, pg. 12.
[17] Management of Behavioral Health Benefits- 05.25.22, pg. 16.

CMS sent a follow-up email to the Plan's CAP response on February 21, 2024 requesting supporting documentation (i.e., a written policy and procedure document) verifying that the prior authorization decision timeframe standards for non-urgent outpatient MH/SUD services and M/S services are applicable to non-urgent inpatient MH/SUD services and M/S services. The Plan submitted a MH/SUD benefits policy that only listed the prior authorization decision timeframes for non-urgent outpatient authorizations.[18] The policy also contained prior authorization decision timeframes for non-urgent denials but did not specify whether they were applicable to inpatient services, outpatient services, or both.

Therefore, the Plan failed to provide sufficient information and supporting documentation regarding its inpatient prior authorization decision timeframe processes for MH/SUD services and M/S services, in violation of PHS Act § 2726(a)(8)(A)(iv).

II. Corrective Actions.

CMS identified the following corrective actions as necessary to resolve the identified instances of non-compliance. Therefore, please take the following corrective actions by October 7, 2024:

- Provide to CMS additional information and supporting documentation (i.e., a written policy and procedure document) describing how the factors "value" and "clinical appropriateness" are applied to each MH/SUD service and M/S service in the inpatient, in-network classification; and
- Provide to CMS supporting documentation (i.e., a written policy and procedure document) verifying the MH/SUD prior authorization decision timeframes and M/S prior authorization decision timeframes used for non-urgent inpatient prior authorization decisions.

III. Next Steps.

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Plan must, by September 4, 2024, notify all individuals enrolled under a plan subject to this NQTL that CMS has determined the plan is not in compliance 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 to CMS by September 4, 2024.

If the Plan 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 *et. seq*.

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 and its implementing regulations. If additional information is provided to CMS regarding this NQTL or Plan, CMS reserves the right

[18] Management of Behavioral Health Benefits- 08.23.23 (1), pg. 16.

to conduct an additional review for compliance with MHPAEA or other applicable PHS Act requirements. [19]

CMS' findings pertain only to the specific plans to which the NQTL under review applies and are offered by the Plan and do not apply to any other plans or issuers. However, these findings should be shared with affiliated entities, and steps should be taken as appropriate to ensure compliance with applicable requirements.

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

Sincerely,

Jeffrey C. Wu -S

Digitally signed by Jeffrey C. Wu -S
Date: 2024.08.23 10:33:33 -04'00'

Jeff Wu

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

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