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

February 21, 2024

Oregon Health Authority - Public Employees' Benefit Board (PEBB) - Oregon

Ali Hassoun, OEBB-PEBB Director
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503-378-2798

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

Dear Mr. Hassoun,

This letter informs you that a review of the Corrective Action Plan (CAP) submitted to address the instances of non-compliance noted in the MHPAEA NQTL Analysis Review (Review) is complete.

The purpose of the Review was to assess compliance of the Providence Health Plan sponsored by the Oregon Health Authority - Public Employees' Benefit Board (Plan) 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.

The Review covered prior authorization for outpatient, in-network services for the 2022 plan year (hereinafter referred to as "the NQTL").

The Centers for Medicare and Medicaid Services (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.

On May 5, 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. In CMS' initial determination letter, we identified the following instances of non-compliance with PHS Act § 2726 and its

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

implementing regulations at C.F.R. § 146.136, all of which have been addressed by the Plan's corrective actions.

I. Failure to Demonstrate Comparability and Relative Stringency as Written and in Operation, in Violation of 45 C.F.R § 146.136(c)(4)(i).

1. Length of prior authorization approval timeframe for applied behavioral analysis (ABA) therapy is not comparable to and is more stringent than for outpatient, in-network medical/surgical (M/S) services.

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

1. Failure to provide sufficient information and supporting documentation pertaining to the specific plan and coverage terms regarding the prior authorization NQTL for outpatient, in-network mental health and substance use disorder (MH/SUD) and M/S services, as written and in operation.
2. Failure to provide sufficient information and supporting documentation regarding the application of the factors considered in the design and application of the prior authorization NQTL, as written and in operation.
3. Failure to provide sufficient information and supporting documentation for the sources or evidence used to develop the factors identified in the design and application of prior authorization NQTL, as written and in operation.

The Plan confirmed in the CAP submission that all prior authorization requirements for outpatient, in-network MH/SUD services would be removed effective July 1, 2023 (MHP PEBB Response to CMS_PEBB_Final 06-19-23, pg. 1). The Plan confirmed that as part of this change, a prior authorization requirement would no longer be imposed on ABA therapy (MHP PEBB Response to CMS_PEBB_Final 06-19-23, pg. 2).

The Plan stated that the documents, "PHP_Prior_Authorization_Code_List_7.1.23" and "General PA Requirements PEBB Statewide.PEBB Choice 7.23," would be updated, effective July 1, 2023, to correspond with the prior authorization removal (MHP PEBB Corrective Action Plan to CMS_PEBB_Final 06-19-23, pg. 1). The Plan provided both updated documents in its CAP submission.

CMS confirmed that an updated comparative analysis would not be required as part of the CAP submission since the Plan no longer applies the NQTL to MH/SUD benefits. Therefore, a comparative analysis was not provided as part of the CAP, since all outpatient, in-network prior authorization requirements have been removed for MH/SUD services effective July 1, 2023. The Plan's removal of these requirements sufficiently addressed the instances of non-compliance noted in CMS' initial determination letter.

On October 16, 2023 CMS requested additional corrective action items pertaining to the removal of the NQTL in order to determine the members affected and allow for re-adjudication and payment of claims. The Plan provided the requested additional corrective action items, which included a list of individuals who were adversely affected by application of the NQTL during the 2022 plan year and supporting documentation demonstrating the Plan's methodology for

identifying the affected individuals and claims (Impacted Member List_PEBB; PEBB Response to CMS; SQL Codes). The submission also included a list of re-adjudicated claims and proof of payment for individuals who were adversely affected by the application of the NQTL and a description of how the Plan notified affected individuals about remedies for claims adversely affected by the application of the NQTL (Readjudicated Claims_PEBB; PEBB_Proof of Payment; PEBB Response to CMS; PEBB_Prior Authorization Letter). The Plan indicated that claims were also re-adjudicated and paid for members who were adversely affected by application of the NQTL during the 2023 plan year up until the date the NQTL was removed on July 7, 2023. In total, 29 individuals were identified for a total of $91,789.10 in re-adjudicated claims. The information submitted sufficiently addressed CMS' requests and instances of non-compliance as noted in CMS' initial determination letter. As such, there is no further action required by the Plan at this time.

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 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 Plan and do not apply to any other plan or issuer, including other plans or coverage for which the Plan acts as an Administrator. However, these findings should be shared with affiliated entities, and steps should be taken as appropriate to ensure compliance with applicable requirements.

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

Sincerely,

Mary M. Nugent -S

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