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) have concluded that the Cigna Health and Life Insurance Company is not in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), as codified at Public Health Services Act § 2726 (42 U.S.C. § 300gg-26), and its implementing regulations. The Issuer must, by January 23, 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 January 23, 2024.

January 11, 2024

Cigna Health and Life Insurance Company – Missouri – HIOS # 74483

David Szostak
Managing Counsel, Regulatory
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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 requirements for outpatient, in-network services.

Dear Mr. Szostak:

This letter informs you that a review of the Corrective Action Plan (CAP) and additional comparative analysis submitted on December 12, 2022, December 16, 2022, January 16, 2023, and June 7, 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 action that is necessary to fully address the instances of non-compliance.

The purpose of the Review was to assess Cigna Health and Life Insurance Company's (Issuer) 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 and 147.160 - Parity In Mental Health And Substance Use Disorder Benefits (MHPAEA and its implementing regulations).

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

After reviewing the CAP and additional comparative analysis provided, CMS is finalizing the initial determination that the Issuer violated PHS Act § 2726 and its implementing regulations at 45 C.F.R. §§ 146.136 and 147.160 by:

- imposing a non-quantitative treatment limitation with respect to mental health and substance use disorder (MH/SUD) benefits for which, as written or in operation, the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to MH/SUD benefits in the classification are not comparable to, or are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical (M/S) benefits in the same classification, in violation of 45 C.F.R. § 146.136(c)(4)(i); and
- 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 Issuer's CAP and comparative analysis fail to comply with PHS Act § 2726 and its implementing regulations. This letter also specifies additional corrective actions for the Issuer to address the findings of non-compliance.

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 October 27, 2022, CMS provided an initial determination letter of non-compliance to the Issuer and directed the Issuer to submit a CAP and additional comparative analysis to CMS to demonstrate compliance with MHPAEA and its implementing regulations. After reviewing the Issuer's December 12, 2022, December 16, 2022, January 16, 2023, and June 7, 2023, CAP submissions and revised comparative analysis, CMS is finalizing the initial determination of non-compliance with MHPAEA and its implementing regulations in the following areas noted in the October 27, 2022 initial determination letter and discussed below:

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

45 C.F.R. § 146.136(c)(4)(i) states that "A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) **as written and in operation**, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification **are comparable to, and are applied no more stringently than**, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification" (emphasis added). CMS identified a violation of this provision in the following instance:

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

1. **Prior authorization decision processes and timeframes are not comparable for MH/SUD benefits and M/S benefits for outpatient, in-network services.**

The Issuer maintained separate processes for "standard" and "urgent" prior authorization requests, as outlined in the initial determination letter sent on October 27, 2022. The Issuer provided an updated written policy with its standard and urgent prior authorization processes and revised state-specific decision timeframe standards in its CAP response submitted on December 12, 2022. Specifically, the revised MH/SUD Missouri state-specific policy for urgent prior authorization requests states,

> *Behavioral Health shall make urgent pre-service determinations within 36 hours, which shall include one business day of obtaining all necessary information (If deadline falls on a non-business day, decision must be made by the end of the next business day)* (HM_CLN_035_Timeliness_of_UM_Decisions_and_Notification_Policy, pg. 19).

According to the M/S Missouri state-specific policy for urgent prior authorization requests, the decision timeframe is *"within 30 minutes of receiving request"* (UM_39_Timeliness_of_Health_Services_Decisions_Policy, pg. 13). Since urgent prior authorization M/S request decisions are to be made within 30 minutes of receiving the prior authorization request, but urgent prior authorization request decisions for MH/SUD benefits are to be made within 36 hours of obtaining all necessary information, the Missouri state-specific decision timeframes that are part of the process of applying the NQTL are not comparable between MH/SUD benefits and M/S benefits in the same benefit classification, as written. As written, the Issuer's policy provides that urgent M/S prior authorization decisions are made more quickly than urgent MH/SUD prior authorization decisions, which may cause delays in access to MH/SUD care. The Issuer did not provide an explanation for the variance within the two timeframes and did not demonstrate comparability between the two timeframes.

The Issuer also failed to demonstrate that the urgent prior authorization process as applied to MH/SUD benefits is comparable to the process as applied to M/S benefits in operation, in violation of PHS Act § 2726(a)(8)(A)(iv). In its CAP response submitted on December 12, 2022, the Issuer provided revised operational data metrics for its standard and urgent prior authorization request processes separately to demonstrate comparability and stringency of its prior authorization processes in operation. The operational data metrics included the total number of requests and the average decision turnaround time for outpatient, in-network MH/SUD and M/S standard and urgent prior authorization requests for the 2021 plan year (2021 Commercial BOB MHP TAT PA CR data). The data fields for urgent MH/SUD prior authorization requests all contained the words "Not Reportable" (2021 Commercial BOB MHP TAT PA CR data).

The Issuer stated that "*[b]y default, Cigna treats all outpatient MH/SUD requests as non-urgent*" in its CAP response provided on June 7, 2023 (06072023 Response Letter (CMS Initial Findings) FINAL, pg. 6). CMS requested a narrative discussion clarifying why the operational data metrics were identified as "Not Reportable" for urgent MH/SUD prior authorization

requests in a follow up email sent on May 16, 2023. The Issuer stated in its CAP response provided on June 7, 2023 that this *"reflect[s] that the process is not used,"* and further stated,

> *In the rare event an outpatient provider, with knowledge of the customer's condition, believes that processing the request under the non-urgent timeframes would subject the customer to severe pain/distress that cannot be adequately managed, the request may be processed as urgent. Although these requests are processed within the urgent timeframes, there is not a systematic way to change the status. The status is set in the system when the request is first received and entered and cannot be updated.* (06072023 Response Letter (CMS Initial Findings) FINAL, pg. 6).

The Issuer's statement indicates that its medical management system cannot change the status of a MH/SUD prior authorization request to urgent, even if requested by the provider. Although the Issuer states that MH/SUD prior authorization requests where a provider requests urgent timeframes are processed within the urgent timeframes, the Issuer's operational data metrics are unable to demonstrate this, as all metrics for MH/SUD urgent prior authorization processes are recorded as "Not Reportable." However, the Issuer's medical management system allows for M/S prior authorization requests to be processed and tracked either as urgent or non-urgent, and the Issuer was able to provide operational data metrics for urgent and non-urgent M/S prior authorization processes separately. While the Issuer stated it has updated its reporting logic within its medical management system going forward, the proposed update would still not allow the Issuer to provide data supporting its assertion that the urgent prior authorization timeframes for M/S and MH/SUD benefits are comparable in operation. That is, the Issuer stated that for MH/SUD urgent operational data metrics, *"Moving forward, we will change the "not reportable" to "not applicable" to more accurately reflect the process"* (06072023 Response Letter (CMS Initial Findings) FINAL, pg. 6). Ultimately, the Issuer's medical management system does not offer information that would enable CMS to determine that the urgent prior authorization processes as applied to M/S and MH/SUD benefits in the outpatient, in-network classification are comparable in operation, and may not even reflect the degree to which MH/SUD urgent prior authorization requests are processed as urgent in accordance with the Issuer's policies.

The Issuer's decision timeframes for the urgent prior authorization processes are not comparable between MH/SUD benefits and M/S benefits in the outpatient, in-network classification, as written, and the Issuer did not demonstrate that the processes for these benefits are comparable in operation. The Issuer previously stated that the urgent process is not used for MH/SUD benefit prior authorization requests, but according to the information provided, if a provider requests that the urgent process be followed for a MH/SUD request, the Issuer's medical management system does not accurately reflect the urgent status. This disparate process for MH/SUD urgent prior authorization requests results in MH/SUD urgent prior authorization operational data metrics reflected as "Not Reportable." The Issuer's comparative analysis affirmatively demonstrated that its urgent prior authorization request processes applied to MH/SUD and M/S benefits in the outpatient, in-network classification are not comparable as written. Therefore, the processes, strategies, evidentiary standards, and other factors used in applying this NQTL to MH/SUD benefits in the outpatient, in-network classification are not comparable to M/S benefits in the same benefit classification, in violation of 45 C.F.R. § 146.136(c)(4)(i).

II. 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. (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. (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.**

    i. **Failure to provide sufficient information and supporting documentation regarding the return on investment (ROI) factor considered in the design and application of MH/SUD and M/S prior authorization processes.**

The Issuer stated in its initial submission that the "*The key factor used to determine the application of utilization management, including prior authorization or concurrent review, to either MH/SUD or M/S benefits in the outpatient/in-network, classification is the projected return on investment (ROI) of applying prior authorization (or concurrent review) relative to not applying prior authorization (or concurrent review) to the MH/SUD or medical/surgical benefits*" (PA_CR INN_OP NQTL Analysis FINAL, Pg. 5). The Issuer provided its calculation of the ROI for each individual M/S procedure/revenue code but only provided ROIs for grouped MH/SUD procedure/revenue codes, as outlined in the initial determination letter sent on October 27, 2022.

In its CAP response submitted on December 12, 2022, the Issuer stated it generally analyzes the ROI for MH/SUD benefits by category but analyzes the ROI for M/S benefits as individual codes. The reasoning the Issuer provided was that, "*with respect to MH/SUD benefits, providers can use different codes for the same service, whereas this is generally not the case for M/S services*" (Cigna response to CMS 2022-12-12, pgs. 7-8). However, we find that this explanation does not justify the Issuer's failure to provide additional information regarding the application of the ROI factor to MH/SUD benefits. For instance, there are M/S benefits that can be billed using different codes for the same service. The Issuer acknowledged that it assesses certain M/S

services associated with several procedure codes as a "grouping," such as procedure codes for spinal fusion services or varicose vein treatment (Cigna response to CMS 2022-12-12, pg. 7). Evidence of such groupings for M/S procedure/revenue codes for outpatient, in-network benefits were demonstrated by color-coding in the Issuer's initial submission, which nonetheless provided the individual ROIs for each code within the grouping (Attachment 1b - Copy of FY 2020 Medical UM List). However, the individual ROIs for MH/SUD procedure/revenue codes in the same benefit classification were not provided as requested in the initial determination letter (2022.02.03 CMS RFI Response, pg. 10). Instead, the Issuer only provided ROIs for grouped MH/SUD procedure/revenue codes. Because the Issuer did not provide its calculation of ROI for MH/SUD benefits at the individual code level, CMS cannot adequately assess how the Issuer determined that this factor used to design the NQTL will apply to MH/SUD benefits or whether that determination was made consistently with how the factor applies to M/S benefits in the same benefits classification.

The Issuer also provided incomplete and inconsistent information regarding the equation used to calculate ROI for MH/SUD benefits and M/S benefits in the outpatient, in-network classification. The Issuer stated in its revised comparative analysis provided on December 16, 2022, that the estimated cost to perform a coverage review, utilized as part of the ROI calculation used in the design and application of the NQTL, is $40 per review for M/S benefits, and $100 per review for MH/SUD benefits (CAA Mental Health Parity NQTL Comparative Analysis Proposed final draft 12.14.22 Version 4.0 Medical Management 12.16.22, pg. 24). This information does not align with prior responses submitted by the Issuer. The Issuer stated in its initial submission that for both MH/SUD benefits and M/S benefits, "*[f]or the purposes of the ROI calculation, the estimated cost to perform a coverage review is $100 per review, which is informed by costs/expenses such as personnel salaries and time for review*" (PA_CR INN_OP NQTL Analysis FINAL, pg. 6). In the revised comparative analysis submitted as part of its CAP response on December 16, 2022, a variation exists in the estimated cost to perform a coverage review between MH/SUD benefits and M/S benefits in the outpatient, in-network classification. The Issuer's December 16, 2022, CAP response did not address this variation in average cost per review for M/S benefits and MH/SUD benefits, nor did it provide supporting documentation to demonstrate comparability and relative stringency of the application of this factor.

The Issuer stated that the estimated cost to perform a coverage review is informed by costs/expenses such as personnel salaries and time, but did not provide an analysis demonstrating how these average estimated costs were determined, and how this resulted in disparate estimated costs per review between MH/SUD and M/S benefits ($100 per review vs. $40 per review) (CAA Mental Health Parity NQTL Comparative Analysis Proposed final draft 12.14.22 Version 4.0 Medical Management 12.16.22, pg. 24). For example, the Issuer's reported "Cost to Review" for procedure codes classified as M/S benefits ranges from $100 to $2,937,900 and for MH/SUD benefits ranges from $1900 to $2,252,000 (Attachment 1a – Copy of FY2020 MHSUD ROI Results and Attachment 1b – Copy of FY 2020 Medical UM List). The Issuer indicated that the ROI results are produced by dividing the total savings for the service category by the "Cost to Review" as provided in the ROI assessments (Attachment 1a – Copy of FY2020 MHSUD ROI Results and Attachment 1b – Copy of FY 2020 Medical UM List). CMS was therefore not able to determine how the Issuer determined an average cost per review of $100 for the entire category of MH/SUD benefits, or how these average costs are utilized in the ROI calculations.

In summary, the ROI calculations for MH/SUD procedure/revenue codes were not provided on an individual basis, as they were provided for M/S procedure/revenue codes. It is also unclear how the estimated cost to perform a coverage review is determined for both MH/SUD benefit prior authorization ROI calculations and M/S benefit prior authorization ROI calculations, whether the average costs per review for M/S benefits was $40 or $100, or how the average cost per review for both MH/SUD and M/S benefits factors into the ROI calculation. The Issuer therefore did not provide sufficient information to demonstrate the comparability and relative stringency of the application of the ROI factor to MH/SUD benefits as compared to M/S benefits, in violation of PHS Act § 2726(a)(8)(A)(iv). In addition, 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).

III. 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 February 26, 2024:

- Remove the prior authorization NQTL for outpatient, in-network MH/SUD benefits from plans for the 2021 plan year and future plan years, following the 2021 plan year, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations;
    - In order for the Issuer to reapply the NQTL for outpatient, in-network MH/SUD benefits to future plan years, a comparative analysis demonstrating that prior authorization decision processes and timeframes are comparable and no more stringent for MH/SUD services compared to M/S services would be necessary to address this finding of non-compliance. For example:
        - The new comparative analysis should demonstrate that the urgent decision processes for prior authorization are comparable and no more stringent for MH/SUD services than for MS services.
        - The new comparative analysis should demonstrate that the ROI factor is applied to prior authorization in a manner that is comparable and no more stringent for MH/SUD services than for M/S services would also be necessary to address this finding of non-compliance.
- Provide to CMS an updated policy and procedure document that reflects the removal of prior authorization requirements for outpatient, in-network MH/SUD benefits;
    - Update the medical management system to reflect the removal of prior authorization for outpatient in-network MH/SUD benefits. Provide to CMS evidence of the removal, or an attestation that this corrective action has been completed; and
- Identify and provide to CMS a list of the participants, beneficiaries, and enrollees who have been adversely affected by the application of the prior authorization requirement to MH/SUD benefits in plan year 2021 and any applicable MH/SUD claims that were affected by the prior authorization requirement, along with supporting documentation outlining the Issuer's methodology for identifying and notifying the affected individuals and claims, and provide evidence that all claims re-adjudications and payments have been completed. Please note that this is separate from and in addition to the seven-day

notification requirement below, which requires notice to all individuals regarding non-compliance with MHPAEA and its implementing regulations.

IV. Next Steps.

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Issuer must, by January 23, 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 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 January 23, 2024.

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 and its implementing regulations. If additional information is provided to CMS regarding this NQTL or Issuer, CMS reserves the right to conduct an additional review for compliance with MHPAEA or other applicable PHS Act requirements.[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. 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 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 09:35:34 -04'00'

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

cc: Missouri Department of Insurance

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