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

September 15, 2022

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 – Provider network participation requirements for inpatient, in-network providers; provider network participation requirements for outpatient, in-network providers

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

This notice is being sent to inform you that a review of the Corrective Action Plan (CAP) submitted on October 30, 2021 and stringency assessment submitted as part of the CAP on March 31, 2022 to address the instances of non-compliance noted in the above-referenced MHPAEA NQTL Analysis Review (Review) is complete. This letter also identifies, as applicable, additional remediation and corrective action 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's (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 analyses reviewed:

42 U.S.C. § 300gg-26, 45 C.F.R. §§ 146.136 and 147.160 - Parity In Mental Health And Substance Use Disorder Benefits

The Review covered provider network participation requirements for inpatient, in-network providers and provider network participation requirements for outpatient, in-network providers for the 2021 plan year.

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 sent an initial determination letter of non-compliance to the Issuer and requested a CAP and additional comparative analyses to demonstrate compliance. After reviewing the Issuer's October 30, 2021 CAP submission and March 31, 2022 stringency assessment, CMS is finalizing the determination of non-compliance with MHPAEA in the following areas addressed in the September 16, 2021 initial determination letter and discussed below:

## I. Failures to Provide Sufficient Information.

PHS Act § 2726(a)(8)(A) requires that the Issuer "make available […] upon request, the comparative analysis and the following information: […] (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" (emphasis added). Additionally, PHS Act § 2726(a)(8)(B)(iii)(I) requires that, "In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A) as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer – (aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section **and provide to the Secretary additional comparative analyses described in subparagraph (a) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or issuer is not in compliance**" (emphasis added). CMS has identified violations of these provisions in the following instances:

1. **The Issuer's comparative analyses did not adequately demonstrate how the Issuer determined whether the processes, strategies, evidentiary standards and other factors used to apply the provider network participation requirements NQTL for inpatient, in-network providers and provider network participation requirements NQTL for outpatient, in-network providers to mental health or substance use disorder (MH/SUD) benefits are comparable to and no more stringently applied than those applied to medical/surgical (M/S) benefits in operation.**

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

The Issuer's October 30, 2021 CAP submission stated that "Community Health Choice will conduct a stringency assessment for NQTLs related to Network Participation requirements" for inpatient and outpatient in-network providers, including assessing reimbursement rates, geographic access standards, specialty requirements or exclusions, facility type requirements or additional requirements for certain facility types, and average credentialing time (Final Provider Network Participation Requirements, cell D7). However, the October 30, 2021 CAP submission did not provide the "date(s) the corrective action is expected to be completed or was completed" as requested in the initial determination letter. In a follow-up response provided on December 23, 2021, the Issuer identified March 1, 2022, as the estimated completion date for their stringency assessment (Revised Final Provider Network Participation Requirements Response 12.23.2021, cell F7). In the Issuer's March 1, 2022, response to CMS' request for the completed stringency assessment, the Issuer modified the estimated completion date to March 31, 2022, with no supporting explanation other than stating "delayed" (Provider Network Participation Requirements 3.1.2022, cells F7 and I7). On March 31, 2022, the Issuer submitted a stringency assessment as part of their CAP submission.

The stringency assessment included a table with average credentialing time, provider reimbursement rate, liability insurance amount, admitting privileges, participation requirements, geographic access, specialty requirements, specialty exclusions, whether the network is open to new applicants, facility participation requirements, liability insurance amount, average facility credentialing time, and facility reimbursement (Marketplace BHSUD Network Stringency 3-31-22). However, the Issuer did not provide a reasoned discussion to support its findings and conclusions related to the comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used to apply the provider network participation requirements NQTL to inpatient, in-network providers and the provider network participation requirements NQTL to outpatient, in-network providers to MH/SUD benefits as compared to M/S benefits, in operation. Specifically, the average facility credentialing turnaround times for MH/SUD facilities are much greater than those for M/S facilities. The average times indicated are "77" for MH/SUD and "54" for M/S (Marketplace BHSUD Network Stringency 3-31-22, cells 17 B and C). The stringency assessment did not include any analysis of these metrics that could explain this discrepancy in average facility credentialing times. Without any analysis or explanation, the metrics alone appear to demonstrate that the facility credentialing time is not comparable in operation and result in longer application times for MH/SUD facilities seeking credentialing as compared to M/S facilities.

Additionally, further clarification is needed regarding the metrics that were included in the stringency assessment. With regard to average facility credentialing time, the Issuer did not provide the units of measurement used to measure the "average facility credentialing time" or "average credentialing time" (Marketplace BHSUD Network Stringency 3-31-22, cells 6 B and C; cells 17 B and C). In addition, the geographic access standards reported in the stringency assessment is "75 miles" for both MH/SUD and M/S providers (Marketplace BHSUD Network Stringency 3-31-22, cells 11 B and C). However, it is unclear whether "75 miles" is a minimum, maximum, or average data metric and whether this is a standard or an observed metric. Further, on March 14, 2022, the Issuer provided policy documents for both MH/SUD and M/S benefits that included various mileage across different geographic areas and provider types, as well as certain standards over 75 miles (Policy 2022NM018-Geographic Access Adequacy Provider

Network Standards Behavioral Health and 2021NM001 Geographic Access Adequacy Provider Network Standards Medical). It is unclear what the "75 miles" metric included in the stringency assessment represents.

Without this information, CMS is unable to validate whether the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, are comparable to and no more stringently applied than those applied to M/S benefits, in operation. As such, the following corrective actions are required:

i. Provide a reasoned discussion of the findings or conclusions regarding comparability and stringency of the NQTLs and its associated processes, strategies, evidentiary standards, and other factors. The discussion should include an analysis of the categories/metrics that were provided in the Issuer's CAP submission (Marketplace BHSUD Network Stringency 3-31-22);
ii. Provide an explanation to define the "75 miles" metric included in the "Geo Access" category of the stringency assessment (Marketplace BHSUD Network Stringency 3-31-22, cells 11 B and C); and
iii. Provide the units of measurement used to measure average provider and facility credentialing times as provided in the stringency assessment (Marketplace BHSUD Network Stringency 3-31-22, cells 6 B and C; 17 B and C) by October 6, 2022.

**2. Failure to provide additional comparative analyses as part of CAP submission.**

The Issuer's October 30, 2021 CAP submission did not include additional comparative analyses for the NQTLs under review, as required by PHS Act § 2726(a)(8)(B)(iii)(I)(aa) and as CMS requested in the initial determination letter. As such, the October 30, 2021 CAP submission is incomplete, and the following corrective action is required:

i. Provide additional comparative analyses demonstrating compliance for the NQTLs under review by October 6, 2022.

## II. Next Steps

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Issuer must, within seven days of the date of this letter, notify all individuals enrolled under a plan subject to these NQTLs 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 September 26, 2022.

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

CMS's findings detailed in this letter pertain only to the NQTLs 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 these NQTLs or plan, CMS reserves the right to conduct an additional review for

compliance with MHPAEA or other applicable PHS Act requirements.[2] CMS's findings pertain only to the specific plans to which the NQTLs 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 analyses, 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,

Mary M. Nugent -S

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Mary Nugent
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cc: Texas Department of Insurance

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