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 Medica Insurance Company - Missouri is not in compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), as codified at Public Health Service Act § 2726 (42 U.S.C. § 300gg-26), and its implementing regulations. The Issuer must, by April 12, 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 April 12, 2024.

April 3, 2024

Medica Insurance Company – Missouri – HIOS ID #53461

Mildred Koranteng, VP & Compliance Officer
Mildred.Koranteng@medica.com
Tel: (952) 992-2090

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 outpatient, in-network services.

Dear Ms. Koranteng,

This letter informs you that a review of the Corrective Action Plan (CAP) and additional comparative analyses submitted on March 22, 2023, April 13, 2023, July 12, 2023, and August 15, 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 fully address the instance of non-compliance.

The purpose of the Review was to assess Medica Insurance Company's (Issuer) compliance with the following requirements under section 2726 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 2022 plan year (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 Issuer violated PHS Act § 2726 and its implementing regulations at 45 C.F.R. §§ 146.136 and 147.160. The factors used by the Issuer in applying the NQTL to mental health and substance use disorder (MH/SUD) benefits in the classification, in operation, are not comparable to those used to apply the NQTL to medical/surgical (M/S) benefits in the same benefit classification.

This final determination letter identifies the ways that the Issuer's CAP and comparative analyses 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.

On February 6, 2023, 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 March 22, 2023, April 13, 2023, July 12, 2023, and August 15, 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 area as noted in the February 6, 2023, initial determination letter and discussed below:

I. Lack of Comparability and Relative Stringency 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. **Use of the Anticipated Return on Investment (ROI) factor is not comparable when determining whether to add or retain a prior authorization requirement on MH/SUD services and M/S services for outpatient, in-network services.**

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

The Issuer identified three factors considered in determining whether to add or retain a prior authorization requirement for outpatient, in-network MH/SUD services and M/S services in its initial submission. The factors identified were "Anticipated Return on Investment (ROI)," "Stakeholder Impacts," and "Alternative UM Options" for both MH/SUD services and M/S services (CMS MHPAEA NQTL Analysis (MO 53461)_FINAL Response 04.15.22, pg. 3). For the ROI factor, the Issuer listed the evidentiary standard as "*services with a positive estimated ROI are generally recommended to be added to the PA list*" (CMS MHPAEA NQTL Analysis (MO 53461)_FINAL Response 04.15.22, pg. 4).

However, information was not provided regarding how all three factors, including ROI, were applied to the NQTL for each MH/SUD service and M/S service, as outlined in the initial determination letter. The Issuer subsequently provided "*PA [Prior Authorization] Decision Tools*," which are used by the Prior Authorization Selection Committee (PASC) to determine which MH/SUD services and M/S services should be added, retained, or removed from the list of services subject to the NQTL in its March 22, 2023 CAP response (CMS MHPAEA Review (MO 53461)_Medica CAP Response_03.22.23, pg. 2). The PA Decision Tools were provided for both MH/SUD services and M/S services and outlined the factors, evidentiary standards, and sources considered for all services subject to the NQTL.

The PA Decision Tools provided for MH/SUD services included both the ROI calculations and the "Est. Savings (Allwd Basis)," "Total FTE Cost," and "Est. Total Operational Cost" inputs used to calculate ROI for each service (3h.PASC PA Tools_Jan2023, pgs. 2, 9, 16). The PA Decision Tools provided for M/S services included general utilization management data and questions on the presence of a net savings for a service but did not include any ROI calculations or any of the inputs used to calculate ROI for M/S services (3a. PASC_PA Tools_Apr2021 – 3g. PASC_PA Tools_Mar2022).

CMS requested the Issuer provide the ROI calculations for M/S services as they were provided for MH/SUD services in a follow up request sent on July 6, 2023. On July 12, 2023, the Issuer did not provide ROI calculations for M/S services. Instead, the Issuer stated it was still working to improve its ROI methodology processes and expected to be in compliance with this request by "*Q4, 2023*" (CMS-MO Regulator Response_Medica_07.13.2023, pg. 1). In response, CMS stated that "Q4, 2023" is not a reasonable timeframe and requested the Issuer provide the requested ROI data calculations by August 16, 2023. In response, the Issuer stated,

> *Data relating to ROI has not yet been presented to PASC. Medica will adjust the timeline and present ROI data to PASC in Q3 instead of Q4. The method will include the ROI data calculations rates for all M/S services* (CMS-MO Regulator Response_Medica_081623_FINALv1, pg. 1).

Documentation provided by the Issuer indicates that the PA Decision Tools provided to the PASC included ROI calculations for MH/SUD services, but did not include ROI calculations for M/S services. The PASC determines which MH/SUD benefits and M/S benefits should be added, retained, or removed from the list of services subject to the NQTL. Therefore, the factors used in applying the NQTL to MH/SUD benefits in the outpatient, in-network benefit classification, in

operation, are not comparable to those used in applying the NQTL to M/S benefits in the same benefit classification, as required by 45 CFR 146.136(c)(4)(i

II. Corrective Actions.

CMS identified the following corrective actions as necessary to resolve the identified instance of non-compliance. Therefore, please take the following corrective actions by 05/15/2024:

- Remove the prior authorization NQTL for outpatient, in-network MH/SUD benefits from plans for the 2022 plan year and subsequent plan years, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations;
    - The Issuer should provide a comparative analysis demonstrating that the ROI factor is applied to prior authorization in a manner that is comparable and no more stringent to MH/SUD services than to M/S services. To address this finding of non-compliance, the Issuer may also choose to remove ROI as a factor considered in applying prior authorization requirements to MH/SUD and M/S services;
- 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 outpatient, in-network MH/SUD benefits in plan year 2022 and any applicable MH/SUD benefit 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 provide evidence that all claims re-adjudications and payments have been completed. Please note that this is separate from and in addition to the notification requirement below, which requires notice to all individuals regarding non-compliance with MHPAEA and its implementing regulations.

III. Next Steps.

Pursuant to PHS Act § 2726(a)(8)(B)(iii)(I)(bb), the Issuer must, by April 12, 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 April 12, 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 *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 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 that 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

Digitally signed by Jeffrey C. Wu -S
Date: 2024.04.02 18:15:10 -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.