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 – Concurrent review 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 concurrent review 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

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

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. **Concurrent review decision processes and timeframes are not comparable for mental health and substance use disorder (MH/SUD) benefits and medical surgical (M/S) benefits for outpatient, in-network services, as written and in operation.**

The Issuer maintained different processes for determining whether a concurrent review request for MH/SUD benefits is subject to "urgent" decision processes and timeframes as compared to M/S benefits in the same classification, as described in the initial determination letter sent on October 27, 2022. According to the Issuer's policy and procedure documents, if a request is received less than 24 hours prior to the end of the current authorization period for MH/SUD benefits, the Behavioral Health clinical supervisor may "opt" to follow the procedure for an urgent pre-service request (HM_CLN_035_Timeliness_of_UM_Decisions_and_Notification_Policy, pg. 3). However, following the urgent concurrent review process is mandatory for M/S concurrent review requests received within the same timeframe. According to the M/S policy, M/S concurrent review requests received less than 24 hours prior to the end of the current authorization period must follow the urgent decision process (UM_39_Timeliness_of_Health_Services_Decisions_Policy, Pg. 8). There is no language relating to urgent M/S concurrent reviews received less than 24 hours prior to the end of the current authorization period making the process optional.

In its CAP response submitted on December 12, 2022, the Issuer provided an updated written policy describing its "standard" and "urgent" concurrent review processes and revised MH/SUD Missouri state-specific decision timeframes for concurrent review (Cigna response to CMS 2022-12-12, pg. 2; HM_CLN_035_Timeliness_of_UM_Decisions_and_Notification_Policy). However, the MH/SUD policy provided still included language stating,

> *For urgent concurrent review of services, Behavioral Health shall make decisions within 24 hours of the receipt of the request […] If a request is received less than 24 hours prior to the end of the current authorization period, Behavioral Health clinical supervisor may opt to follow the procedure for an urgent pre-service request* (HM_CLN_035_Timeliness_of_UM_Decisions_and_Notification_Policy, pg. 3).

There still is no similar opt in language relating to urgent concurrent reviews in the M/S policy. The MH/SUD concurrent review process requires an additional step in order for concurrent review cases received less than 24 hours prior to the end of the current authorization period to be treated as urgent, which is not required for M/S concurrent review cases received within the same timeframe. Therefore, the MH/SUD concurrent review process is not comparable to the M/S concurrent review process, as written.

The Issuer also failed to demonstrate that the urgent concurrent review 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). The Issuer provided operational data metrics to demonstrate comparability and relative stringency of its concurrent review processes in operation in its CAP response submitted on December 12, 2022. 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 concurrent review requests for the 2021 plan year (2021 Commercial BOB MHP TAT PA CR data). The data fields for urgent MH/SUD concurrent review requests all contained the words "Not Reportable" (2021 Commercial BOB MHP TAT PA CR data). CMS requested a narrative discussion clarifying why the operational data metrics were identified as "Not Reportable" for urgent MH/SUD benefit concurrent review requests in a follow up email sent on May 16, 2023. The Issuer stated in its CAP response 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 concurrent review request to urgent, even if requested by the provider. Although the Issuer states that MH/SUD concurrent review 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 concurrent review processes are recorded as "Not Reportable." 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 M/S and MH/SUD urgent concurrent review timeframes 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, including with the updates, does not offer information that would enable CMS to determine that the urgent concurrent review processes as applied to M/S and MH/SUD outpatient, in-network benefits are comparable in operation, and may not even accurately reflect the degree to which MH/SUD urgent concurrent review requests are processed as urgent in accordance with the Issuer's policies.

As written and in operation, the Issuer's MH/SUD concurrent review request processes include additional steps for either the Behavioral Health clinical supervisor or requesting provider in order for the request to be processed following the urgent concurrent review process. There are no additional process steps required for M/S concurrent review requests in the same classification received within the same timeframe (less than 24 hours prior to the end of the existing authorization period) to be processed as urgent. 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 and are applied more stringently than those used in applying the NQTL to M/S benefits in the same 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 concurrent review 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 in the same classification 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 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 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 in the design and application of the NQTL, is $100 for both MH/SUD ROI calculations and M/S ROI calculations (CAA Mental Health Parity NQTL Comparative Analysis Proposed final draft 12.14.22 Version 4.0 Medical Management 12.16.22, pg. 34). 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 (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 "Cost to Review" for M/S benefits ranges from $100 to $2,937,900 and for MH/SUD benefits ranges from $1900 to $2,252,000, according to the Issuer's ROI assessments provided in its initial response (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). It is unclear 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 utilized for both MH/SUD ROI calculations and M/S ROI calculations, or how the average cost per review of $100 was determined. 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 ROI factor considered in the design and application of the NQTL, as written and in operation, in violation of PHS Act § 2726(a)(8)(A)(ii).

2. **Failure to provide sufficient information and supporting documentation to demonstrate the comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used to apply the NQTL, in operation.**

    i. **Failure to provide sufficient information and supporting documentation demonstrating the comparability and relative stringency of appeal decisions for concurrent review processes between MH/SUD and M/S benefits, in operation.**

The Issuer provided combined concurrent review and prior authorization operational data metrics regarding appeal decision overturn rates for plan year (PY) 2020 and PY 2021, as outlined in the initial determination letter sent on October 27, 2022. The decision overturn data provided was not separately provided for the concurrent review NQTL.

The Issuer provided the requested disaggregated decision overturn rate data for concurrent review for PY 2021 in its CAP response submitted on December 12, 2022 (Appeals summary for MO). The data provided showed there were 625 MH/SUD concurrent review cases overturned, for a decision overturn rate of 5.67%, and 307 M/S concurrent review cases overturned, for a decision overturn rate of 0.24% (Appeals summary for MO, cells 4B-E; 06072023 Response Letter (CMS Initial Findings) FINAL, pg. 7). CMS requested that the Issuer provide a reasoned discussion concerning the comparability and relative stringency of the process, strategies, evidentiary standards, and other factors used, which resulted in a higher rate of MH/SUD concurrent review decisions overturned compared to M/S benefit decisions overturned. In response, the Issuer stated,

> *[T]here are several possible reasons for the higher rate of MH/SUD concurrent review determinations overturned as compared to the M/S concurrent review determinations overturned [….] A higher overturn rate for concurrent review of MH/SUD vs. M/S could be a function of providers submitting additional information at the appeals stage. Cigna would have made an initial determination based on the information it had at the time, but if additional information is submitted by the provider later (which is outside of Cigna's control), this could contribute to a higher overturn rate for MH/SUD concurrent review determinations. MH/SUD outpatient care also tends to be very individualized and fact-specific, and therefore more reliant on clear and complete documentation from the provider, as opposed to most M/S outpatient care.* (06072023 Response Letter (CMS Initial Findings) FINAL, pg. 7).

The Issuer's response provided general speculation as to the reasons why MH/SUD decisions could have been overturned at a higher rate compared to M/S decisions in the same benefit classification, as opposed to performing and providing an analysis of the overturn metrics and identifying the processes, strategies, evidentiary standards, and other factors that explain why MH/SUD concurrent review decisions are overturned at a higher rate than M/S concurrent review decisions. For example, the Issuer did not provide evidence that MH/SUD providers submit unclear or incomplete documentation at the initial review stage or submit more information at the appeals stage relative to M/S providers. Therefore, the Issuer did not provide

sufficient information, documentation, or supporting analysis to demonstrate comparability and relative stringency of the NQTL, in operation, in violation of PHS Act § 2726(a)(8)(A)(iv).

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 concurrent review 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 concurrent review 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 concurrent review 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 concurrent review in a manner that is comparable and no more stringent for MH/SUD services than for M/S services.
        - The new comparative analysis should contain sufficient information and supporting documentation demonstrating the comparability and relative stringency of appeal decisions for concurrent review processes between MH/SUD and M/S benefits, in operation.
- Provide to CMS an updated policy and procedure document that reflects the removal of concurrent review requirements for outpatient in-network MH/SUD benefits;
    - Update the medical management system to reflect the removal of concurrent review 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 concurrent review requirement to MH/SUD benefits in plan year 2021 and any applicable MH/SUD claims that were affected by concurrent review 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

Digitally signed by Jeffrey C. Wu -S
Date: 2024.06.14 09:36:36 -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.