DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

BEHAVIORAL HEALTH INVESTIGATION REPORT

CIGNA HEALTHCARE OF CALIFORNIA, INC.

AUGUST 31, 2023

Behavioral Health Investigation
Cigna HealthCare of California, Inc.
August 31, 2023

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (Department) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the Department licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975 and regulations promulgated thereunder (collectively, Knox-Keene Act).[1] The Department received approval from the 2020-21 state budget to conduct focused Behavioral Health Investigations (BHI) of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with California laws and to assess whether enrollees have consistent access to medically necessary behavioral health care services. The full-service commercial health plans will be investigated in phases. The investigation of Cigna HealthCare of California, Inc. (Plan) is included in Phase One.

On April 16, 2021, the Department notified the Plan of its BHI covering the time period of April 1, 2019, through March 31, 2021. The Department requested the Plan submit information regarding its health care delivery system, with a focus on the Plan's mental health and substance use disorder services.[2] The investigation team interviewed the Plan, its behavioral health provider and affiliate, Evernorth Behavioral Health of California, Inc.[3] (Evernorth), and its Pharmacy Benefit Manager (PBM), Express Scripts, Inc. (Express Scripts), an affiliate, on December 1, 2, and 3, 2021.

The BHI uncovered the following three Knox-Keene Act violations in the areas of Utilization Management and Grievances and Appeals:

1. The Plan's delegate is operating at variance with utilization management policies and procedures.
2. The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855).
3. The Plan does not consistently notify the grievant of the right to contact the Department and receive an expedited review of urgent grievances.

Additionally, the Department identified the following two barriers to care not based on Knox-Keene Act requirements in the areas of Cultural Competency, Health Equity and Language Assistance, and Enrollee and Provider Experience:

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[1] The Knox-Keene Health Care Service Plan Act of 1975 is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

[2] For purposes of this Report, the term "behavioral health" or "behavioral health services" refers to mental health as well as substance use disorder conditions, and the services used to diagnose and treat those conditions.

[3] Formerly Cigna Behavioral Health.

1. The Plan's policies, procedures and assessments pertaining to cultural competency and health equity have been developed and implemented on an enterprise basis and lack focus on community needs and engagement.
2. Barriers impacting the enrollee and provider experience.

This BHI Report also includes Plan initiatives or operations, if any, identified as potentially having a positive impact on the Plan's provision of and/or enrollee access to behavioral health services. The investigation identified one Plan practice that positively impacts access to behavioral health services. The Plan's online provider directory includes both medical/surgical and behavioral health providers in one location. This is extremely helpful to enrollees to only need to access one link on the Plan's website when searching for a provider.

The Plan is hereby advised that the findings and violations noted in this BHI Report will be referred to the Department's Office of Enforcement. The Department's Office of Enforcement will evaluate appropriate enforcement actions, which may include corrective actions and assessment of administrative penalties, based on the Knox-Keene Act deficiencies.

FRAMEWORK FOR THE BEHAVIORAL HEALTH INVESTIGATIONS

I. Background

Both California and federal laws require health plans to cover services to diagnose and treat behavioral health conditions. Senate Bill (SB) 855 (Wiener, 2020) made amendments to California's mental health parity law and requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. Health plans must also provide all covered mental health and substance use disorder benefits in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The MHPAEA requires health plans to provide covered benefits for behavioral health in parity with medical/surgical benefits.

Other Knox-Keene Act provisions and corresponding regulations establish standards for access to care, requiring health plans to provide or arrange for the provision of covered health care services, including behavioral health services, in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.[4] Plans must ensure enrollees can obtain covered health care services, including behavioral health services, in a manner that assures care is provided in a timely manner appropriate for the enrollee's condition.[5]

[4] Rule 1300.67.2.2(c)(1).
[5] Rule 1300.67.2.2(c)(2).

The Department utilizes a variety of regulatory tools to evaluate access to behavioral health services, including routine medical surveys, annual assessments of provider networks, and tracking enrollee complaints to the Department's Help Center to identify trends or issues in enrollee complaint patterns. In 2014-2017, the Department conducted MHPAEA compliance reviews of health plans subject to MHPAEA. This included analysis of benefit classifications, cost sharing requirements and non-quantitative treatment limitations to determine if health plans were meeting parity requirements under MHPAEA. As a result of this focused compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA. Since the initial compliance review, the Department conducts ongoing review of MHPAEA compliance when plans make changes to policies or operations, or when licensing new health plans. Additionally, the Department has incorporated into routine surveys review for compliance and the enforcement of requirements of SB 855 (Wiener, 2020) that expanded the scope of access and coverage for behavioral health benefits.

II. Methods for BHIs

The BHIs involve evaluation of health plans' commercial products regulated by the Department.[6] To evaluate the Plan's operations for the review period of April 1, 2019, through March 31, 2021, the Department requested and reviewed plan documents, files, and data, and conducted interviews with Plan and pharmacy delegate staff. The BHI involved reviewing and assessing the Plan's operations pertaining to the delivery of behavioral health services. The BHI focused on the following areas:

- Appointment Availability and Timely Access
- Utilization Management, including Triage and Screening
- Pharmacy
- Quality Assurance
- Grievances and Appeals
- Claims Submission and Payment
- Cultural Competency, Health Equity and Language Assistance
- Enrollee and Provider Experience

To further understand potential barriers to care from the perspective of enrollees and providers, the Department sought enrollee and provider participation in separate interviews concerning their experiences with the Plan. The Department reached out to stakeholders for assistance in identifying enrollees and providers who would be willing to participate in the interviews. Additionally, the Department reviewed complaints submitted to the DMHC Help Center and followed up with interested providers and enrollees. Participation was voluntary and neither enrollees nor providers were compensated for their participation. In connection with the Plan's BHI, the Department

[6] The BHIs do not include plan products or plan enrollees covered by Medicare, California's Medi-Cal program, self-insured Administrative Services Organizations or non-Department regulated product.

interviewed five providers and two enrollees whose input was considered for the Plan's BHI. The interviews were conducted between July and December 2021. The two enrollees worked or lived in San Diego County and Orange County. Of the five providers, one serviced Los Angeles County, one serviced San Diego County, one serviced Alameda County and two serviced Alameda, San Francisco, Santa Clara, Sacramento, Yolo, Placer, Stanislaus, San Joaquin, Fresno, Madera, Los Angeles, San Diego, Imperial, and Orange counties.

The issues raised by interviewed enrollees included difficulty accessing child therapy services and reduction in autism services. The issues raised by interviewed providers included low reimbursement rates, high denial rates for requested services, vague denial reasons, provider directory inaccuracies, unpaid claims, and a complaint that the provider portal is outdated, cumbersome and not user friendly. Additionally, interviewed providers also identified Plan strengths, stating the Plan is transparent, communicative, responsive and professional. The Plan was also praised for authorizing more telehealth services since the beginning of the Covid-19 pandemic, resulting in increased access to care.

PLAN BACKGROUND

The Plan received its Knox-Keene license on March 23, 1979, and operates as a for-profit full-service health care plan. The Plan is headquartered in Glendale, California with a total enrollment of 145,870 commercial enrollees.[7] The Plan's service area includes all counties in the state of California.

The Plan provides commercial Health Maintenance Organization (HMO) large group products for employers with over 100 employees. Cigna offers a full network of health care providers, facilities, laboratories, and pharmacies to provide a full range of health care services to enrollees. The Plan's parent company is Healthsource, Inc., located in Wilmington, Delaware.

The Plan provides pharmacy services through its affiliate Express Scripts, and behavioral health services through Evernorth, an affiliate. Evernorth (formerly Cigna Behavioral Health) has been the Plan's exclusive provider of behavioral health services since 1990.

SECTION I: KNOX-KEENE ACT VIOLATIONS

UTILIZATION MANAGEMENT, INCLUDING TRIAGE AND SCREENING

#1: The Plan is operating at variance with its filed utilization management policies and procedures.

Statutory/Regulatory Reference(s): Section 1386(b)(1)

Supporting Documentation

- *Peer-To-Peer Review – California Addendum* HM-CLN-CA-033 (Policy Committee Approval 9/22/20; 2/9/21)
- *Clinical Review* policy HM-CLN-012 (Policy Committee Approval 11/17/20)
- 30 Evernorth[8] Utilization Management denial files (April 1, 2019 through March 31, 2021)

Assessment: Pursuant to Section 1352(a), the Plan filed with the Department the utilization management policies and procedures utilized by its behavioral health delegate, Evernorth. Among the policies and procedures filed was a policy titled *Peer-To-Peer Review – California Addendum* and *Clinical Review* policy. In relevant part, the *Peer-To-Peer Review – California Addendum* policy states:

[7] Enrollment data reported by the Plan as of March 31, 2021.
[8] During the BHI review period of April 1, 2019 to March 31, 2021, Cigna Healthcare of California's behavioral health delegate was Cigna Behavioral Health, since renamed Evernorth. For purposes of this Report, the delegate is referred to as Evernorth, however, the documents submitted by the Plan referred to the delegate as Cigna Behavioral Health.

> When care managers receive clinical information that does not appear to meet Cigna Standards and Guidelines/Medical Necessity Criteria For Treatment of Mental Health Disorders, the ASAM Criteria, Cigna's Coverage Policies, or initial or concurrent authorization for level of care requested, care managers will refer the case for a Peer-to-Peer Review.

This policy defines "Clinical Peer Reviewer" as "[a] licensed physician or behavioral health care professional who is competent to review the mental health or substance use level of care requested by the treating provider." Furthermore, the policy states: "[T]he peer reviewer may offer an alternative level of care for which Medical Necessity Criteria are met. If the provider agrees to the alternative level of care, the peer reviewer will authorize the agreed upon service. Written notification of modification will be sent to all impacted parties."

Similarly, the *Clinical Review* policy states:

> Whenever a Cigna Behavioral Health care manager is unable to approve a request for service based on medical necessity the care manager shall refer the case to a peer reviewer as per the Peer Review Policy.

Therefore, according to the *Peer-To-Peer Review – California Addendum* policy and the *Clinical Review* policy, care managers must refer requests to peer reviewers when the requested service does not appear to meet the applicable clinical guidelines, and only peer reviewers may offer alternative levels of service.

The Department reviewed 30 Evernorth utilization management denial files. Of the 30 files, 21 files[9] (70% of the files reviewed) included documentation demonstrating that care managers, when finding clinical criteria were not met for the requested level of care, offered requesting providers alternative levels of care. Care managers documented the alternate level of care offered and that the offered alternative level of care was not accepted by the requesting provider. Only then did the care manager refer the case to a peer reviewer. Some of the 21 files also documented requesting providers asking for the case to go to peer review. This suggests the providers are given an option to accept the offered alternative level of care or elect peer review. The process of permitting care managers to offer alternative levels of care and permitting providers to accept or elect peer review is contrary to the Plan's filed policies and procedures.[10]

[9] Utilization Management denial File # 1, File #2, File #3, File #4, File #6, File #7, File #8, File #9, File #10, File #12, File # 13, File #15, File #16, File #18, File #22, File #23, File #25, File #27, File #28, File #29, File #30.

[10] See, e.g., Utilization Management denial File # 13 (stating the care manager and the provider's utilization review staff [UR] "discussed step down vs peer review. UR requested peer review.") File #15 (stating the care manager "offered UR the option of a peer review or to withdraw request. UR withdrew the request. CM offered UR the option of a peer review.") File #16 (stating "Facility UR declined [offered alternative level of care] at this time and request case be sent to peer [review].") File #18 (stating care manager "offered [alternative level of care] of [chemical dependency partial hospitalization program] . . . UR declined requesting peer review.")

Section 1386(b)(1) includes the following as grounds for disciplinary action against a health plan:

> The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director. Section 1351(t) requires health plan applications for licensure to be accompanied by information reasonably required by the director.

File review demonstrated that contrary to the requirements of the *Peer-To-Peer Review – California Addendum* policy and the *Clinical Review* policy, care managers offered alternative levels of care when requested services did not appear to meet medical necessity criteria. These policies require care managers to forward cases that do not appear to meet medical necessity for peer review. Only peer reviewers are authorized to offer alternative levels of care, and modification or denial letters must be sent to enrollees and providers as required. For these reasons, the Department finds the Plan out of compliance with Section 1386(b)(1).

#2: <u>The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)</u>

Statutory/Regulatory Reference(s): Sections 1374.72 and 1374.721

Supporting Documentation:

- Plan documents and communications submitted in eFiling #s 20210549, 20211012 and 20211031
- 40 Utilization Management denial files (April 1, 2019, to March 31, 2021)
- Pre-onsite Questionnaire

Assessment: Effective January 1, 2021, all commercial full-service and behavioral health specialized health plans were required to comply with the requirements of Sections 1374.72 and 1374.721, enacted by SB 855 (Wiener 2020). Among the requirements was the obligation to conduct utilization review for behavioral health services applying the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.[11]

Health plans were required to submit documentation to the Department's Office of Plan Licensing to demonstrate timely compliance with Sections 1374.72 and 1374.721. The Plan's submitted filings demonstrated the Plan was not in compliance with all

[11] Section 1374.721(b).

requirements of Sections 1374.72 and 1374.721 as of January 1, 2021.[12] As of the date of this Report, the Department has not approved the Plan's filing concerning compliance demonstration with all requirements of Sections 1374.72 and 1374.721.

Review of utilization management denial files further confirmed the Plan was out of compliance with use of the required nonprofit clinical criteria. For mental health services requested on and after January 1, 2021, the Plan applied MCG Behavioral Health Guidelines in making medical necessity determinations.[13] Of the 40 utilization management denial files reviewed, five files involved requests submitted on or after January 1, 2021. Of the five files involving requests submitted on or after January 1, 2021, three files involved requests for mental health services[14] and two files involved requests for substance use disorder services.[15] All three of the mental health service requests involved application of MCG Behavioral Health Guidelines in evaluating medical necessity rather than the applicable nonprofit professional association for the relevant clinical specialty. Only when making medical necessity decisions for substance use disorder services did the Plan use relevant nonprofit criteria, American Society of Addiction Medicine criteria (ASAM).

Case File #11 involved a request for residential behavioral health care for a 14-year-old child. To comply with the requirements of Sections 1374.72(a)(7) and 1374.721(b), the plan must apply the criteria and guidelines set forth in the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. In this case, the plan should have used CALOCUS[16] for this request, rather than MCG Behavioral Health Guidelines.

Case File #14 involved a request for partial hospitalization behavioral health care for an adult. To comply with the requirements of Sections 1374.72(a)(7) and 1374.721(b), the plan must apply the criteria and guidelines set forth in the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. In this case, the plan should have used LOCUS[17] for this request, rather than MCG Behavioral Health Guidelines.

Case File #17 involved a request for inpatient behavioral health care for an adult. To comply with the requirements of Sections 1374.72(a)(7) and 1374.721(b), the plan must apply the criteria and guidelines set forth in the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. In this case, the plan should have used LOCUS for this request, rather than MCG Behavioral Health Guidelines.

[12] Plan response to Questionnaire, Utilization Management section, questions 8 and 9.
[13] Utilization Management denial File #s 11, 14, 17.
[14] Utilization Management denial File #s 11, 14, 17.
[15] Utilization Management denial File #s 20, 35.
[16] Child and Adolescent level of Care Utilization System
[17] Level of Care Utilization System

During interviews, the Plan stated it believed MCG Behavioral Health Guidelines are consistent with SB 855 (Sections 1374.72 and 1374.721) requirements because the MCG Behavioral Health Guidelines reference LOCUS and CALOCUS. The Plan admitted it had been working with the Department's Office of Plan Licensing for a year concerning the Plans' compliance with Sections 1374.72 and 1374.721 requirements.

Conclusion: Based on review of the Plan's submitted filings to the Department's Office of Plan Licensing, as well as Plan statements and utilization management files, the Department finds the Plan failed to timely comply with the requirements of Sections 1374.72 and 1374.721.

GRIEVANCES AND APPEALS

#3: The Plan does not consistently notify the grievant of the right to contact the Department and receive an expedited review of urgent grievances.

Statutory/Regulatory Reference(s): Section 1368.01(b) and Rule 1300.68.01(a)(1)

Supporting Documentation:

- 37 Plan Grievance and Appeal files (April 1, 2019 - March 31, 2021)

Assessment: Section 1368.01(b) states:

> The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance.

Rule 1300.68.01(a)(1) states:

> Every Plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include: (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance.

The Department reviewed a random sample of 37 Plan grievance and appeals files. Of the 37 files reviewed, seven[18] were expedited appeal files. Of the seven files, three

[18] Grievance and Appeals File #1, File #6, File #8, File #11, File #13, File #28, File #29.

files[19] (43%) involved instances where the enrollee was not immediately informed of their right to contact the Department, in violation of Section 1368.01(b) and Rule 1300.68.01(a)(1).

Conclusion: Based on grievance and appeals file reviews, the Department found the Plan in violation of Section 1368.01(b) and Rule 1300.68.01(a)(1) for failing to immediately notify complainants who submit urgent grievances or appeals of the right to contact the Department.

[19] File #11 (This file included no documentation that notice of the right to contact the Department was provided to either the enrollee or the provider facility), File #13 (This file included no documentation that notice of the right to contact the Department was provided to either the enrollee or the provider facility), and File #29 (This file included no documentation that notice of the right to contact the Department was provided to the enrollee).

SECTION II: SUMMARY OF BARRIERS TO CARE NOT BASED ON KNOX-KEENE ACT VIOLATIONS

The following is an overview of the barriers to care the Department identified through its investigation of the Plan. Additional information on the barriers will be included in the Department's Phase One Summary Behavioral Health Investigation Report.

For purposes of the BHIs, barriers to care mean those barriers, whether inherent to health plan operations or otherwise, that may create undue, unjustified, needless or unreasonable delays or impediments to an enrollee's ability to obtain timely, appropriate behavioral health care. As applied to providers, barriers refer to those barriers that result in undue, unjustified, needless or unreasonable delays or impediments to a provider's ability to provide timely, appropriate behavioral health services to an enrollee.

#1: <u>The Plan's policies, procedures and assessments pertaining to cultural competency and health equity have been developed and implemented on an enterprise basis and lack focus on community needs and engagement.</u>

Summary: The Department requested the Plan to produce (1) documents describing processes for identification of disparities across the enrollee population for age, race, culture, ethnicity, sexual orientation, gender identity, income level and geographic location, (2) documents demonstrating Plan activities to monitor and address those disparities, and (3) policies and procedures describing Plan community outreach and engagement with identified racial, cultural, linguistic and smaller populated cultural communities.

The Plan submitted several documents in response. With the exception of a California-specific language assistance program and processes to assess compliance with California language assistance requirements, the documents submitted by the Plan indicated Cigna's cultural, language, demographic and population needs assessment activities are conducted on a company-wide, national basis. Plan documents, including the *2019* and *2020 Cigna Behavioral Health Quality, Utilization Management, Case Management, and Behavioral Screening Program Descriptions*, and the *Cigna Behavioral Health Quality Management and Behavioral Operations 2021 Behavioral Program Description* documents included generalized, broad descriptions of assessment of population demographics, cultural and linguistic needs and behavioral management programs. The topical discussions, however, were generalized and included minimal California-specific data. Additionally, the documents included no particular efforts to address disparities experienced by any specific population in California.

Similarly, the *2019* and *2020 Cigna Population Assessments* (Assessments) that presented demographics and population data and the *2019* and *2020 Cigna Behavioral Demographic and Diagnostic Analysis* documents included assessments and data that appeared to be collected, analyzed and reported on a national, enterprise-wide basis.

No documents submitted by the Plan addressed California-specific activities pertaining to community outreach and engagement.

#2: <u>Other barriers impacting the enrollee and provider experience.</u>

Summary:

Provider complaints involving contract rates and disputed payment amounts.
The Department reviewed a sample of the provider complaint files. For Cigna Healthcare of California, the Department reviewed 30 provider complaint files. The provider complaints and the corresponding Plan or delegate responses revealed disagreement and misunderstanding about applicable contract terms and reimbursement rates. Additionally, responses include incomplete written explanations and rationale for the Plan or delegate's determination, and indicated a potential foundation for diminished Plan-provider relationships and increased provider dissatisfaction. Lack of clarity and understanding about claims payment creates a barrier for providers who spend time and resources disputing payments received and may result in frustration and possibly a sense of being taken advantage of or even defrauded by the health plan. In turn, these frustrations can result in providers electing to discontinue their contract with the health plan, avoid providing services to the health plan's enrollees and/or choosing to provide services on a fee-for-service basis only, thereby reducing the number and availability of network providers.

SECTION III: CONCLUSION OF BEHAVIORAL HEALTH INVESTIGATION

The Department completed its Behavioral Health Investigation of the Plan and identified three Knox-Keene Act violations and two barriers to care not based on Knox-Keene Act requirements.

The Plan was afforded an opportunity to respond to any factual errors in this Report and submit a CAP reasonably calculated to correct the identified Knox-Keene Act violations.

The Plan may submit a statement describing actions the Plan has or will take to address the two barriers to care not based on Knox-Keene Act requirements (Barriers Statement). This separate Barriers Statement is **not** part of the corrective action plan described below and should be submitted separately. Should the Plan wish to submit a Barriers Statement, please submit it to the Department no later than **Friday, September 8, 2023**, using the DMHC Web Portal process described below.

The Plan must submit its Response, if any, via the Department's Web portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps shown below to view and submit the documents required:

- Click the e-Filing link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the DPS Routine Survey Document Request titled, DPS 2021 Mental Health Investigation– Document Request.

This Report, along with the Plan's submitted CAP will be sent to the Office of Enforcement for review and appropriate enforcement action, which may include corrective actions and assessment of administrative penalties. A copy of the Report that includes any appropriate factual corrections, along with the CAP and any Barriers Statement submitted by the Plan, will be posted to the **Department's website**.

APPENDIX A

APPENDIX A: INVESTIGATION TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM MEMBERS	
Holly Pearson	Assistant Chief Counsel
Tammy McCabe	Attorney IV
Laura Beile	Supervising Health Care Service Plan Analyst
Marie Broadnax	Staff Services Manager II
Lezlie Micheletti	Health Plan Specialist II
Christian Jacobs	Health Plan Specialist II
CONSULTANT TEAM MEMBERS: THE INS COMPANIES, INC.	
Heather Harley	Project Manager
JoAnn Baldo	Investigator
Anita Edington	Investigator
Sam Muszynski	Investigator
Marilyn Vadon	Investigator
Katie Dublinski	Investigator
Donna Lee Williams	Investigator

APPENDIX B

APPENDIX B. PLAN STAFF AND DELEGATES INTERVIEWED

PLAN STAFF INTERVIEWED FROM: CIGNA HEALTHCARE OF CALIFORNIA, INC.	
Anne Sween-LeVan	Quality Clinical Management Advisor
Badalin Helvink, MD	Medical Director
Brooke Tomblin	Clinical Program Senior Manager
Carlos Bermudez III	Quality Clinical Management Advisor
David Witte	Quality Clinical Management Senior Manager
Ella Avagyants	Personal Advocate Supervisor
Erika Tietze	Appeals Compliance
Ervin Aquino	Personal Advocate Supervisor
Greg Boone	Business Compliance Director
Hana McFarlane	Program Management Advisor
Kristen Moen, MA, LPCC	Lead Clinician, Crisis 24/7 Triage
Lauren Neu	Network Compliance and Reporting Manager
Linda Diaz	Behavioral Operations Supervisor
Liz Richo	Quality Clinical Management Advisor
Lois Fischer, MA, LMFT	Clinical Supervisor, Crisis 24/7 Behavioral Triage
Margaret Rudich	Claims Lead Representative
Mariah Brockel	Behavioral Operations Adherence Lead
Megan Jerger	Personal Advocate
Michelle McKune, MS, LPCC	Director of Behavioral Triage, After-Hours Services and Community Support Program
Nicole Carpenter	Quality Management Advisor
Niki Lehnherr	Behavioral Risk Manager
Patrick Doyle	Personal Advocate
Peggy Payne	Clinical Program Director
Ramnik Singh, MD	Medical Director
Ruth Ellerbroek, LMFT	Clinical Senior Supervisor, Crisis 24/7 Behavioral Triage
Sofia Ksendzovsky	Case Management Senior Manager
Stacy West	Credentialing Manager
Stuart Lustig, MD	National Medical Executive for Behavioral Health
Suki Ewers	Credentialing Lead Analyst
Val Walker	Language Assistance Program Compliance Sr. Manager
Vanessa Craft	Claims Senior Supervisor
Wendy Sanstrom	Network Operations Advisor
Zula Saunders	Quality Clinical Management Senior Manager
Imelda Rivera-Arroyo	Legal Compliance Sr. Advisor

PLAN STAFF INTERVIEWED FROM: CIGNA HEALTHCARE OF CALIFORNIA, INC. (continued)	
Shelley Furr	California Grievance Officer and California Compliance
Beth Fleck	Quality Review and Audit Lead Analyst
Jeffrey Klein, MD	Medical Senior Principal
Kim Dillen	California Quality Manager
Mike Krauson	Network Solutions & Operations Regulatory Support Lead
Patrice Waters	Quality Clinical Management Senior Manager, Regulatory Quality
Kathleen Kovalik, RN, BSN, MPH	Quality Clinical Management Lead Analyst
Mike Imperato, RPH	Clinical Program Director - Pharmacy
Trevor Shaff	Clinical Program Director
Bill Jameson	Associate Chief Counsel
Libby Orendorff	Managing Counsel
Sarang Chehrazi	Supervising Counsel
Madalyn Soliz-McElmurry	Investigation Coordinator

APPENDIX C

APPENDIX C. LIST OF FILES REVIEWED

Type of Case Files Reviewed	# of Files	Case ID Number
Customer Service Inquiries	**6**	11551379 12484834 11246106 12898355 14036184 12978795
Type of Case Files Reviewed	**# of Files**	**Case ID Number**
Provider Complaints	**31**	1177592220 1269964216 1218245568 1280267359 1212631355 2627526 1245309521 1280266549 1198855254 1218798727 5597224 1220341774 5068770 1182115837 5792081 1269964216 1170469482 1174000773 1182588993 1259092190 1246197901 1228042660 1188570632 1195942519 1136674917 1280266198 1182974332 1254783671 1211292257 1202321524 5716911

Type of Case Files Reviewed	# of Files	Case ID Number
Denied Claims	**30**	20345Z0050*4 21053Z0595*1 20254Z3749*1 19354Z3932*1 21054Z1617*1 20232Z1942*1 20245Z2511*1 20192Z3229*6 21062Z2880*1 21074Z0670*1 19341Z0212*1 20268Z4535*1 21025Z3208*1 20246Z3295*1 21047Z2971*1 20217Z3271A*3 20020Z0672*15 20072Z4717*1 20191Z0585*1 21058Z0727*1 19193Z0670*6 20233Z3229A*1 20043Z0811*1 20252Z0151*2 19327Z0546*1 21078Z3414*3 19123Z1175*2 20048Z3837*3 20254Z3557*1 19308Z4369*6

Type of Case Files Reviewed	# of Files	Case ID Number
Paid Claims	**32**	20022Z2553 20038Z4052 20318Z3996 19197Z2235 20303Z3511 19182Z3155 20307Z1066 19186Z1272 2001310130 20315Z0081 20123Z0900 19268Z1107 21084Z3004 20312Z0099 20281Z2798 20016Z2347 20293Z4881 20224Z2030 19091Z0314 20286Z3654 20168Z0317 20118Z2966 19235Z3901 20090Z3249 20182Z4851 19263Z2413 20254Z0615 19136Z0426A 19304Z0381 20116Z0066 19103Z0511 20275Z2130

Type of Case Files Reviewed	# of Files	Case ID Number
Grievance and Appeals	**37**	1275191079 CART00002753190 1229000641 CART00002824197 CART00002597634 1183237603 CART00002470806 1220341502 1241243587 1157995882 1153930164 1226070664 1143547800 CART00002724852 CART00002503627 1242052002 1244067423 1211670805 1160953591 CART00002472492 CART00002447490 1157379742 1220496448 1255603396 1202844304 1202858605 1172782834 1190264201 1135884660 1167387430 CART00002716534 CART00002773573 CART00002536375 1149033169 CART00002578363 CART00002472489 CART00002505403

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management - Authorizations	**68**	13231662 12112645 13064716 13673697 12940635 13207787 13073167 13097225 12383706 11913875 13187993 12877070 12893006 12965224 12669101 12946721 11573924 13727579 11059968 12750624 13084657 13630993 11361428 13035752 10199498 12738524 13205626 12138573 13212292 12725655 11246106 13636174 13526397 13038422 12839918 13387867 13043767 10748247 10775111 13230478 11622872 12537714 12653170 12508346

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management – Authorizations (continued)		12725205 11246106 13505319 12897249 12162174 12780480 13661868 13746850 13016695 9608690 10027748 12854189 12851568 12987126 13364225 13749532 13322787 12978795 12911193 13336222 12119119 13517925 11913875 12750624

Type of Case Files Reviewed	# of Files	Case ID Number
Utilization Management - Denials	**30**	11984173 13355535 12733345 13564053 11355025 11238772 12898939 12935113 12970815 13766278 12994691 11417383 13965387 11324168 13296460 14015032 12650044 13636720 13964794 10661114 11873562 13585993 12533938 11246106 13277102 12974978 11806214 11324113 11238772 13590005 12938506

Type of Case Files Reviewed	# of Files	Case ID Number
Potential Quality Issues	**30**	CART00002776537 CART00002788054 CART00002788766 CART00002793188 CART00002538090 CART00002713629 CART00002785824 CART00002536462 CART00002475602 CART00002647599 CART00002761772 CART00002785246 CART00002499213 CART00002458933 CART00002614426 CART00002756956 CART00002708151 CART00002528003 CART00002688678 CART00002763368 CART00002579662 CART00002518843 CART00002671007 CART00002528637 CART00002599779 CART00002568104 CART00002503627 CART00002685466 CART00002527241 CART00002572159

Type of Case Files Reviewed	# of Files	Case ID Number
Enrollee Requests for Out of Network Behavioral Health Provider	**42**	3407 2924 6011 1844 4406 5875 1959 5792 3864 6035 4735 6377 4254 6011 6827R 5521 6799 25 2123 78 1171 3991 4680 1299 4036 3439 713 6595 2925 6318 4185 4789 636 1299 838 6040 1115 718 2123 6797 2414 3230

Type of Case Files Reviewed	# of Files	Case ID Number
Benefit/Coverage/Experimental Denials of Behavioral Health Services	**36**	13674806 12350461 12063600 13722807 12183912 13024834 7515563 13558428 12879790 11028615 11736237 13557650 11385806 12876333 13630993 12704453 9905470 13107935 9715734 11736237 13689510 13691615 13560263 11440458 13309413 13350178 9146621 11376278 13447715 12892964 12633013 13124004 13653029 12636764 13709540 13700738

Type of Case Files Reviewed	# of Files	Case ID Number
Benefit/Coverage/Experimental Denials of Behavioral Health Services (Pharmacy)	**8**	U1142720601 U0766341302 U4117379203 U6925495001 U0532494302 U6484139902 U4259371303 U4558657502

CIGNA HEALTHCARE OF CALIFORNIA, INC.
CORRECTIVE ACTION PLAN RESPONSE

Cigna HealthCare of California
400 N. Brand Blvd, Ste 300
Glendale, CA 91203

June 21, 2023

Dear Ms. Galli,

Enclosed is Cigna HealthCare of California's (The Plan) response to the Department of Managed Health Care's Behavioral Health Investigation (BHI) Report, issued on May 22, 2023 (Report).

The Plan wishes to express its appreciation for the Department's review and assessment of its operations. The enclosed response details the actions the Plan has taken and is taking to correct the deficiencies identified. We believe you will find these actions to be substantial in addressing the deficiencies and look forward to continued dialogue and partnership.

In addition to the corrective actions noted below, the Plan respectfully requests to append a statement to the final-issued report consistent with other California examinations.

Utilization Management

Deficiency 1

The Plan is operating at variance with its filed utilization management policies and procedures. Section 1368 (b)(1).

Response:

Following the Department's 2019 Routine and 2021 Follow-Up surveys of Evernorth Behavioral Health of California, Inc. (Evernorth), the Plan and its delegated behavioral health provider, Evernorth, have implemented several corrective actions—including updates to policies and procedures, trainings, and auditing—to correct this deficiency.

The corrective actions include the following measures:

1. Q4 2020
    - Updated internal tools to alert staff that only appropriately licensed health care professionals should modify requests for services.

2. October 2020
    - Issued a communication (Evidence 1 – Communication) to staff clarifying that beginning on October 28, 2020, only clinical peer reviewers are qualified to provide an alternative level of care. Additionally, once an alternative level care is accepted, a modification letter is required.

3. May 2021
    - A reminder of how a Clinical Peer Reviewer is the only appropriately licensed health care professional able to provide modifications of the workflow change was provided during team meetings.
    - The Operations Auditing Team began a Bi-Monthly Audit (Evidence 2 – Audit Tool and Evidence 3 - Audit Tool Explanation) and sent notifications to the staff and their aligned supervisors when errors are identified and corrections are needed. Based on results, trends are identified and individual performances are addressed.

4. August 2021
    - Bi Monthly Audit - The CA DMHC Care Management Manager & CA DMHC Lead Clinician were added to notifications when staff made an error to ensure remediation is completed and provide additional individual training/education if needed.

5. February 2022
    - Bi-Monthly Audit was moved over to 1st line of defense team (operations).

6. March 2022
    - Instituted a daily case check of peer review determinations in order to review in real-time a communication and documentations of Modifications.

7. May 2022
    - Created prompts to remind Case Managers not to provide modifications.

8. Q3 2022
    - Enterprise compliance conducted audits in November/December 2022 for the months of June, July and August 2022; and results were delivered on January 4, 2023. The audit determined that no modifications were provided by Case Managers.

10. November and December 2022
    - The DMHC Care Management Manager & DMHC Lead Clinician provided coaching reinforcement.

11. January 2023 –
    - Re-training regarding CA modifications provided during National Forum (Evidence 4 - January 2023 California Modifications ALOCs PP).

12. Feb 2023
    - Provided Care Managers additional training to review California Modifications.

The Plan respectfully refers the Department to Audit Results (Evidence 5 – Audit Results) from December 1, 2022 - May 31, 2023 regarding modifications as only three errors have been identified.

Deficiency 2

The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855).

Response:

The DMHC has not established that the Plan's proposed approach to manually apply non-profit criteria that was in written form (as opposed to the use of Deerfield LLC's algorithm) is noncompliant.

Although the Plan understands and complied with the DMHC's interpretation that LOCUS and CALOCUS shall only be applied through Deerfield LLC., the Plan has also demonstrated in good faith that its manual application of the written non-profit criteria was both legally and factually compliant with law.

Indeed, over the last two years, the Plan and its delegated specialized health care service plan Evernorth Behavioral Health of California, Inc., have provided the DMHC with responses to hundreds of comments, policies and procedures, and a detailed crosswalk demonstrating the factual and legal compliance of our proposed approach as an alternative to the purchase of Deerfield LLC's algorithm as ultimately required by the DMHC for approval of its filing.

Moreover, the Director's Order of Postponement keeps under review the DMHC's filings that describe the Plan's use and manual application of non-profit criteria.[1]

Significantly, the Office of Plan Licensing (OPL) has since February 1, 2021, undertaken a more extensive and targeted examination of the Plan's manual application of non-profit criteria process. The Plan's filings remain pending as the Plan continues to work in good faith with OPL to resolve substantive issues and to obtain approval. Therefore, BHI's determination that the Plan's manual application of written non-profit criteria violates SB 855 is factually unsupported because it has not investigated the issue; and it has not considered the factual and evidentiary record produced to OPL, which has refrained from making such a determination to date.

In contrast, the Plan has demonstrated that its proposed approach complies with section 1374.721(c) because it does "not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth" by non-profit professional associations. Upon procurement of the Deerfield tool, the Plan retroactively reviewed every case that was previously denied for medical necessity, dating back to January 1, 2021. The Deerfield tool confirmed that in 45% of the cases (15), the Plan approved a higher level of care over Deerfield's recommendation. 52% of the cases (13) yielded the same result. The retroactive review of cases factually demonstrates there was no violation of law.

The Plan respectfully requests correction of the BHI report dated May 22, 2023, for the reasons above.

<u>Grievance and Appeals</u>

Deficiency 3

The Plan does not consistently notify the grievant of the right to contact the Department and receive an expedited review of urgent grievances. Section 1368.01(b) and Rule 1300.68.01(a)(1).

Response:

[1] eFiling nos. 20211031, 20211012; 20210549; 20210998 (delegated plan partner); 20210993 (delegated plan partner); 20210550. Note: as agreed upon between the Plan and the DMHC, the Plan's SB 855 compliance was primarily considered via submissions made by its delegated plan partner, Evernorth Behavorial Health of California in eFiling nos. 20210998 and 20210993.

During quarterly oversight reviews, the Plan identified this issue and began to take steps to prevent and remediate this deficiency shortly after this Behavioral Investigation review period.

In July 2021, the Plan reviewed, revised, and trained internal procedures to reinforce the importance of the immediate notification requirement to both the enrollee and the provider/facility which included documenting the notification in the grievance/appeal case notes.

The Plan also implemented, in July 2021, a monthly audit of all expedited grievance/appeals to ensure each case was handled appropriately and accurately. All errors and requirement misses are reviewed directly with the individual to re-educate and/or correct if necessary. Error trending from this monthly audit along with additional oversight review by the Grievance Officer are all included and reported by the Grievance Officer to the Board of Directors. The Grievance Officer reviews any recommendations from the Board of Directors along with all oversight observations with the applicable business unit's management leads for each area to take action as needed.

As a result of these monitoring efforts, the Plan determined additional coaching sessions on the immediate notification process and procedures would help reinforce the importance of the requirements. Coaching sessions were held with all applicable staff in October and November 2022.

Upon receiving the Department's findings from this investigation, the Plan took steps to review the procedures again to ensure each procedure identifies all requirements and their importance as well as indicating additional emphasis on the requirement for documenting the immediate notifications with details.

The Plan has included the following procedures that outline the Expedited Grievance-Appeal immediate notification processes:

1. BHI_DEF_3_GA_EBH-CA Expedited GA Enrollee Immediate Notification
2. BHI_DEF_3_GA_EBH-CA Expedited GA Written Ack-Res Process
3. BHI_DEF_3_GA_EBH-CA Expedited GA QST Process

The Plan is also providing the expedited grievance/appeal immediate notification compliance results for the time period following the December 2021 Behavioral Investigation to current:

January 2022: (1/1) 100%
February 2022: (0/0) N/A
March 2022: (0/0) N/A
April 2022: (0/0) N/A
May 2022: (2/2) 100%
June 2022: (1/0) 0%
July 2022: (0/0) N/A
August 2022: (1/1) 100%

September 2022: (2/0) 0%
October 2022: (0/0) N/A
November 2022: (3/1) 33.33%
December 2022: (1/1) 100%

January 2023: (0/0) N/A
February 2023: (2/2) 100%
March 2023: (1/1) 100%
April 2023: (0/0) N/A
May 2023: (0/0) N/A

We appreciate the Department's ongoing partnership and look forward to further discussing the positions noted above.

Sincerely,

Madalyn Soliz-McElmurry