



**OFFICE OF PLAN MONITORING  
DIVISION OF PLAN SURVEYS**

**FINAL REPORT**

**FOCUSED SURVEY OF MENTAL HEALTH  
PARITY AND ADDICTION EQUITY ACT  
(MHPAEA) IMPLEMENTATION  
OF**

**CIGNA HEALTHCARE OF CALIFORNIA, INC.**

**A FULL SERVICE HEALTH PLAN**

**DATE OF FINAL REPORT: DECEMBER 26, 2017**

**Final Report**  
**Focused Survey of Mental Health Parity and Addiction Equity Act Implementation**  
**Cigna HealthCare of California, Inc.**  
**December 26, 2017**

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## **EXECUTIVE SUMMARY**

On November 16, 2016, the California Department of Managed Health Care (Department) notified Cigna HealthCare of California, Inc. (Plan) that the Focused Survey for compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) and California Health and Safety Code section 1374.76 had commenced, and requested the Plan submit information regarding its healthcare delivery system.

The survey team conducted the onsite portion of the Focused Survey from February 14, 2017 through February 16, 2017. For the survey review period of January 1, 2016 to November 16, 2016, the Department did not identify any findings that were non-MHPAEA compliant.

The Preliminary Report was issued to the Plan on November 6, 2017. The Plan had 45 days to file a certification document that bears the signature of one of the Plan's principal officers to certify the Report's accuracy.

This Final Report describes the Focused MHPAEA Survey of the Plan.

MHPAEA does not require health plans to offer mental health and substance use disorder (MH/SUD) benefits, but plans that do so are required to provide covered MH/SUD benefits in parity with medical/surgical (M/S) benefits. The Knox-Keene Health Care Service Plan Act of 1975,<sup>1</sup> specifically California Health and Safety Code section 1374.76, directs group and individual plans to provide all covered MH/SUD benefits in compliance with MHPAEA no later than January 1, 2015, and authorizes the Department to issue guidance to plans concerning MHPAEA compliance.

The Department's Focused Survey evaluated plans' MHPAEA compliance, for the survey review period specific to each plan, by reviewing the two general categories of MHPAEA treatment limitations: Nonquantitative Treatment Limitations (NQTLs) and Quantitative Treatment Limitations (QTLs). MHPAEA states that treatment limitations are applicable to both NQTLs and QTLs.<sup>2</sup>

- NQTLs are types of treatment limitations that limit the scope or duration of benefits, but are not quantifiable by a specific number. MHPAEA regulations provide an illustrative list of eight specific NQTLs, but explains the list is not meant to be comprehensive.<sup>3</sup> Medical management standards, one NQTL, is

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<sup>1</sup> The Knox-Keene Act 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.

<sup>2</sup> 45 CFR 146.136(a)

<sup>3</sup> The illustrative NQTL list at 45 CFR 146.136(c)(4)(ii) includes: (A) medical management standards limiting or excluding benefits on the basis of medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental; (B) formulary design for prescription drugs; (C) standards for provider admission to participate in a network, including reimbursement rates; (D) refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective; (E) conditioning benefits on completion of a course of treatment; (F) restrictions based on geographic location, facility type, or provider specialty; (G) standards for providing access to out-of-network providers.

listed and defined as a NQTL that limits or excludes benefits based on medical necessity, medical appropriateness or whether the treatment is experimental or investigative. The Department's NQTL review focused on medical management standards based on the Plan's utilization management (UM) processes.

For NQTLs, MHPAEA provides a general rule that a health plan may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification<sup>4</sup> unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification.<sup>5</sup>

To determine whether UM processes are comparable between M/S and MH/SUD services, the Department reviewed and compared UM files,<sup>6</sup> to the extent plans were able to produce files, within Inpatient, Outpatient, and Other Findings categories.<sup>7</sup> The

Department also conducted interviews with plan staff to assess implementation of processes, strategies, evidentiary standards, and/or other factors used in plans' daily operations when applying UM criteria to both MH/SUD and M/S services. The Department evaluated whether plans' UM processes utilized for MH/SUD services were being applied in a manner that is no more stringent than the processes applied for M/S services. Finally, the Department reviewed relevant plan documents such as policies and procedures, and Evidences of Coverage (EOCs) to assess application of UM criteria and other written NQTLs.

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<sup>4</sup> In 45 CFR 146.136(c)(2)(ii), the six classification of benefits are 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network, 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.

<sup>5</sup> 45 CFR 146.136(c)(4)(i)

<sup>6</sup> With regard to approval files, the Department found the files often lacked documentation that identified formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. As a result, the Department reviewed both approval and denial files and assessed factors evident in file review together with information presented during interviews and processes described in policies and procedures.

<sup>7</sup> The categories reviewed by the Department are: 1) Inpatient Hospitalization; 2) Skilled Nursing Facility/Residential; 3) Outpatient Office Visits; 4) Outpatient – Other Items and Services and 5) Other Findings. Although the Department recognizes that MHPAEA identifies Emergency as a separate classification, the Department utilized an Other Findings classification because it determined an Emergency classification, by itself, would not provide meaningful analysis of the Plan's UM processes because plans do not conduct prior authorization of emergency services and few plans conduct retrospective review of emergency services. The Other Findings category allowed the Department to evaluate each plan's unique operations. Finally, the Department did not review the prescription drug classification in this focused survey.

- QTLs are typically numeric based treatment limitations. They may include financial requirements such as deductibles and copayments/coinsurance, limits on the total number of hospital days allowed within a year, and other limits or caps on benefits based on the frequency of treatment, number of visits, days of coverage or days in a waiting period.

MHPAEA prohibits a health plan that provides both M/S and MH/SUD benefits from applying a financial requirement and/or QTL to MH/SUD services in any classification of benefits<sup>8</sup> that is more restrictive than the predominant financial requirement or QTL of that type applied to substantially all M/S benefits in the same classification.

The Department assessed the Plan's QTL compliance by reviewing financial requirements such as co-pays and coinsurance, within specific plan products. The Department also conducted interviews concerning QTL processes and reviewed relevant documents.

## **PLAN BACKGROUND**

Cigna HealthCare of California, Inc. is a for-profit, full-service health care plan headquartered in Glendale, California. The Plan provides HMO, network, and some in-network Point-of-Service (POS) plans. The Plan's parent company is HealthSource, Inc., located in Wilmington, Delaware.

The Plan offers a broad network of health care professionals and facilities throughout 30 counties in California. As of March 2015, the Plan stated it had 172,509 large group commercial enrollees.

The Plan delegates initial UM coverage determinations for M/S services to 298 Independent Practice Associations (IPAs) and medical groups.<sup>9</sup> The Plan contracts with Cigna Behavioral Health of California (CBH) to provide behavioral health services to Plan enrollees.

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<sup>8</sup> The six classifications provided in 45 CFR 146.136(c)(2)(ii).

<sup>9</sup> For ease of reference, this Report will use the term medical groups when referring to IPAs and/or medical groups.

## **MHPAEA IMPLEMENTATION OVERVIEW**

MHPAEA was enacted by Congress in 2008.<sup>10</sup> Originally applicable only to large group coverage, MHPAEA was amended by the Affordable Care Act to also apply to individual and small group coverage.<sup>11</sup> The U.S. Departments of Treasury, Labor, and Health and Human Services issued final rules for MHPAEA on November 13, 2013.<sup>12</sup> The federal government authorized states to ensure compliance with MHPAEA and the final rules (hereinafter, MHPAEA) within health plan and insurer coverage.

California law mandates that commercial health plans cover specified mental and substance use disorders as well as certain services to treat those disorders.<sup>13</sup> MHPAEA requires health plans to provide covered benefits for MH/SUD in parity with M/S benefits.

### **The Department's Oversight**

To assess health plans' compliance with MHPAEA, the Department has undertaken a two-phased approach.

Phase One began in September 2014 when the Department required 26 licensed full service health plans to submit up to 15 benefit plan designs (BPDs) that were reviewed for MHPAEA compliance.<sup>14</sup> The Department's Office of Plan Licensing, Office of Financial Review, and clinical consultants reviewed each of the health plans' submissions. After extensive discussions with the Department, each plan was required to make corrections and implement changes by January 1, 2016.

Phase Two is the Focused Survey. The purpose of the Focused Survey is to review the Plan's implementation of the required changes made in Phase One, and to further evaluate NQTL and QTL to determine MHPAEA compliance.

The Department's findings for Phase One and Two with respect to Cigna HealthCare of California, Inc. are described in this Report.

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<sup>10</sup> Public Law 110-343, 42 U.S.C. § 300gg-26.

<sup>11</sup> 42 U.S.C. § 300gg-26(a)(1),-(a)(3), as amended by ACA, Title X, subtitle A, § 10107(b)(1); 78 Fed. Reg. 68240-68241, 68251 (Nov. 13, 2013); 45 C.F.R. § 156.115(a)(2).

<sup>12</sup> 45 CFR § 146.136 (2013).

<sup>13</sup> Health and Safety Code section 1374.72 requires plans to cover inpatient, outpatient, and psychiatric hospitalization treatment for nine severe mental illnesses for a person of any age and children with serious emotional disturbances. In addition, Health and Safety Code section 1367.005 applies the Affordable Care Act's essential health benefits to nongrandfathered commercial individual and small group coverage while Rule 1300.67.005 requires plans to cover substance use disorders and almost all mental disorders with a range of medically necessary treatments such as intensive outpatient programs, outpatient counseling, and residential care.

<sup>14</sup> Depending on each plan's participation in the individual, small group and large group commercial markets, plans were required to submit up to a maximum of 15 BPDs for review (5 products for each market served).

## **SECTION I: PHASE ONE OVERVIEW**

For the Phase One review, the Plan submitted 15 BPDs for the Department's review. The Department assessed the BPDs for compliance with parity requirements in the Knox-Keene Act and with MHPAEA requirements. Upon completion of its review, the Department issued the Plan a closing letter (the Phase One Closing Letter) that described cost-sharing changes required for two of the 15 BPDs submitted. A copy of the Phase One Closing Letter is attached to this report (see Appendix A.)

## **SECTION II: DISCUSSION OF FOCUSED SURVEY – PHASE TWO**

The Department verified whether the Plan met the conditions set forth in the Department's Phase One Closing Letter. The Department also reviewed Plan documents (Evidences of Coverage, Summaries of Benefits and Coverage, and other disclosure documents), conducted interviews with Plan representatives and delegated entities, and reviewed and compared the UM practices for M/S and MH/SUD in each classification as described in the Plan and delegates' (if applicable) M/S and MH/SUD files.

The Department also reviewed one additional BPD to assess whether the Plan implemented appropriate cost-sharing and financial requirements for the BPD. Because the Plan only had large group products for review, the Department selected for review the large group BPD with the greatest enrollment.

### **FINDINGS**

#### **A. NONQUANTITATIVE TREATMENT LIMITATIONS**

##### **#1 The Department identified no MHPAEA issues with respect to utilization management.**

Health & Safety Code section 1374.76; 45 CFR 146.136(c)(4)(i).

**Statutory/Regulatory Reference:** Health and Safety Code section 1374.76 requires that plan contracts for individual, small and large group shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) and Section 1367.005.

45 CFR 146.136(c)(4)(i) requires that the processes, strategies, evidentiary standards, or other factors used by a health plan in applying a nonquantitative treatment limitation to mental health or substance use disorder benefits within a classification be comparable to, and 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 same classification.

##### **Supporting Documentation or Evidence:**

- Review of 152 UM files (see Table 1)
- Plan policies and procedures
- Interviews with plan staff conducted February 14, 2017 and February 15, 2017.

**Assessment:** In order to assess MHPAEA parity between the Plan's MH/SUD and M/S benefits, the Department requested the Plan and delegates submit UM files. The UM files included those for requested M/S and MH/SUD services that the Plan and/or its delegates authorized, modified or denied. The Department found that approval files often lacked documentation that identified the formal UM criteria/guidelines utilized or narrative that explained the full rationale for approval. However, the Department's

purpose in reviewing these files was not to ensure the Plan documented the basis for approval. MHPAEA and the Knox-Keene Act do not require plans to document criteria/guidelines in approval files. Rather, the Department reviewed UM files to gather information about the Plan's UM processes and operations. In reviewing the files, the Department assessed the following within each classification of benefits:

- the nature, frequency of use and application of UM factors, criteria and processes utilized for M/S and MH/SUD services;
- application of clinical rationales;
- file documentation of the UM processes and/or clinical rationale, and
- variation in application of UM processes by the Plan and/or its delegated entities.

The table below lists the total number files reviewed by the Department:

**TABLE 1 – Total Number of Files Reviewed**

| <b>Category of Benefits</b>              | <b>Number of Medical/Surgical Files Reviewed</b> | <b>Number of Mental Health Files Reviewed</b> | <b>Number of Substance Use Disorder Files Reviewed</b> |
|------------------------------------------|--------------------------------------------------|-----------------------------------------------|--------------------------------------------------------|
| Inpatient                                | 11                                               | 10                                            | 10                                                     |
| SNF/ Residential                         | 6                                                | 10                                            | 10                                                     |
| Office Visit                             | 9                                                | 16                                            | 0                                                      |
| Other Outpatient                         | 11                                               | 12                                            | 10                                                     |
| Other Retrospective Findings             | 8                                                | 9                                             | 20                                                     |
| <b>Total Files Reviewed<sup>15</sup></b> | <b>45</b>                                        | <b>57</b>                                     | <b>50</b>                                              |

## **1. Inpatient Hospitalization**

### **A. File Review**

#### **(i) Inpatient Hospitalization**

##### **Medical/Surgical:**

The Department reviewed 11 inpatient M/S files. Six of the files were medical group files and the remaining five files were Plan files. Five of the total 11 files involved auto-authorization for emergent admissions. Five files evidenced use of national UM criteria

<sup>15</sup> The Department requested the Plan provide files for review. The Plan provided 43 Inpatient hospital files, 41 SNF/Residential files, 40 Office Visit files, 41 Other Outpatient files, and 85 Other Findings (Retrospective) files. The Department discarded from its review 98 files because they did not meet review criteria

(Milliman or InterQual criteria) and one file involved authorization based on medical group guidelines. Four of the eleven files involved services subject to concurrent review.

Mental Health:

The Department reviewed 10 CBH files involving mental health inpatient admissions. All of the files demonstrated use of CBH Guidelines, and seven of the files also evidenced use of clinical information. Additionally, five of the 10 files indicated that a UM authorization process called “Fast Cert” was utilized (see Interviews and Documents section below for description of the Fast Cert process). Eight of the 10 files were subject to concurrent review for continued services.

Substance Use Disorder:

The Department reviewed 10 CBH files involving requests for SUD inpatient admissions. All 10 files demonstrated use of the Fast Cert process and CBH Guidelines, including the Acute Inpatient Drug and Alcohol Detoxification Guideline. Four of the ten files involved concurrent review for continued services.

**(ii) SNF/Residential**

Medical/Surgical SNF:

The Department reviewed six files involving requests for M/S skilled nursing facility (SNF) services. Of the six files, three files demonstrated use of Milliman Care Guidelines, along with clinical information. The other three files demonstrated application of CBH guidelines together with other national criteria, including InterQual criteria. One of the files involved concurrent review for continued services.

Mental Health Residential:

The Department reviewed 10 CBH files involving requests for MH Residential Services. All 10 of the files demonstrated use of CBH Guidelines in making UM determinations. Of the 10 files, nine involved concurrent review for ongoing services.

Substance Use Disorder Residential:

The Department reviewed 10 CBH files involving requests for SUD Residential Services. All 10 of the files demonstrated use of CBH Guidelines in making UM determinations. Of the 10 files, six files involved concurrent review.

Inpatient file review results are summarized as follows:

| File Type                     | Number of Files Reviewed | Basis for UM Determination                                                                                                                                                                                                                                                                                                 |
|-------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| M/S Inpatient Hospitalization | 11                       | <ul style="list-style-type: none"> <li>• 3 files (2 Plan/1 medical group): Milliman Care Guidelines</li> <li>• 5 files (3 Plan/2 medical group): Auto-authorization for emergency admission</li> <li>• 2 files (medical group(s)): InterQual criteria</li> <li>• 1 file (medical group): Medical Group criteria</li> </ul> |
| MH Inpatient Hospitalization  | 10                       | <ul style="list-style-type: none"> <li>• 10 files (CBH): CBH Guidelines/Fast Cert, Clinical factors</li> </ul>                                                                                                                                                                                                             |
| SUD Inpatient Hospitalization | 10                       | <ul style="list-style-type: none"> <li>• 10 files (CBH): CBH Guidelines/Fast Cert</li> </ul>                                                                                                                                                                                                                               |
| M/S SNF                       | 6                        | <ul style="list-style-type: none"> <li>• 3 files (2 Plan/1 medical group): Milliman Care Guidelines, clinical factors</li> <li>• 3 files (medical group(s)): CBH Guidelines, InterQual</li> </ul>                                                                                                                          |
| MH Residential                | 10                       | <ul style="list-style-type: none"> <li>• 10 files (CBH): CBH Guidelines</li> </ul>                                                                                                                                                                                                                                         |
| SUD Residential               | 10                       | <ul style="list-style-type: none"> <li>• 10 files (CBH): CBH Guidelines</li> </ul>                                                                                                                                                                                                                                         |

## B. Interviews and Documents

The Department interviewed Plan staff and representatives of several M/S delegates. The Plan stated that all scheduled inpatient M/S services require preauthorization. This prior authorization requirement was consistent with the Plan's UM policy. The Plan's *California Utilization Management Process* policy (2016), states in part:

Cigna utilizes established criteria and length of stay guidelines for determination of appropriateness of requested services and procedures. These review criteria are utilized to evaluate appropriate level of care, location of care, medical necessity and appropriate length of stay . . . . In any situation where the Health Service Clinical staff is unable to make a determination based on criteria or feels that a situation may warrant a potential for denial the case is to be referred to a Cigna Medical Director or designated physician for final determination. A physician must make all denial decisions predicated on medical necessity/ appropriateness.

The interviewed delegates stated they use Plan criteria, Milliman Care Guidelines or InterQual criteria for inpatient M/S UM determinations. If a specific case does not meet

guidelines, the case is sent to a Medical Director for review and determination. M/S delegates stated they relied on their own medical group guidelines only when no national or Plan criteria were available.

The Department found that some M/S delegates used a UM process called “Fast Cert” for non-urgent inpatient services. Using the Fast Cert process, which, for M/S services, is based on Milliman Care Guidelines, the delegate is able to authorize an initial number of inpatient days. If the enrollee is not discharged from the facility by the end of the authorized period, then concurrent review is performed.

Cigna Behavioral Health (CBH), which conducts UM for the Plan’s MH/SUD benefits, stated that scheduled MH/SUD inpatient services require preauthorization, similar to that for M/S inpatient services. Fast Cert is also used for MH/SUD inpatient services, however, the initial number of days authorized are not based on Milliman Care Guidelines, but on CBH internally developed criteria intended to allot more days than would be authorized under Milliman Care Guidelines. In developing the criteria, CBH stated it first looked at the number of days that would have been authorized under Milliman Guidelines, and added additional days. CBH representatives stated, for example, if Milliman Guidelines would have authorized 3 initial inpatient days, CBH would authorize 5 or 6 days. Similar to M/S UM operations, if the enrollee is not discharged from the facility by the end of the authorized period, then concurrent review is performed.

**Conclusion:** Based on file review and information from policies and procedures and interviews, the Department found that the UM criteria, factors and processes applied to inpatient MH/SUD benefits were comparable to, and applied no more stringently than, the UM criteria, factors and processes used by the Plan and its delegates for inpatient M/S benefits. The UM criteria used for both M/S and MH/SUD benefits were based on nationally recognized guidelines. While some M/S inpatient files involved auto-authorization for emergency admissions, the Department determined that the Fast Cert process used for emergent MH admissions, was, in operation, a process comparable to, and no more stringent than, the M/S auto-authorization process. CBH’s application of criteria for MH/SUD inpatient services was found to be less stringent than that used for M/S inpatient services because use of Fast Cert by CBH is based on guidelines that are more liberal than the process used for M/S inpatient services.

## **2. Outpatient**

### **A. File Review**

#### **(i) Outpatient Office Visits**

##### **Medical Surgical:**

The Department reviewed nine medical group files involving requests for M/S office visits. Of the nine files, five involved auto-authorized requests for referrals to specialists. Three files involved UM determinations based on clinical factors, and one file involved application of a Plan guideline.

Mental Health:

The Department reviewed 16 CBH files involving requests for mental health office visits. All 16 files involved requests for either an initial assessment for applied behavioral analysis (ABA) services, or for concurrent review for ongoing ABA services, for treatment of autism spectrum disorders. For all cases, CBH used Autism Behavioral Intervention Therapy standards (ABIT), as applied to the member's clinical information, to make the UM determination.

Substance Use Disorder:

The Plan had no files pertaining to requests for preauthorization for SUD outpatient visits for the review period.

**(ii) Outpatient Other Services**

Medical Surgical:

The Department reviewed 11 delegate files involving requests for outpatient M/S services other than office visits. Requested services included, for example, a CT scan, MRI and colonoscopy. Of the 11 files, four files involved application of Milliman Care Guidelines, three files involved auto-authorization for services such as physical therapy or colonoscopy, two files demonstrated use of clinical factors, one file involved application of Plan guidelines, and one file involved use of a medical group guideline.

Mental Health:

The Department reviewed 12 CBH files involving requests for outpatient MH services other than office visits, such as intensive outpatient services or partial hospitalization. All 12 files demonstrated application of CBH Guidelines and clinical factors. Four of the files also involved concurrent review for ongoing services.

Substance Use Disorder:

The Department reviewed 10 CBH files involving requests for outpatient substance use disorder services other than office visits, such as intensive outpatient services or partial hospitalization. All 10 files demonstrated application of CBH Guidelines and clinical factors.

Outpatient file review results are summarized as follows:

| File Type              | Number of Files Reviewed | Basis for UM Determination                                                                                                                                                                                                                                                                                                         |
|------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| M/S Office visits      | 9                        | <ul style="list-style-type: none"> <li>• 5 files (medical groups): Auto-authorization</li> <li>• 3 files (medical groups): Clinical factors</li> <li>• 1 file (medical group): Plan guideline</li> </ul>                                                                                                                           |
| BH Office Visits       | 16                       | <ul style="list-style-type: none"> <li>• 16 files (CBH): Autism Behavioral Intervention Therapy Standards</li> </ul>                                                                                                                                                                                                               |
| SUD Office visits      | 0                        | N/A                                                                                                                                                                                                                                                                                                                                |
| M/S Outpatient - Other | 11                       | <ul style="list-style-type: none"> <li>• 4 files (medical groups): Milliman Care Guidelines</li> <li>• 3 files (medical groups): Auto-authorization</li> <li>• 2 files (medical groups): Clinical factors</li> <li>• 1 file (medical group): Plan guidelines</li> <li>• 1 file (medical group): Medical group guideline</li> </ul> |
| MH Outpatient - Other  | 12                       | <ul style="list-style-type: none"> <li>• 12 files (CBH): CBH Guidelines, clinical factors</li> </ul>                                                                                                                                                                                                                               |
| SUD Outpatient - Other | 10                       | <ul style="list-style-type: none"> <li>• 10 files (CBH): CBH Guidelines, clinical factors</li> </ul>                                                                                                                                                                                                                               |

## B. Interviews and Documents

In interviews, CBH representatives stated that CBH does not require prior authorization for routine outpatient services, including services below the level of intensive outpatient services. Routine outpatient services not requiring prior authorization include, for example, group or individual therapy, electroconvulsive therapy and neuropsychiatric testing. Outpatient MH/SUD services that require prior authorization include intensive outpatient services, partial hospitalization, ABA and transcranial magnetic stimulation. CBH's policy, *Clinical Review* (2015), supported statements made in interviews. The *Clinical Review* policy states in Section 5.e.: "Pre-service review and authorization is [sic] not required for routine outpatient care."

Further, CBH Guidelines for UM are national based criteria. The *Cigna Behavioral Health Quality, Utilization Management, Case Management, and Behavioral Screening 2016 Program Description* states on page 25 that CBH adopts "best practice, evidence-based, clinical practice guidelines from recognized national professional organizations."

All delegated M/S medical groups interviewed stated that they use a hierarchy of criteria, including use of Plan criteria first, then Milliman Care Guidelines if the Plan's

criteria are silent with respect to the requested service. These criteria are utilized for both prior and concurrent authorization operations.

Interviews revealed variation between medical groups concerning prior authorization requirements and use of auto-authorization. Some medical groups do not require prior authorization for certain outpatient M/S services, such as diagnostic testing and radiology services. Also, some medical groups use auto-authorization for certain services, such as referrals. A representative from one medical group stated that the medical group developed auto-authorization rules based on internal trending and data for requests that the medical group never denies, such as requests for consultations. However, requests for out-of-network M/S services are never auto-authorized, but must be reviewed. Not all medical groups use auto-authorization processes, and services auto-authorized or not requiring prior authorization varied from group to group.

There was no indication from interviews or review of policies and procedures that CBH uses auto-authorization for any outpatient service. However, outpatient files involving requests for initial assessments for ABA services appeared to be authorized without clinical review. Information in the files stated that ABA initial assessments were authorized based on the California mandate<sup>16</sup> when the enrollee had an autism diagnosis and ABA coverage was verified for that enrollee. Thus, there was no clinical review upon confirmation of diagnosis and coverage, and therefore, the approval was comparable to auto-approval.

**Conclusion:** Based on the Department's review of files, policies and procedures and information obtained during interviews, the Department determined that the UM processes, factors and criteria used for outpatient MH/SUD services is comparable to, and applied no more stringently than, those used for M/S services. UM criteria applied to both M/S and MH/SUD services involve or are based on national or recognized criteria.

While CBH did not appear to have a per se auto-authorization process, CBH's process for authorizing initial assessments for ABA therapy was found to be comparable to the auto-authorization process used for authorizing some M/S services. Additionally, CBH does not require prior authorization for routine outpatient MH/SUD services, which is a less stringent process than that applied to most M/S outpatient services. The fact that there were no SUD office visit files for review and the only MH office visit files involved requests for ABA (initial or ongoing), served to support CBH's statements and CBH policy standards that no prior authorization is necessary for routine MH/SUD outpatient office services.

### **3. Other Findings**

#### **Retrospective File Review:**

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<sup>16</sup> Health & Safety Code section 1374.72 requires plans that provide hospital, medical or surgical coverage to provide for the diagnosis and medically necessary treatment of severe mental illnesses and serious emotional disturbances of children, including autism. Applied behavioral analysis (ABA) is used for patients with autism.

The Department reviewed eight M/S files, nine MH files and 20 SUD files that involved retrospective UM review, following delivery of services. All files demonstrated use of clinical factors in making the UM determination. Additionally, all MH, all SUD and all but three of the M/S files indicated application of criteria or guidelines, such as Plan guidelines or medical group clinical practice guidelines. Retrospective UM operations appeared to be consistent across benefit type (M/S, MH and SUD) in that processes and criteria used to make UM determinations were comparable and no more stringent for MH/SUD than for M/S.

### **Emergency Services:**

In interviews, one M/S delegate stated that Level 5 emergency benefits (i.e., the highest level of services) are reviewed by the Medical Director, but all other emergency room (ER) services are not subject to medical necessity review. Other M/S delegates stated there is no medical necessity review for ER services, and all ER and related services, such as scans and procedures delivered in connection with an ER visit, are approved.

Similarly, CBH representatives stated that ER services are not reviewed. When an enrollee in MH/SUD crisis calls CBH, the calls are triaged by a team of clinicians who can make arrangements for appropriate care. There is no prior authorization requirement for M/S or MH/SUD emergency services.

**Other Findings Conclusion:** The Department identified no parity issues with respect to retrospective review or emergency services UM practices and operations for MH/SUD services as compared to M/S services.

**Plan Response:** The Plan timely responded to the Preliminary Report and submitted the required signed certification. The Plan's response offered no comment with respect to the Department's findings in this section.

**Status:** No NQTL MHPAEA issues were identified during this Focused Survey.

## **B. QUANTITATIVE TREATMENT LIMITATIONS**

### **#2 The Department identified no MHPAEA issues with respect to QTL, including the Plan's implementation of financial requirements.**

Health & Safety Code section 1374.76; 45 CFR 146.136(c)(2)(i) and (ii); 45 CFR 146.136(c)(3)(i)(A)

**Statutory/Regulatory Reference:** Health and Safety Code section 1374.76 requires that plan contracts for individual, small and large group shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) and Section 1367.005.

45 CFR 146.136(c)(2)(i) requires that plans providing both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

45 CFR 146.136(c)(2)(ii) provides that if a plan provides mental health or substance use disorder benefits in any classification of benefits described in paragraph (c)(2)(ii),<sup>17</sup> mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.

45 CFR 146.136(c)(3)(i)(A) provides that a financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

**Supporting Documentation or Evidence:**

- The Plan's Exhibit J-11-A and Exhibit J-12 worksheets<sup>18</sup>
- 2016 Evidence of Coverage and Summary of Benefits

**Assessment:** The Plan filed and the Department reviewed cost-sharing amounts within each classification of benefits for one BPD not previously filed during Phase One. By reviewing the additional BPD, the Department had the opportunity to assess whether the Plan properly implemented cost-sharing in other BPDs as set forth at the close of Phase One.

In furtherance of this review, the Plan filed an Exhibit J-11-A worksheet for the one additional BPD that included the services identified by the Plan as belonging in each classification of benefits, for M/S and MH/SUD benefits, along with the applicable cost sharing requirements for each classification as calculated by the Plan. The Department reviewed the Plan's Exhibit J-11-A for MHPAEA compliance and found that the reviewed BPD covers all required benefits. The Department also reviewed the Plan's Exhibit J-12 worksheet that included calculations demonstrating its predominant financial requirement in each classification of benefits that applies to substantially all benefits within the classification. The Department's Office of Financial Review reviewed

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<sup>17</sup> See footnote 4 above for a description of the classifications.

<sup>18</sup> Exhibit J-11-A and J-12 are worksheets developed by the Department to guide the plans (use is optional) in demonstrating compliance with MHPAEA. Exhibit J-11-A addresses the classification of benefits requirement of MHPAEA. Exhibit J-12 is utilized to demonstrate compliance with the financial requirements of MHPAEA.

the Plan's calculations and determined that the Plan correctly calculated the financial requirements.

**Conclusion:** Based on the Department's review of the Plan's Exhibit J-11-A worksheet and Exhibit J-12, as well as review of the EOC and information from staff interviews, the Department identified no MHPAEA issues for the BPDs reviewed in the Focused Survey.

**Plan Response:** The Plan timely responded to the Preliminary Report and submitted the required signed certification. The Plan's response offered no comment with respect to the Department's findings in this section.

**Status:** No QTL MHPAEA issues were identified during this Focused Survey.

### **SECTION III: PLAN EXPERIENCE IN IMPLEMENTING MHPAEA**

The Department's Focused Survey also included inquiry into the Plan's experience implementing MHPAEA and maintaining parity.

#### **1. Delegation Oversight**

According to the Plan's *California Utilization Management Process* policy (2016), oversight of delegates includes an annual audit conducted by the Cigna Health Services Department. The delegation audit involves review of UM policies and procedures and UM criteria or guidelines used to render UM decisions. If a delegate has developed its own criteria or guidelines, Plan staff review the medical group guidelines to ensure that recognized sources were used in the development process and that the delegate's guidelines are comparable to those used by Plan.

Plan representatives stated that if a delegated medical group's performance falls below a standard threshold, the medical group is re-audited. The Plan provided an example of a delegate that was audited on a monthly basis in 2016. Alternatively, a medical group may be subject to a 3-month or 6-month audit schedule, depending on the issue to be monitored. The Plan requires a corrective action plan for any medical group whose audit results in less than a 100% rating.

While the Department found the Plan's annual audit of its M/S delegates was thorough with respect to the issues audited, the Plan has not assessed its 298 delegated medical groups for parity, or performed a comparison of its delegates' operations with CBHs operations.

With respect to MH/SUD services, the Plan and CBH work closely and continuously to review and compare processes and operations between the Plan and CBH.

#### **2. Assessment of Plan's Ability to Maintain Parity**

The Plan's quality committee structure is organized to ensure monitoring, review and comparison of Plan UM standards, criteria and factors with CBH UM standards, criteria and factors. The relationship and operations of the Plan with CBH help ensure ongoing parity as between the Plan and CBH. However, as stated above, the Plan has not assessed and compared UM of its delegated medical groups with CBH. Because of the large number of M/S delegates, the Plan stated that the logistics of comparison pose difficulties.

#### **SECTION IV: SURVEY CONCLUSION**

Within the scope of this Focused Survey, the Plan's operations were found to be compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA) and California Health and Safety Code section 1374.76.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, [DMHC Web Portal](#).

Once logged in, follow the steps shown below to submit the Plan's response to the Preliminary Report:

- Click the eFiling link.
- Locate the MHPAEA Filing.
- Submit the Plan's response to the Final Report as an Amendment to the MHPAEA filing, as an Exhibit J-12-D MHPAEA Survey, Plan Response to the Final Report.

## **APPENDIX A PHASE ONE CLOSING LETTER**



Edmund G. Brown Jr., Governor  
State of California  
Health and Human Services Agency

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**Department of Managed Health Care**  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814-2725

March 23, 2016

### **VIA ELECTRONIC MAIL**

Cigna HealthCare of California, Inc.  
400 N. Brand Blvd., Suite #400  
Glendale, CA 91203

The Department of Managed Health Care (Department) has reviewed the information submitted in the above-referenced filing (Amendment) filed by Cigna HealthCare of California, Inc. (Plan) for compliance with the Knox-Keene Health Care Service Plan Act of 1975<sup>19</sup>, as amended and with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act<sup>20</sup> (MHPAEA) and federal final rules<sup>21</sup> and with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act<sup>22</sup> (MHPAEA) and federal final rules.<sup>23</sup>

The Department has completed review of the Amendment, and at this time has no further objection to implementation of the changes as described in the Amendment, as amended, subject to the following conditions:

1. The Plan shall implement the revisions to the cost-sharing for mental health and substance use disorder benefits (MH/SUD) that have been reviewed and not objected to by the Department within the Amendment. Those revisions are summarized in the chart below.

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<sup>19</sup> California Health and Safety Code sections 1340 et seq. (Act). References herein to "Section" are to sections of the Act. References to "Rule" refer to California Code of Regulations, title 28.

<sup>20</sup> California Health and Safety Code sections 1340 et seq. (Act). References herein to "Section" are to sections of the Act. References to "Rule" refer to California Code of Regulations, title 28.

<sup>21</sup> California Health and Safety Code sections 1340 et seq. (Act). References herein to "Section" are to sections of the Act. References to "Rule" refer to California Code of Regulations, title 28.

<sup>22</sup> Public law 110-343, 42 U.S.C. § 300gg-26.

<sup>23</sup> 45 CFR § 146.136 (2013).

| <b>Plan Coverage Name</b>                           | <b>Benefits Impacted (All In-Network)</b>                                                                                                                                                                                                                              | <b>2015 Cost-Sharing</b>        | <b>Cost-Sharing as of 1/1/2016</b>  |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------|
| Large Group: Network Copay Plan                     | Mental health/substance use disorder office visits                                                                                                                                                                                                                     | \$20 copay                      | \$20 copay                          |
| Large Group: Network Copay Plan                     | Mental health/substance use disorder services, outpatient other items and services: intensive outpatient treatment, partial hospitalization, behavioral health treatment for PDD/autism, ambulatory detoxification, medication assisted treatment of opiate dependence | No copay, subject to deductible | No copay, not subject to deductible |
| Large Group: Network Hospital Only Coinsurance Plan | Mental health/substance use disorder office visits                                                                                                                                                                                                                     | \$20 copay                      | \$20 copay                          |
| Large Group: Network Hospital Only Coinsurance Plan | Mental health services, outpatient other items and services: intensive outpatient treatment, partial hospitalization, behavioral health treatment for PDD/autism, ambulatory detoxification, medication assisted treatment of opiate dependence                        | \$20 copay                      | No copay                            |

The Plan shall utilize nonquantitative treatment limits that have been reviewed and not objected to by the Department in the Amendment, including but not limited to the following revised policies and procedures: Policy HM Clin 012 Behavioral Clinical Review Policy.

2. The Plan shall revise its EOCs, copayment summaries, Summaries of Benefits and Coverage (SBCs), and other disclosure documents for enrollees to disclose MHPAEA-compliant cost-sharing, quantitative treatment limits, and nonquantitative treatment limits, and other revisions to disclosure text that have been reviewed and not objected to by the Department in the Amendment. These revisions include, but are not limited to:
  - a. Schedule of Copayments and Summary of Benefits and Coverage: both documents for 2016 now report MHPAEA-compliant cost-sharing for mental health and substance use disorder services.
  - b. EOCs/Group Agreements:
    - i. Prior authorization requirements for MH/SUD services have been clarified.

- ii. Disclosure text now clarifies that no referral is necessary for enrollees to access MH/SUD services.
  - iii. The “Covered Services and Supplies” section has been revised to describe more completely the MH/SUD conditions, and the types of inpatient and outpatient MH/SUD services to treat those conditions, that are covered.
  - iv. The “Covered Services and Supplies” and “Services and Urgent Care” sections have both revised the definition of “emergency medical condition” to include the definition of “psychiatric emergency medical condition.”
3. The Plan shall use the classification of benefits standards, the methodology for calculating financial requirements and quantitative treatment limits, and the factors used to apply nonquantitative treatment limits that have been reviewed and not objected to by the Department within the Amendment to provide covered mental health and substance use disorder benefits in compliance with MHPAEA within the Plan’s individual and group commercial plan coverage.<sup>24</sup>
4. The Plan shall implement the changes to comply with MHPAEA delineated above according to the Department’s guidance in the July 17, 2015, All Plan Letter concerning January 1, 2016, final implementation of MHPAEA compliance and the August 7, 2015, email update to the July 17 All Plan Letter.<sup>25</sup>

This letter does not constitute a waiver of any compliance issues that may be identified on subsequent review and analysis of the Amendment, whether or not highlighted to reflect a change, or of any other Plan documents or operations, whether or not disclosed in the Amendment.

The revisions necessary to correct the compliance concerns identified by the Department in this Amendment apply to all Plan documents that contain similar language or provisions, whether previously filed or not. Plan documents and operations that do not reflect compliance with the Act, Rules, and MHPAEA in accordance with the Department’s determinations regarding this Amendment are not approved. Accordingly, please review and revise all Plan documents as necessary to identify and correct similar compliance concerns where they may exist. If language approved in the context of this Amendment is the only change made by the Plan to its existing variations of the same forms of documents as submitted in this Amendment, the Plan need not file those revised documents. The Department reserves the right to require additional revisions to the Plan’s operations and documents, including but not limited to subscriber and provider documents, and written policies and procedures, as further review may indicate is necessary for compliance with the Act.

Please contact the Department if you have any questions regarding the above.

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<sup>24</sup> California Health and Safety Code § 1374.76

<sup>25</sup> Ibid.