Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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July 29, 2019

SENT VIA FACSIMILE ONLY TO: (818) 500-6365

William S. Jameson
Cigna HealthCare of California, Inc.
400 N. Brand Blvd., Suite 400
Glendale, CA 91203

RE: ENFORCEMENT MATTER NUMBER: 17-1703

LETTER OF AGREEMENT

Dear Mr. Jameson:

The Office of Enforcement within the Department of Managed Health Care (the Department) has concluded its investigation of Cigna HealthCare of California, Inc., (the Plan) concerning the above matter. This investigation concerned the Plan's violations of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and regulations promulgated thereunder. The relevant facts are fully set forth below.

This matter was opened in October 2017 based on confidential whistleblower allegations relating to falsified documents submitted to the Department and health plans during audits. The Department has been conducting an investigation to assess this information and other information received in the course of its investigation, which is presently ongoing. Based on the information received from EHS's contracted health plans, derived from the Department's investigation, and information independently obtained from SynerMed and its staff, the Office of Enforcement has determined the following:

SynerMed operated EHS as though it was actually EHS.

From approximately 2006 through January 7, 2018, SynerMed and EHS operated as substantially the same entity. The board of directors for SynerMed and EHS were nearly identical, and both corporate headquarters occupied the same physical address. Furthermore, James Mason (Mason), SynerMed's Chief Executive Officer and EHS' attorney-in-fact, directed the day-to-day operations of both EHS and SynerMed with

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virtually no oversight, and SynerMed employees acted on behalf of EHS when performing their assigned administrative duties throughout this timeframe.

At the time this investigation was opened, EHS employed no individuals. It relied on SynerMed to perform the claims, credentialing and utilization management functions for which EHS had contracted with the Plans. EHS maintained no independent information systems where its medical records and health data were maintained, stored, and controlled. Instead, SynerMed maintained, stored, and controlled all EHS medical and health data. SynerMed managed all of EHS' financial operations, including, but not limited to, financial reporting to regulators, and payments to EHS medical directors. Mason, as EHS' attorney-in-fact, screened, interviewed, and hired the medical directors on behalf of EHS.

SynerMed failed to send notifications approving, modifying, or denying requests for authorization to enrollees, in violation of Health and Safety Code section 1367.01, subdivision (h)(3), then falsified documents during audits to make it appear as though it had actually sent notifications.

Under Health and Safety Code section 1367.01, subdivision (h)(3), decisions to deny, delay, or modify requested health care services must be communicated to the enrollee within two business days of the decision.

The Department's investigation determined that SynerMed did not send thousands of Notice of Action letters for denied or modified treatment authorization requests to enrollees and their providers. The failure to provide these notifications is a significant barrier to enrollees' ability to timely obtain care, appeal a denial, or take other action to address their health needs. This problem was systemic and is believed to have initially started due to a lack of staffing. Over time, it appears the failure to send these notices became a part of SynerMed's routine course of business.

Compounding this violation were the steps that SynerMed took to conceal its failure to send these notices in compliance with statutory timeliness requirements. As admitted by SynerMed staff, documents were falsified and altered during health plan and Department audits for the purpose of making it appear that EHS was compliant with Knox-Keene Act requirements.

Therefore, not only did these failures result in violations of Health and Safety Code section 1367.01, subdivision (h)(3), SynerMed's subsequent cover-up, which was ongoing for an indeterminate number of years, fundamentally undermined and flaunted the regulatory structure designed to detect and correct these violations in a manner that cannot be tolerated by the Department or by the health care industry.

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Health plans failed to disclose EHS's implementation of an economic profiling system, in violation of Health and Safety Code section 1367.02, subdivision (a), and therefore operated at variance with their filed policies and procedures.

Under Health and Safety Code section 1367.02, subdivision (d), "economic profiling" is defined as any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

While economic profiling is not expressly prohibited under the Knox-Keene Act, health plans which engage in economic profiling must file their policies and procedures regarding economic profiling with the Department. This includes any economic profiling undertaken by the plan, its medical groups, and its individual practice associations. (Health & Saf. Code, § 1367.02, subd. (a).) Such filings must indicate how the economic profiling activities avoid being in conflict with Health and Safety Code section 1367, subdivision (g), which requires that medical decisions are rendered by qualified medical providers, *unhindered* by fiscal and administrative management. (*Id.*) When such policies and procedures change, health plans are required to file such changes through an amendment or material modification, pursuant to Health and Safety Code section 1352.

EHS's contracted provider network was being restricted based primarily on cost. In a June 2017 e-mail to senior personnel, Mason acknowledged that "specialty costs are climbing fast," and "we can't gain the benefits of a [n]arrowed network" if they did not instruct staff "who to send the business to." In another e-mail, Mason created a "Contracting Playbook" which contained a short list of goals and directives, including, "Re-narrow the specialty network via termination and removing them from the portal." Through this directive, SynerMed senior management directed subordinates to surreptitiously suppress providers deemed to be high-cost providers from the electronic list of contracted providers available for referrals through the EHS electronic portal.

Based on the email correspondence between SynerMed senior management and their subordinates, SynerMed senior management acknowledged that this network narrowing violated Health and Safety Code section 1367.02, subdivision (a). Senior management also realized that would jeopardize their relationships with health plan clients and contracted physicians if this narrowing were disclosed to their plan and provider partners. SynerMed senior management generated a list of untruthful "talking points" in case affected providers questioned their removal, which included blaming the removal of the providers on modifications to the system.

Based on the above, the Plan, through its delegated entity, engaged in economic profiling without filing the applicable policies and procedures with the Department, in violation of Health and Safety Code section 1367.02, subjecting it to penalties pursuant to Health and Safety Code section 1386, subdivision (b)(1).

SynerMed's utilization management program maintained a system to divert certain high cost enrollees to other medical groups, resulting in a failure to ensure that requests for authorization were approved within five business days, in violation of Health and Safety Code section 1367.01, subdivision (h)(1).

Under Health and Safety Code section 1367.01, subdivision (h)(1), decisions to approve, deny, delay, or modify requests for authorizations for health care services must be made within five business days of the request.

SynerMed maintained a system referred to as "COCO," or "Continuity of Care Operations." The Office of Enforcement reviewed e-mails between members of the COCO team and discovered a roster of enrollees who were subject to the COCO program. These e-mails indicated that SynerMed maintained a system in which requests for high-cost services were diverted to the COCO program in an attempt to encourage enrollees to transfer out of EHS to a different medical group.

The COCO team identified and flagged enrollees based on a request for authorization for a high-cost service or based on repeated emergency admissions. SynerMed case managers were instructed to refer newly eligible or newly transferred enrollees who were seeking treatment for any sort of high-cost chronic condition, including cancer, HIV, renal disease, and high-risk pregnancies among others, to the COCO team for handling. "Hot potatoes," the term used to identify those newly eligible high-cost members, were referred by various SynerMed internal divisions to the COCO team, where the team would check enrollee eligibility, effective date with EHS, and prior medical group health history. According to SynerMed records, between January 2015 through May 2017, the COCO team ushered or attempted to usher more than 5,000 high-cost enrollees out of EHS to a different medical group.

This process frequently required SynerMed to make multiple phone calls to the enrollees in order to convince them to switch medical groups. This process – which entailed manually identifying high-cost enrollee authorization requests, referral to the COCO team queue, which itself was backlogged, and contacting the enrollee until they were convinced to switch medical groups – frequently spanned weeks, resulting in delays in approving or denying care to enrollees well beyond five business days.

Accordingly, SynerMed, and by extension, the Plan, maintained a system that failed to ensure that requests for authorization were approved within five business days, in violation of Health and Safety Code section 1367.01, subdivision (h)(1).

The Plan failed to ensure that EHS had sufficient administrative capacity to meet contractual obligations, in violation of California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1..

A health plan may not unilaterally delegate its functions to third party entities without sufficient safeguards to ensure that the contractor can actually perform the duties. Under California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1.,

a plan with capitation or risk-sharing contracts must, "[e]nsure that each contracting provider has the administrative and financial capacity to meet its contractual obligations."

SynerMed admitted that the falsification of enrollee notification letters was due to a backlog caused by its long-standing failure to adequately staff the unit responsible for sending the letters. While the Plans' delegation oversight audits contained numerous metrics that assessed EHS's compliance with basic Knox-Keene Act requirements, these metrics were not sufficient to discover SynerMed's failure to maintain sufficient administrative capacity to meet its contractual obligations.

Based on the above findings, the Plan failed to *ensure* that EHS and SynerMed had sufficient administrative capacity to meet their contractual obligations. Accordingly, the Plan failed to comply with California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1..

The responsibility to comply with the Knox-Keene Act is not waived when a health plan delegates its operations to a third-party entity. (Health & Saf. Code, § 1367, subd. (j).)

Under Health and Safety Code section 1367, subdivision (j), et al., and under general principals of agency, the obligation of health plans to comply with the Knox-Keene Act is not waived when a plan delegates services that it is required to perform to a medical group, independent practice association, or other contracting entity. The Plan maintained contracts with EHS and/or entities contracted with EHS, which, in turn, contracted with SynerMed. Accordingly, the Plan maintained the responsibility to comply with the Knox-Keene Act.

While the Department acknowledges that the Plan has cooperated with and participated in its investigation, this cooperation does not negate the fact that, for years, EHS, through its exclusive sub-delegate, SynerMed, engaged in practices that violated California law and compromised the health and welfare of health plan enrollees.

The Plan has acknowledged its responsibility for the aforementioned violations of the Knox-Keene Act and title 28 of the California Code of Regulations in this enforcement matter. The Department has determined that a Corrective Action Plan (CAP) and an administrative penalty of $2,500 are warranted. The Department has accepted the CAP proposed by the Plan as detailed in the table below, and affirmatively agrees to continue to work cooperatively with the Department in ensuring appropriate oversight over delegated entities. The Department agrees that performance of the CAP to the Department's satisfaction and payment of the penalty will settle all issues, accusations, and claims pertaining to this enforcement matter with respect to the Plan.

This Letter of Agreement does not resolve any issues, accusations, and claims with respect to any other entity.

This Letter of Agreement may not be used as an admission against the Plan in any civil or criminal proceedings; however, it may be used by the Department in future administrative proceedings.

Deliverable Number	Description of Deliverable	Deliverable Due Date or Date Completed	DMHC Office to Receive the Deliverable	Related Statutes or Regulations
1	The Plan will submit a preliminary non-confidential high-level overview of corrective actions that it has already taken and will take, addressing each of the issues listed in Attachment A, attached hereto and incorporated by reference herein, and notating any collaboration with other health plans or entities.	September 6, 2019	Office of Enforcement*	Health and Safety Code section 1367.01, subdivisions (h)(1) and (h)(3); Health and Safety Code section 1367.02, subdivision (a); California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1.
2	The Plan will submit a final non-confidential high-level overview of corrective actions that it has already taken and will take, addressing each of the issues listed in Attachment A, attached hereto and incorporated by reference herein.	October 31, 2019	Office of Enforcement*	Health and Safety Code section 1367.01, subdivisions (h)(1) and (h)(3); Health and Safety Code section 1367.02, subdivision (a); California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1.
3	The Plan will submit a detailed final plan of corrective actions addressing each of the issues listed in Attachment A,	October 31, 2019	Office of Enforcement*	Health and Safety Code section 1367.01, subdivisions (h)(1) and (h)(3); Health and Safety

Deliverable Number	Description of Deliverable	Deliverable Due Date or Date Completed	DMHC Office to Receive the Deliverable	Related Statutes or Regulations
	attached hereto and incorporated by reference herein, including timelines for the implementation of those corrective actions. The Plan may request confidentiality pursuant to California Code of Regulations, title 28, section 1007.			Code section 1367.02, subdivision (a); California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1.
4	The Plan will submit a follow-up report affirming the implementation of corrective actions addressing each of the issues listed in Attachment A, attached hereto and incorporated by reference herein. The Plan may request confidentiality pursuant to California Code of Regulations, title 28, section 1007.	February 21, 2020	Office of Enforcement*	Health and Safety Code section 1367.01, subdivisions (h)(1) and (h)(3); Health and Safety Code section 1367.02, subdivision (a); California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)1.

***A plan must submit its deliverable(s) to the Office of Enforcement via email only at EnforcementCAP@dmhc.ca.gov.**

In summary, the statute(s) and/or regulation(s) prosecuted herein are:

- Health and Safety Code section 1367.01, subdivision (h)(1);
- Health and Safety Code section 1367.01, subdivision (h)(3);
- Health and Safety Code section 1368.02, subdivision (a);
- California Code of Regulations, title 28, section 1300.70, subdivision (b)(2)(H)(1)..

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This agreement contains the entire understanding among the parties and supersedes any prior understandings and/or written or oral agreements among them respecting the within subject matter.

Sincerely,

Dated: 8/8/2019

/Original Signed/
Drew Brereton
Deputy Director | Chief Counsel
Office of Enforcement

Accepted by Cigna HealthCare of California, Inc.

Dated: 8/8/2019

/Original Signed/
William Jameson
Secretary and Counsel
Cigna HealthCare of California, Inc.

CBL: klj

ATTACHMENT A

Items to be addressed by the Plan's Corrective Action Plan

The Corrective Action Plan shall address how the Plan does and/or will:

1. Prevent the falsification, fabrication, or inappropriate alteration of database entries and physical records by delegated entities.

2. Identify and conduct outreach conducted to enrollees, if any, to ensure that enrollees affected by SynerMed's actions received appropriate treatment.

3. Implement live and on-site audits, systems integrity testing, and other tools and methods designed to protect against fraudulent activity by delegated entities.

4. Prevent the use of undisclosed economic profiling by delegated entities.

5. Prohibit or discourage the use of verbal denials or other intangible methods of documenting physician review of authorization requests by delegated entities.

6. Ensure that employees of delegated entities are appropriately trained that falsifying documents and inappropriate alteration of records is unacceptable.

7. Ensure that employees of delegated entities are made aware of and have appropriate outlets to report internal fraud and abuse without fear of retribution.

8. Ensure that when employees of delegated entities do report internal fraud and abuse, such reports are forwarded to or reviewed by the Plan, meaningfully and independently investigated, and appropriately addressed.

9. Ensure that there are tangible consequences for delegated entities that fail to achieve compliance standards or comply with corrective action plans, including institution of policies ensuring that termination actually occurs after a specific amount of time. In addition, these policies must ensure that delegated entities cannot remain contracted indefinitely while on a corrective action plan.