DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

CIGNA BEHAVIORAL HEALTH OF

CALIFORNIA, INC.

A BEHAVIORAL HEALTH PLAN

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Final Report of a Routine Survey
Cigna Behavioral Health of California, Inc.
A Behavioral Health Plan
August 20, 2015

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EXECUTIVE SUMMARY

On August 5, 2013, the California Department of Managed Health Care (the "Department") notified Cigna Behavioral Health (the "Plan") that its Routine Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from December 3, 2013 through December 5, 2013. The Department completed its investigatory phase and closed the survey on May 11, 2015.

The Department assessed the following areas:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Access to Emergency Services and Payment
Language Assistance

The Department identified **six** deficiencies during the current Routine Survey. The 2013 Survey Deficiencies table below notes the status of each deficiency.

2013 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
QUALITY MANAGEMENT		
1	**The Plan does not ensure that the quality of care is consistently reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated, nor does the Plan ensure that its quality management processes are directed by providers.** Section 1386(b)(1); Rule 1300.70(a)(1); Rule 1300.70(b)(2)(D); and Rule 1300.70(b)(2)(E)	**Not Corrected**
2	**The Plan's Governing Body does not provide adequate oversight of the Quality Management Program.** Rules 1300.70(a) and (b)(2)(C)	**Not Corrected**
GRIEVANCES AND APPEALS		
3	**The Plan does not include an accessible online grievance form on its web site.** Sections 1368.015(a) and (b); Rule 1300.68(b)(7)	**Not Corrected**

4	**The Plan's grievance process does not ensure that grievances are:** • **acknowledged timely,** • **completely resolved,** • **responded to with a clear explanation of the Plan's decision, and** • **reviewed by appropriate personnel.** Section 1368(a)(4)(A); Rule 1300.68(a)(4); Rules 1300.68(d)(1) through (3); Rule 1300.70(a)(1)	**Not Corrected**
UTILIZATION MANAGEMENT		
5	**The Plan does not have a process in place to disclose its utilization management process or criteria to the public, or to ensure the disclosure is accompanied by the required notice.** Sections 1363.5(b)(5) and (c)	**Not Corrected**
6	**The Plan does not have a process in place to notify the provider and the enrollee in writing, when the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and the anticipated date on which a decision may be rendered.** Section 1367.01(h)(5)	**Not Corrected**

SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] At least once every three years, the Department conducts a Routine Survey of a Plan that covers seven major areas of the Plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the Plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Continuity of Care – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.

Access to Emergency Services and Payment – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary behavioral health care.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The Department issued the Preliminary Report to the Plan on May 19, 2015. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Survey of the Plan, which commenced on August 5, 2013 and closed on May 11, 2015.

[1] 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.

PLAN BACKGROUND

CIGNA Corporation is the parent company of CIGNA Behavioral Health of California, Inc. (the "Plan") which is a for-profit health plan originally founded in 1974. The Plan was incorporated in the State of California in December 1989 and began operations during August 1, 1990, as a licensed Specialized Health Care Plan under the Knox-Keene Health Care Service Plan Act of 1975. From 1989 to 1999, the Plan was known as MCC Managed Behavioral Care of California, Inc. The Plan is a Mixed Model Specialty Plan.

The Plan provides mental health and chemical dependency counseling and treatment to subscribers of health maintenance organizations ("HMO") for predetermined, prepaid monthly fees. The Plan provides inpatient and outpatient services as well as employee assistance programs ("EAP"). The Plan pays discounted fees for services provided to its subscribers by its participating behavioral care providers, based generally upon contracted services by client companies.

The Plan's service area encompasses all California counties. As of May 1, 2013, the Plan reported 183,288 commercial enrollees. The Plan currently has a network of psychiatrists, psychologists, and Masters level service providers numbering 1,784 providers, and the network includes facilities and programs.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On May 19, 2015, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

(a) Develop and implement a corrective action plan for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

QUALITY MANAGEMENT

Deficiency #1: The Plan does not ensure that the quality of care is consistently reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated, nor does the Plan ensure that its quality management processes are directed by providers.

Statutory/Regulatory Reference(s): Section 1386(b)(1); Rule 1300.70(a)(1); Rule 1300.70(b)(2)(D); and Rule 1300.70(b)(2)(E)

Assessment: Rule 1300.70(a)(1) requires that the Plan's "QA program … must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow up is planned where indicated."

a. The Plan failed to identify potential quality issues in grievances consistently.

Pursuant to Rule 1300.70(a)(1) the Plan's "QA program … must document that the quality of care provided is being reviewed, that problems are being identified …" The Department conducted a review of the Plan's grievance files, which consisted of 53 total files, and found 11 files that should have been identified, referred, and investigated as potential quality issues (PQI). Of these 11 files, 10 (91%) had not been elevated for clinical review.

Relevant Case Summaries:

Case #1 - The enrollee complained that the provider "almost killed me" by not following up on a prescription resulting in the enrollee's hospitalization. The complaint was not referred as a potential quality issue.

Case #2 - The enrollee complained the provider tried to write a prescription after only a 10-minute session and had difficulty communicating with the enrollee in English. The complaint was not referred as a potential quality issue.

Case #3 - The enrollee complained that the provider had an inappropriate discussion with another member while the enrollee was in the provider's office. The complaint was not referred as a potential quality issue or investigated.

b. The Plan failed to ensure a Clinical Manager reviews the potential quality issues to determine appropriate staff conducts investigations.

The Department's review of the 17 PQI files identified by the Plan revealed that the Plan is not following its processes. The Plan's policy entitled, *HM-NET-001 Adverse Events*, describes the procedures for identifying and investigating potential quality of care issues. Under this policy, to determine the appropriate staff person to conduct an investigation, the Plan assigns each case to a Clinical Manager. Contrary to Plan policy, file review revealed that, of the 17 files, a clinician (i.e., MFT or LCSW staff) reviewed five, a Risk Manager reviewed three, and the Plan did not document any evidence of clinical review in the remaining nine cases. In none of the 17 cases was there a documented review by a Clinical Manager, or any appropriately licensed staff, to determine the need for an investigation.

c. The Plan failed to ensure that it investigates all potential quality issues. Thus, the Plan is unable to ensure that effective action to improve care is taken where indicated.

To demonstrate that the Plan is reviewing the "quality of care provided" and "identifying problems" pursuant to Rule 1300.70(a)(1), the Department assessed whether the Plan conducts an investigation into the potential quality issue. The Department's review of 17 potential quality issue files revealed that in 14 cases there was no evidence that any investigation occurred. Five of the 14 cases indicated that an investigation was requested, but there was no documentation or evidence of any investigation occurring. Significantly, none of the 17 cases were referred to a Medical Director, or designee, for review.

The Department also found that the Plan does not ensure compliance with its policy number *HM-NET-001*, which states: "when medical records are available, all cases will be investigated within 30 days of being identified." As evidenced during file review, the three cases that did undergo investigation reflected a much longer investigation period, ranging from five to ten months. In the remaining 14 cases, the Plan did not request medical records or conduct any investigation. Thus, it was unable to demonstrate any tracking of timeliness to ensure compliance to Plan policy.

Relevant Case Summaries:

Case #4 - The wife of an enrollee complained that the enrollee, who was in a facility, was not being treated respectfully and *was not receiving treatment.* The Plan referred the case to Risk Management and five months later a licensed clinician documented that review showed no risk concerns. There was no evidence there was ever a discussion with the facility, or a review of medical records or any other review or investigation. Therefore, the Plan did not determine whether there was a quality of care issue, did not initiate a clinical investigation, and did not implement corrective action.

Case #5 - An enrollee complained that his doctor spent only 10 minutes talking to him, did not take a medical history, changed his diagnosis and medication, and did not take into consideration his co-morbid disorders. At the time of the complaint, the Plan did not ensure that the enrollee was in appropriate treatment. There is no documentation of any investigation at the time of the complaint. However, 10 months later a lead clinician reviewed the case notes and documented a decision not to take action. The file indicates the Plan did not contact the provider, did not request medical records, and did not take other investigative steps. As a result, the Plan did not determine whether there was a quality of care issue and did not initiate corrective action.

Case #6 - The father of a minor patient complained that the group treating his son had an unlicensed supervisor, the staff did not understand his son's needs, there were many skipped sessions, and that the staff were unprofessional. The Plan documents simply state that the case was referred to Risk Management and Provider Relations. However, there was no documentation demonstrating the Plan investigated the case. Therefore, the Plan did not determine whether there was a quality of care issue and did not take corrective action.

Case #7 - The Plan identified an adverse event in which "a patient hurt a nurse with the intent to break her neck." The Plan referred the case to Risk Management for review. A lead clinician reviewed the notes from the Plan's computer system, which included notes from the Customer Service Representative who took the call and any notes made by the Utilization Management Department, and determined that the patient was psychotic and no further investigation was necessary. The Plan did not request any medical records and did not attempt to contact the facility for additional inquiry. The lead clinician did no investigation into the facility's treatment plan, approach to care, conceptualization of the case, explanation for the attack, or request the facility's analysis of the incident. Therefore, the Plan did not determine whether there was a quality of care issue, did not initiate a clinical investigation, and did not implement corrective action.

The Department also found that the Plan's process contributed to the Plan's failure to investigate. The Plan's practice is to request permission from the enrollee to use the enrollee's name to conduct an investigation of the issue. File review revealed that in one file, this practice presented an impediment to completing a thorough review and identifying potential quality issues. In this particular case, the Plan's lead clinician determined that the enrollee had not given permission for her name to be used, or that the Plan could conduct an investigation, and therefore no investigation was performed. The Department notes this is a repeat deficiency from the previous 2011 routine survey, where the Department cited the Plan for requiring the enrollee to give permission in order to conduct an investigation.

Relevant Case Summary:

Case #8 - The enrollee complained she had been in the hospital for two days without getting a bed and was restrained, unable to leave, and abused. The complaint originally came in through the CA HMO and it is not clear when it was forwarded to the Plan. The Plan's lead clinician determined that since the enrollee had not been asked if she gave permission to have her name used, the Plan could not ask the facility for detail about the enrollee. The Plan determined that nothing further could be done to investigate the issue.

Due to the Plan's failure to conduct an adequate investigation, it is unable to meet its obligation under Rule 1300.70(a)(1) to take "effective action … to improve care where deficiencies are identified." The Plan is unable to determine if any potential quality issue constitutes a confirmed quality issue in any of the 17 potential quality issue files, as it fails to ensure it obtains medical records necessary to conduct this review. Thus, the Plan did not initiate corrective action plans in any of these cases, including any referrals to the Credentialing Committee for further review.

d. The Plan failed to demonstrate adequate oversight of the quality management processes for identification and review of potential quality issues.

The Plan was unable to provide evidence of oversight by the Medical Director or the Chief Medical Director of the process by which the Plan identifies and reviews potential quality issues. No evidence was found in the file review or committee reports (to any committee) to indicate any review by the Medical Director or Chief Medical Director. At the time of the onsite interview, the Medical Director and Chief Medical Director acknowledged that they did not oversee the potential quality issues process. Moreover, there was no evidence of oversight by any clinician to assure that appropriate personnel investigated potential quality issues and initiated necessary corrective actions.

Conclusion: Section 1386(b)(1) prohibits the Plan from "operating at variance with the basic organizational documents … filed pursuant to Section 1351 or 1352, … or in any manner contrary to the Plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing a variation have been submitted to, and approved by, the director."

File review revealed no evidence that the Clinical Manager reviewed the files and determined the appropriate staff to conduct investigation of the Plan's potential quality issues, as required by the Plan's Policy, entitled *HM-NET-001 Adverse Events*. Specifically, the Plan's policy states:

> [The Plan] shall establish and follow a consistent process for identifying, collecting, investigating and monitoring adverse events and incorporating adverse events into the ongoing monitoring of credentialed practitioners/providers …
>
> The Clinical Program Manager, or designee, will retrieve and evaluate each individual adverse event and assign the appropriate staff person to investigate the adverse event …
>
> The assigned staff person will investigate each incident … Investigation may include, but is not limited to … review of relevant documents (e.g., medical records, participant complaints) …
>
> The following actions may result from [the Credentialing Manager's] review [of investigatory findings:] Require that additional monitoring be done or that specific corrective action be completed in order for the practitioner/provider to remain in the network.

However, in many of the Plan's potential quality issues, the Plan did not always request medical records, did not always conduct investigations, nor take follow-up action to resolve and address

all of its potential quality issues. Therefore, the Department has determined that the Plan's acts are in variance of organizational documents filed with the Department that constitutes grounds for disciplinary action pursuant to Section 1386(b)(1).

Rule 1300.70(a)(1) requires that the Plan's "QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow up is planned where indicated."

Rule 1300.70(b)(2)(D) requires that the Plan's "implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate."

Rule 1300.70(b)(2)(E) states, "[E]ach plan's Q[uality] A[ssurance] program shall meet all of the following requirements: Physician, …. psychologist or other appropriate licensed professional participation in Q[uality] A[ssurance] activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved."

The Plan's lack of overall oversight and insufficient monitoring of its Quality Assurance Program and activities is evidenced in both the potential quality issue files and related activities, as well as in the Grievance Program activities. This results in the inability to adequately identify and resolve issues related to potential quality issues. The Department found that the Plan has not met the requirements relative to ensuring that problems are being identified, and that effective corrective action is taken to improve care where deficiencies are identified. Further, the Department finds that the Plan has not implemented sufficient oversight and the Medical Director's activities are inadequate to ensure ongoing monitoring of the full scope of clinical services rendered. Therefore, the Department finds the Plan is in violation of the requirements of Rule 1300.70(a)(1); Rule 1300.70(b)(2)(D) and Rule 1300.70(b)(2)(E).

The Department also notes that file review revealed that the Plan, in some instances, is still requesting permission to investigate potential quality issues. Thus, this deficiency contains repeat issues from a prior survey. The Department intends to refer this matter to Office of Enforcement for further investigation and possible disciplinary action.

TABLE 1
Potential Quality Issue Identification and Confirmation

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Potential Quality Issue	17	Reviewed by appropriate personnel	5	12
Potential Quality Issue	17	Plan conducted an investigation	3	14

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan indicated it was taking the following steps to correct the deficiency:

- The Plan is updating its Standard Operating Procedures (SOP) and Job Aides, and providing refresher training for the Behavioral Health Complaint and California Clinical Review teams, by August 1, 2015. The training will review key concepts of not obtaining enrollee permission, timely generation of acknowledgement letters, identification and handling of quality of care issues to forward to the California Clinical Team for review, investigation and resolution.

- As of July 1, 2015, the Plan implemented a new database that supports complaint workflow, adding 48 additional touch points to ensure quality of care issues are properly reviewed, investigated, and resolved.

- Also on July 1, 2015, the Plan completed enhancements to the existing Complaint and Appeals (CART) system in order to capture and handle PQI grievances.

- The Plan has scheduled to revise its CA Inquiry and Complaint Contract Resolution Policy by August 1, 2015 to reflect all enhancements.

- The Plan's Director is responsible for monitoring and overseeing the handling and timeframes of the Quality of Care Report, and to report the status of the Plan's corrective actions to the Behavioral Health Committee on July 30, 2015, and the Board of Directors (BOD) Committee on September 15, 2015.

Final Report Deficiency Status: Not Corrected

The Department finds that while the Plan has initiated actions to correct this deficiency, not enough time has elapsed for the Plan to prove effectiveness and implementation of the Plan's revised process, and policy and procedure. Staff refresher training is not yet completed. In addition, the Behavioral Health Committee has not received the report of Plan updates nor has the Board of Directors approved the updates to the Plan's processes and policy. At the follow-up survey, the Department will assess the effectiveness of the Plan's corrective actions in remedying each issue set forth in this deficiency. This review will include, but will not be limited to, conducting a file review to ensure the Plan is identifying and reviewing grievances with potential quality issues.

Based upon the corrective actions undertaken, the Department has determined that this deficiency is not fully corrected.

Deficiency #2: The Plan's Governing Body does not provide adequate oversight of the Quality Management Program.

Statutory/Regulatory Reference(s): Rules 1300.70(a) and (b)(2)(C)

Assessment: The Plan's *2013 Behavioral Health Quality and Utilization Management Program Description* states that "the [Plan's] Board of Directors has the ultimate authority and responsibility for the Quality Management Program." However, the documents presented to the Board of Directors for review and approval do not include the *Quality Management Plan*, therefore, the members of the Board do not have the opportunity to provide any input.

Additionally, the Plan does not include sufficient detail in its grievances and potential quality issues reports to ensure care is being delivered in accordance with recognized standards. The reports contain the volume of issues by category and information on details of processing, but the report does not include any summaries of the cases, the issues they raise, or information about their resolution. Therefore, the Board cannot provide any oversight into how well the grievances and potential quality issues are being resolved and whether the issues they raise have been addressed.

When asked about the reports available to the Quality Management Committee and the Board of Directors, the Plan acknowledged that they were not sufficiently detailed. The Plan agreed that they needed to improve the reports. The Plan also acknowledged that the Board of Directors did not review the Quality Management Plan.

Rule 1300.70(a)(3) states that the "Q[uality] A[ssurance] program … monitor whether the provision and utilization of services meets professionally recognized standards of practice." Rule 1300.70 (b)(2)(C) requires that the Plan's Board of Directors and Quality Assurance Committee meet quarterly "to oversee its respective Q[uality] A[ssurance] program responsibilities." Rule 1300.70 (b)(2)(C) further requires that reports presented in these meetings provide "[sufficient detail] to include *findings and actions* taken as a result of the Q[uality] A[ssurance] Program *and to identify those internal or contracting provider components which the Q[uality] A[ssurance] program has identified as presenting significant or chronic quality of care issues*." [Emphasis added.] The Plan's lack of a process to ensure review of reports in sufficient detail hinders the Plan's ability to provide adequate oversight of its Quality Program or to ensure care is being delivered in accordance with recognized standards. Therefore, the Department finds the Plan to be in violation of the requirements of Rules 1300.70(a) and (b)(2)(C).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan reported that it is taking multiple steps to improve its Quality Management Program. Plan management presented the 2015 Work Plan and 2015 Behavioral Health Quality Management Program Description documents to the Board of Directors for approval in a meeting on July 6, 2015. Management presented the California State Specific Program Annual Evaluation at the Board of Directors' meeting of July 6, 2015. The Plan will present a newly implemented quarterly CA Quality Management and Utilization Management Key Indicator Report at the Board of Directors' meeting on September 15, 2015. The Plan will share results of monitoring of quality of care complaints by the Behavioral Health Quality Review team and root cause analysis conducted by the Complaint and Clinical Departments at the Board of Directors' meeting on December 8, 2015, and quarterly thereafter.

Final Report Deficiency Status: Not Corrected

The Department finds that although the Plan has taken steps to correct this deficiency, not enough time has elapsed for the Plan to show the effectiveness of those steps or to fully implement the updated processes. In addition, the Plan is to report to the Board of Directors these changes to the Plan's processes, in upcoming meetings of September 15 and December 8, 2015.

Based upon the corrective actions undertaken, the Department has determined that the Plan has not fully corrected this deficiency.

GRIEVANCES AND APPEALS

Deficiency #3: The Plan does not include an accessible online grievance form on its website.

Statutory/Regulatory Reference(s): Sections 1368.015(a) and (b); Rule 1300.68(b)(7)

Assessment: The Plan provided hyperlinks to online grievance forms and grievance procedures prior to the onsite portion of the survey. However, when the Department attempted to access the grievance forms and procedures from the Cigna home page, these forms were not readily available. While onsite, the Plan demonstrated the process for accessing and completing the online grievance forms, which was as follows:

1) Begin on the "Cigna Behavioral Health" home page (www.cignabehavioral.com)
2) Click on "Visit Our Education & Resource Center,"
3) Select "Forms" from a list
4) Click "California Grievance Form

This form can be printed or filled out and submitted online, and contains some instructions regarding the filing of a grievance. However, the home page of the Plan's website does not include a readily accessible or recognizable link to the grievance form or process, and does not identify any way to learn about the grievance process. The California behavioral health grievance form is accessible, though not easily, from the www.cignabehavioral.com home page only if one knows to follow the steps outlined above.

Section 1368.015(b) requires every Plan with a "web site [to] have an *easily accessible online* grievance submission procedure that shall be accessible through a hyperlink on the Internet web site's home page or member services portal, clearly identified as 'GRIEVANCE FORM'." [Emphasis added.] Rule 1300.68(b)(7) requires that "grievance forms and a description of the grievance procedure … be readily available … on the plan's website."

The Department finds that because the Plan does not have a readily accessible link to a grievance form and its grievance process on its home page it is in violation of Section 1368.015(b) and Rule 1300.68(b)(7).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that it has taken to correct the deficiency.

Plan's Compliance Effort: The Plan indicated that they modified the website to provide accessible online grievance forms as evidenced by the screen shots of the online process that were sent by the Plan to the Department as part of its corrective action.

Final Report Deficiency Status: Not Corrected

The Department finds that this deficiency is not corrected. Regulation 1368.015(b) requires "easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the Internet web site's home page or member services portal clearly identified as "GRIEVANCE FORM." On July 21, 2015, the Department accessed the Plan's web page confirming the corrective action returned by the Plan for this deficiency remains a four-step process; therefore, the online grievance form is not easily accessible, nor does the Plan include "GRIEVANCE FORM" on it home page.

Based upon the corrective actions undertaken, the Department has determined that the Plan has not fully corrected this deficiency.

Deficiency #4: The Plan's grievance process does not ensure that grievances are:

- **acknowledged timely,**
- **completely resolved,**
- **responded to with a clear explanation of the Plan's decision, and**
- **reviewed by appropriate personnel.**

Statutory/Regulatory Reference(s): Section 1368(a)(4)(A); Rule 1300.68(a)(4); Rules 1300.68(d)(1) through (3); Rule 1300.70(a)(1)

Assessment: The Department reviewed 53 randomly selected grievance files provided by Plan and identified as quality of service issues. The Plan separates grievances into three categories: Quality of Care, Quality of Service, and Administrative. The Member Services Department forwards quality of care grievances to the Customer Service Analyst as "Potential Quality Issues." The Central Appeals Unit reviews and resolves "Quality of Service" grievances if the issue is not considered a "Potential Quality Issue." The Central Appeals Unit forwards physician service related "Quality of Service" issues that it cannot resolve to Provider Relations or the clinical staff responsible for quality complaint reviews.

During file review, the Department found that:

1) Forty-five percent (45%) of the grievances did not receive acknowledgement letters within the required timeframe;
2) Fifty-five percent (55%) of the grievance resolution letters did not always include a final resolution and were not clear and concise; and
3) The Plan did not always refer grievances to the appropriate department for review.

a. The Plan fails to acknowledge grievances within five calendar days as required by Section 1368(a)(4)(A) and Rule 1300.68(d)(1).

File review of 53 Quality of Service grievance files revealed that 24 (45%) did not comply with the required five calendar days to send an acknowledgement letter. The Plan sent acknowledgement letter on six grievance files, but not within the required five calendar days, and did not send acknowledgement letters on the remaining 18 (75%) grievances. The Plan recognized it was not sending acknowledgement letters timely in the quarterly "Service Metrics Report," for the 4th Quarter 2012, presented to the Quality Committee.

Relevant Case Summaries:

Case #9 - Dated March 5, 2012, this was a contact regarding an enrollee being balance billed by a provider. The Plan did not send an acknowledgement letter.

Case #10 - October 16, 2012, this was a complaint about improper billing and the provider discussing confidential information with a different patient over the phone while the enrollee was in session. This was referred to the Central Appeals Unit and "picked up for review" 21 days after the call. The Plan did not send an acknowledgement letter.

Case #11 - August 5, 2013, this file concerned an enrollee call complaining that the psychiatrist "almost killed [her]" by not following up on the medication prescribed which resulted in her hospitalization. The Plan sent an acknowledgement letter, but not within the required five days.

Case #12 - Dated July 3, 2012, this file concerned a bill from a hospital that the Plan denied, contending that the hospital admission was due to a medical issue and not a behavioral health issue. The Plan did not send an acknowledgement letter.

Case #13 - Dated December 30, 2011, this was an enrollee notification that an Explanation of Benefits showed the Plan had paid for three visits but that the enrollee only had one visit. The Plan did not send an acknowledgement letter.

Case #14 - Dated May 14, 2012, this file accused the Cigna Health Plan of holding a claim for 30 days and then denying it for lack of timely filing. The Plan did not send an acknowledgement letter.

b. The Plan fails to consistently ensure each grievance receives "adequate consideration and rectification" as required by Section 1368(a)(1), nor does the Plan ensure responses "contain a clear… explanation of the Plan's decision" as required by Rule 1300(d)(3).

The Department found that in 29 of the 53 Quality of Service grievance files (55%) the resolution letter did not include a complete and appropriate response to the complainant. In several letters, the response was limited to "Thank you for bringing this to our attention, we will track and trend future issues of this kind." Further, the Plan issued resolution letters prior to identifying an appropriate resolution. In using this "canned" response or by sending a resolution letter prematurely, the Plan fails to "ensure adequate consideration of the enrollee grievance and rectification where appropriate" under Section 1368(a)(1). Furthermore, the Plan's use of a

canned response does not provide a "clear…explanation" of the Plan's decision as required under Rule 1300.68(d)(3).

In addition, the Department also reviewed the Plan's potential quality issue files (17 in total), and discovered that two of the files were actually appeals in which the enrollees had complained in writing about the Plan's denial decision. However, the Plan treated the issues as complaints. Consequently, the appeals did not undergo the appeals process, and the enrollees did not receive the appropriate information about the appeals process.

Relevant Case Summaries:

Case #15 - Dated May 14, 2012, this file indicates that the Plan may have held a claim for 30 days and then denied it for lack of timely filing. The Plan did not send an acknowledgement letter, and on May 31, 2012, the Plan issued a resolution letter without resolving the grievance. The Plan's resolution letter stated, "Thanks for letting us know," and went on to explain that the Plan pays all claims within 30 days. The letter continued stating, "We would need more information about the claim to follow up further."

Case #16 - Dated February 15, 2012, concerned a call from an enrollee who contacted two provider offices that were closed or were not at the stated address. The enrollee was given information on different providers during the initial call. However, the resolution letter and follow-up information did not provide a resolution to the issue, just a statement that the providers were not available.

Case #17 - On March 9, 2012, an enrollee received two lists of providers and both were "inaccurate." The resolution letter was a typical form letter that thanked the enrollee and indicated the Plan would track and trend this issue. It did not state whether this was resolved and whether correct provider information was given to the enrollee or if she was able to get the appointment.

c. The Plan does not refer complaints to the appropriate department for resolution. Grievances regarding claims do not always go to the Claims Department, and issues regarding inappropriate billings do not always go to the Provider Relations Department.

Five (5) of the 53 quality of service grievance files reviewed (9%) revealed some type of provider billing issue, such as balance billing or inappropriate billing. There was no indication that the Plan forwarded these cases to Provider Relations or that the issues were reviewed by the Quality Review Department. The file review of these issues revealed that the Central Appeals Unit staff would document that they left a message for the provider (with no documentation of a response from the provider), rather than resolve the issue, as with Case #9. The Department cited the Plan for failing to issue clear and concise resolution letters at the last routine survey. Therefore, this issue may be referred to enforcement for further investigation and possible disciplinary action.

One complaint involved an inappropriate prescription written by a psychiatrist that was sent to Provider Relations. The Provider Relations department sent a letter to a different provider, not the provider who was the subject of the complaint. The Plan's response to the enrollee did not

indicate that the Plan took any action, and the Plan did not elevate the complaint to the clinical reviewer or to the Medical Director as a potential quality issue. If the complaint was about an inappropriately prescribed drug, whoever was reviewing and resolving the grievance should have referred it to the Quality Department.

Relevant Case Summaries:

Case #18 - Dated July 3, 2012, this file concerned a bill from a hospital that the Plan denied, contending that the hospital admission was due to a medical issue and not a behavioral health issue. The Plan did not send an acknowledgement letter. The Plan's Complaint Unit handled the complaint, and did not forward it to the Claims Department for review. The Plan left a message with the facility's billing department, but there was no response recorded. The Plan closed the case and issued a resolution letter without waiting to find out the nature of the issue and bring it to resolution. The file contained no indication as to the final resolution, or whether the Plan upheld or overturned the denial.

Case #19 - Dated August 27, 2012, was a complaint about inappropriate billing by a provider. Member Services left a message with the provider office that they should not bill patient. Although the Plan left the message with the provider office, they did not speak to the provider or the office to clarify why there were billings and what needed to be done. This was an incomplete resolution and should have been reviewed by Provider Relations.

Case #20 - Dated July 3, 2012, concerned a bill from facility for an amount that was denied. The letter states a message was left for the hospital to contact Member Services. The complaint was responded to by the Complaint Unit and not sent to claims for review. A message was left with the facility Billing Department, but its response was not recorded. The case was then closed.

Case #21 - Dated December 15, 2011, the enrollee's mother complained that enrollee (son) never completed phase 1 of rehabilitation and that Cigna set him up for failure. The Plan responded, "We appreciate your feedback in this matter and apologize for any inconvenience. We will continue to track and monitor all complaints regarding this issue."

The Project Analyst did not pursue this case where an enrollee's mother called to essentially appeal a discharge. The Analyst merely wrote a resolution letter and closed the case. This appeal was not referred to Quality Management as a potential quality issue, nor did it appear to be evaluated for treatment as an urgent appeal.

Upon inquiry by the Department, the Appeals & Grievances (G&A) Manager said that the Plan does not have an established quality person to work on these issues and that he is busy with the National G&A for Behavioral Health and does not have time to review all grievances. At the end of the onsite survey, it was determined that a clinician followed the case but the Central Appeals Unit (CAU) did not recognize this in the closing letter or in case notes.

d. The Plan fails to forward quality issues for to the Clinical Team Leaders as required by the Plan's policy and Rule 1300.70(a)(1).

A review of 53 Quality of Service grievance files found that 11 involved some type of clinical or accessibility issue. The Plan's policy number *HM OPS CA 012*, titled *Inquiry and Complaint Contract Resolution Policy – California Addendum*, states:

> Quality of Service Complaints, which are not of an administrative nature and/or cannot be immediately resolved and require further investigation and action are forwarded to the Inpatient/Outpatient Clinical Team Leaders [(Quality Management designees),] for review to identify any potential Quality of Care implications.

According to this policy and Rules 1300.70(a)(1) and (3), the Plan should have forwarded these 11 grievances for clinical review and investigations to ascertain whether a potential quality issue existed and whether corrective action is necessary to improve care. However, ten (91%) of these files were never referred to a clinician for review and action.

Notably, the Central Appeals Unit staff reviewing grievances sends grievances regarding providers to the Provider Relations Department. However, the Plan does not have a procedure to ensure that the Medical Director or the Clinical Review department review the cases.

Relevant Case Summaries:

Case #22 - Dated October 16, 2012, this was a complaint about improper billing and the provider discussing confidential information with a different patient over the phone while the enrollee was in session. The Plan directed the complaint to the Central Appeals Unit, which "picked [the claim] up for review" 21 days after the call. The Plan did not send an acknowledgement letter. The Central Appeals Unit staff person contacted the provider, who agreed to reimburse the enrollee. However, the Plan did not elevate this complaint to the Quality Management Department for review, and sent the resolution letter 41 days after recording the complaint.

Case #23 - Dated August 5, 2013, this file concerned an enrollee call complaining that the psychiatrist "almost killed [her]" by not following up on the medication prescribed which resulted in her hospitalization. The Plan sent an acknowledgement letter, but not within the required five days. The Plan directed the case to the Provider Relations Department. Follow- up notes indicate that the Provider Relations Department sent a letter about the incident to the wrong provider, and did not follow-up on the quality issue regarding the Psychiatrist.

Case #24 - Dated December 30, 2011, this was a notification that an Explanation of Benefits showed that the Plan paid for three visits, but that the enrollee only had one visit. The Plan did not send an acknowledgement letter. The resolution letter stated that the Plan had contacted the provider. System notes stated that the Plan left a message with the provider asking if she had billed incorrectly. The Plan did not elevate this case to the Quality Management Department as a potential fraud issue and the issue was never fully resolved.

Section 1368(a)(1) requires Plans to maintain a grievance system "that shall ensure adequate consideration of enrollee grievances and rectification when appropriate."

Section 1368(a)(4)(A) and Rule 1300.68(d)(1) require Plans to respond to grievances with a written acknowledgment within five (5) calendar days of receipt.

Rule 1300.68(a)(4) defines "resolution" as meaning that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance.

Rule 1300.68(d)(2) requires that grievances receive a prompt review by the management or supervisory staff responsible for the services or operations that are the subject of the grievance.

Rule 1300.68(d)(3) requires the written response within thirty (30) calendar days of receipt and that the response contain a clear and concise explanation of the Plan's decision.

Rule 1300.70(a) (1) requires the Plan review, identify quality of care problems, and take effective action where problems exist.

The Department found that the Plan does not consistently acknowledge receipt of grievances within the required period, even after identifying this as a problem in its last Survey. The Department also determined that grievance responses were often incomplete and non-responsive to all of the enrollee's issues. Additionally, the Department found that the Plan does not always refer grievances to appropriate personnel for proper consideration and resolution, nor does the Plan ensure the grievances undergo appropriate clinical review.

Therefore, the Department finds that the Plan does not comply with the requirements of Section 1368(a)(4)(A), Rule 1300.68(a)(4), Rules 1300.68(d)(1) through (3) and Rule 1300.70(a)(1).

TABLE 2
Grievance Files

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Quality of Service Grievances	53	Acknowledgement letter sent within 5 calendar days	29	24
Quality of Service Grievances	53	Grievance reviewed by appropriate personnel	36	17
Quality of Service Grievances	53	Resolution letter addresses all issues in the grievance	24	29
Potential Quality Issues	17	Classified appropriately as potential quality issues	15	2

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that it has taken to correct the deficiency.

Plan's Compliance Effort:

- The Plan is updating its Standard Operating Procedures (SOP) and Job Aides, and providing refresher training to the Behavioral Health Complaint and California Clinical Review teams by August 1, 2015. The training will include investigation and resolution, amongst other topics.
- The enrollee Complaint and Appeals letter template was updated on February 7, 2014.
- To reflect enhancements to the system for behavioral health complaints, the Plan was scheduled to revise its CA Inquiry and Complaint Contract Resolution policy by August 1, 2015.
- On a quarterly basis, the Plan's Grievance Officer will monitor and oversee the timeframes and handling of the quarterly grievance reports.
- The Plan will conduct a Board of Directors' meeting on September 15, 2015, and present for review and approval the updated Standard Operating Procedures (SOP), Job Aides, and the revised CA Inquiry and Complaint Contact Resolution policy.

Final Report Deficiency Status: Not Corrected

The Department finds that while the Plan has initiated actions to correct this deficiency, not enough time has passed for the Plan to prove effectiveness and implementation of the Plan's revised process and policy and procedure. Staff refresher training was not yet completed at the time the Plan provided its response to the Preliminary Report. In addition, the Board of Directors' meeting is set for September 15, 2015, at which time the Board is to approve the updates to the Plan's processes, and policy. At the Follow-Up Survey, the Department will assess the effectiveness of the Plan's corrective actions by conducting a file review of the Plan's grievance files to ensure they are appropriately processed.

Based upon the corrective actions undertaken, the Department has determined that the Plan has not fully corrected this deficiency.

UTILIZATION MANAGEMENT

Deficiency #5: The Plan does not have a process in place to disclose its utilization management process or criteria to the public, or to ensure the required notice accompanies the disclosure

Statutory/Regulatory Reference(s): Sections 1363.5(b)(5) and (c)

Assessment: Onsite Interviews with the Medical Director, Compliance Manager, and Quality Director revealed that the Plan does not have a process in place for disclosing utilization management processes or criteria to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. During the onsite survey, the Compliance Manager was not able to locate any documents to demonstrate that the Plan had a process or the required statement in place. The Compliance Manager indicated at survey closing that the Plan would be adding the disclosure and related required statement to the Plan's Evidence of Coverage (EOC).

Section 1363.5(a) requires the Plan "disclose [the] process [for utilization management and review used to authorize, modify or deny health care services] to enrollees or persons designated by an enrollee, or to any other person or organization, upon request."

Pursuant to Section 1363.5(b)(5), "The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall be available to the public upon request."

Further, Section 1363.5(c) provides

> The following notice shall accompany the disclosure required by paragraph (5) of subdivision (b): "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The Department finds that the Plan does not have a process in place to disclose to the public the criteria used to make determinations, or ensure the required notice is included, therefore, the Plan is in violation of Sections 1363.5(a) and (b)(5).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that it has taken to correct the deficiency.

Plan's Compliance Effort: The Plan updated its public website, www.cignabehavioralhealth.com to include a link to its utilization management procedures and criteria used to make medical necessity decisions. The Plan also updated its public website to disclose the standards and guidelines as required by Section 1363.5(b)(5); however, the standards and guidelines do not include the mandated language set forth under Section 1363.5(c).

The Plan submitted an updated policy, HM-CLN-CA-035 Timeliness of Utilization Management Decisions & Notifications-California Addendum that will be presented to the Board of Directors for approval on September 15, 2015. However, the updates do not appear to address the deficiency as it did not address the process for responding to requests for disclosure of the Plan's utilization management process or criteria and there was no indication that this document would be disclosed to a requesting party.

Final Report Deficiency Status: Not Corrected

The Plan did not include the mandated language set forth under Section 1363.5(c) in the update to its public website, www.cignabehavioralhealth.com. The Compliance Manager indicated at survey closing that the Plan would be adding the disclosure and related required statement to the Plan's Evidence of Coverage; however, the corrective action plan documents submitted to the Department on July 2, 2015 did not include the Evidence of Coverage reflecting these changes. Further, the Plan has not set forth a written process for handling requests for disclosure of the Plan's utilization management process or criteria.

Based upon the corrective actions undertaken, the Department has determined that the Plan has not fully corrected this deficiency.

Deficiency #6: The Plan does not have a process in place to notify the provider and the enrollee in writing, when the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and the anticipated date on which a decision may be rendered.

Statutory/Regulatory Reference(s): Section 1367.01(h)(5)

Assessment: Review of the Plan's policies and procedures indicate that the Plan has written documents in place that address the written notice to providers and enrollees when a delay in determination is necessary, and is evidenced in the following excerpts from two of the Plan policies:

Cigna Behavioral Health Peer-to-Peer Policy, #HM-CLN-033

> E. If the peer reviewer determines there is insufficient information on which to make a determination, Cigna Behavioral Health will ensure there are at least three attempts to obtain needed information over no more than two business days. However, determinations must occur within required timelines as defined in the Policy on Timeliness of Utilization Management Decisions and Notification. When additional information is not available, the determination must be made based on available information

Timeliness of Utilization Management Decisions and Notifications Policy, #HM-CLN-035

> Definitions: Tolling: Where allowed by state law Cigna Behavioral Health will toll required timelines when additional information is required to make a decision. Length of time allowed for gathering additional information varies as defined in this policy. Tolling means stopping a timeline clock while waiting for requested information or during an approved extension. Length of delay varies as allowed by the policy. When tolling timeframes, other than for urgent pre-service, the participant must be notified in writing of the need for additional information and the tolling period.

However, documents submitted to the Department prior to the Survey, including the following two items, indicate that the Plan does not employ a process, or follow its own policies related to written notification to the provider and enrollee when a delay or extension is needed to make the determination:

UM-004 - UM Communication Requirements for UM Decisions – Sample Utilization Management modification template letters

> Cigna Behavioral Health of California, Inc. does not utilize a Modification Letter; instead, Cigna Behavioral Health of California, Inc. generates a new authorization letter when a new authorization is created.

UM-004 - UM Communication Requirements for UM Decisions – Sample Utilization Management extension letters (when the Plan cannot make a determination within the required timeframe)

> Plan does not currently utilize an extension letter. Decisions are made within the established timeframe.

Additionally, during onsite interviews with the Medical Director, Compliance Officer, and the Quality Manager, it was stated that if the Plan does not receive the necessary clinical information in time to meet the required decision timeframe, the Plan makes the determination based on the information available. When the requested information is obtained, the Plan then makes a determination and issues a new authorization.

File review of 32 Standard Denials revealed that 30 of the 32 files met the required timeframe for determinations. The two files where the determinations were untimely were Case #25 and Case #26 below. In both files, the Plan did not send a notice to the provider or enrollee with the anticipated decision date. The Plan flagged both files for a 15-day decision timeframe, rather than the required five days.

> Case #25 and Case #26 - This did not require a delay notice because the Plan denied the claim as a non-covered benefit for out-of-network services, as the services were available in-network. However, the notes in Case #26 stated, "Our peer reviewer reviewed the available clinical information and determined there is insufficient evidence to support in-network coverage." In this case, the need for additional information necessitated a notification to the provider and enrollee.

Section 1367.01(h)(5) requires the Plan to notify the provider and enrollee in writing when the Plan cannot make a decision to approve, modify or deny the request for authorization within the required timeframes and the anticipated date on which a decision may be rendered. Section 1367.01(h)(5) also requires the Plan to notify the provider and enrollee of the anticipated date on which a decision may be rendered.

Section 1367(h)(1) requires the Plan to ensure non-urgent decisions to approve, modify or deny based on medical necessity are made within five business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination.

The documents provided by the Plan are not in concert with the regulations. Furthermore, the Department finds that the Plan does not, in practice, employ a process to notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify or deny the request for authorization within the required timeframe, and specify the information requested

but not received, or the expert reviewer to be consulted, or the additional examinations or tests required, or the anticipated date on which a decision may be rendered. Further, the Plan does not ensure that determinations are made within the five business day requirement. Therefore, the Department finds the Plan to be in violation of Section 1367.01(h)(5) and Section 1367.01(h)(1).

Corrective Action: Within 45 days following notice of a deficiency, the Plan is required to file a written statement with the Department signed by an officer of the Plan, describing any actions that it has taken to correct the deficiency.

Plan's Compliance Effort: The Plan will present its updated *HM-CLN-CA-035 Timeliness of Utilization Management Decisions & Notifications-California Addendum* policy and procedure, *and HM-CLN-CA-033 Peer-to-Peer Review-California Addendum* policy and procedure to the Board of Directors for approval on September 15, 2015. In addition, the Plan implemented the ICE Approved Delayed-Extension letter template as of July 15, 2015.

Final Report Deficiency Status: Not Corrected

The Department finds that not enough time has elapsed for this deficiency to be considered corrected. The Board of Directors is due to meet in September at which time, updates to the Plan's policies and procedures will be approved.

Based upon the corrective actions undertaken, the Department has determined that the Plan has not fully corrected this deficiency.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey. The Department will conduct a Follow-Up Review of the Plan and issue a Report within 14-16 months of the date of this Final Report.

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 Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled**, 2013 Routine Behavioral Health Survey - Document Request.**
- Submit the response to the Final Report via the "DMHC Communication" tab.

Plan Response to the Final Report