CONTRACT AND ENROLLMENT REVIEW
DIVISION – SOUTH LOS ANGELES
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

UNITEDHEALTHCARE COMMUNITY PLAN OF CALIFORNIA INC.

2022

Contract Number:	17-94404
Audit Period:	June 1, 2021 Through May 31, 2022
Dates of Audit:	September 19, 2022 Through September 23, 2022
Report Issued:	March 14, 2023

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I. INTRODUCTION

UnitedHealth Group Inc., is a publicly traded company incorporated in 1977, which operates on two business platforms. Health care coverage and benefits services are provided under the UnitedHealthcare branch, and information and technology-enabled health services are provided under Optum branch.

UnitedHealthcare provides services to an array of customers in different markets under various companies. UnitedHealthcare Community and State is the segment that manages healthcare benefit programs for Medicaid across the United States. UnitedHealthcare Community Plan of California Inc. (Plan), which incorporated in March 2013, is the California segment for Medi-Cal.

The Plan obtained its Knox-Keene Health Care Service Plan license in October 2014 and contracted with the Department of Health Care Services (DHCS) in October 2017 as a Geographic Managed Care (GMC) plan to provide health care services to Medi-Cal beneficiaries in the GMC counties of Sacramento and San Diego.

The Plan terminated its Medi-Cal contract in Sacramento County at the end of October 2018. Also, the Plan is closing its Medi-Cal line of business in San Diego County on December 31, 2022. The Plan will continue to serve its Dual Eligible Special Needs Plan (D-SNP) members under a State Medicaid Agency Contract with DHCS.

As of August 2022, the Plan’s total membership in San Diego County was 31,196 for Medi-Cal and 4,346 for D-SNP.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of June 1, 2021 through May 31, 2022. The audit was conducted from September 19, 2022 through September 23, 2022. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on February 14, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. No additional information was submitted after the Exit Conference.

The audit evaluated four categories of performance: Utilization Management, Access and Availability, Member's Rights, and Quality Management.

The prior DHCS medical audit for the period of June 1, 2019 through May 31, 2021 was issued on November 22, 2021. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its prior year's Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings were noted for the audit period.

Category 3 – Access and Availability

Category 3 includes requirements to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) for members.

The Plan is required to have a completed Physician Certification Statement (PCS) form from the member's provider for NEMT services. The Plan did not ensure that a PCS form was utilized for NEMT services.

Category 4 – Member's Rights

Category 4 includes requirements to establish and maintain a grievance system.

The Plan is required to aggregate and analyze grievance data, on a quarterly basis for quality improvement. Grievance data shall include access to care, quality of care, and denial of services and appropriate action shall be taken to remedy any problems identified. The Plan did not document remediation for the identified grievances related to access to specialists and Primary Care Providers (PCP) appointments, and balance billing.

The written record of grievances shall be reviewed periodically by the governing body, the public policy body, and by an officer of the Plan or designee. The Plan's governing body and public policy body did not review the written record of grievances on a periodic basis.

The Plan is required to provide subscribers and members with the written response to grievances, with a clear and concise explanation of the reason for the Plan's decision. The Plan did not send grievance resolution letters with a clear and concise explanation of its decision to members.

Category 5 – Quality Management

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Contract and Enrollment Review Division conducted the audit to ascertain that the medical services provided to the Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the Contract.

PROCEDURE

The audit was conducted from September 19, 2022 through September 23, 2022. The audit included a review of the Plan's Contract, policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews conducted with the Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 19 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Category 3 – Access and Availability

NEMT: 20 NEMT member records and one NEMT grievance record were reviewed for compliance with NEMT requirements.

NMT: 20 NMT member records and four NMT grievance records were reviewed for compliance with NMT requirements.

Category 4 – Member's Rights

Grievances: A total of 126 grievances (ten quality of care, 61 quality of service, 47 exempt and eight expedited) were reviewed for timely resolution, response to complainants, and submission to the appropriate level of review and medical decision-making.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthcare Community Plan of California Inc.

AUDIT PERIOD: June 1, 2021 through May 31, 2022
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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 Physician Certification Statement Form

The Plan is required to cover NEMT services required by members to access Medi-Cal services, as provided for in California Code of Regulations (CCR), Title 22, section 51323, subject to the PCS form being completed by the member's provider. *(Contract, Amendment A01, Exhibit A, Attachment 10 (8)(H)(2))*

Plans must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. In order to ensure consistency amongst all Plans, all NEMT PCS forms must include, at a minimum: function limitations justification, dates of service needed, mode of transportation needed, and certification statement. (All Plan Letter (*APL) 17-010*, *NEMT and NMT Services)*

The Plan Policy and Procedures: CA OPS 130 *Transportation Services* (Effective: 12/01/2021), stated that PCS forms are required for NEMT services. The PCS forms are to be used by the transportation vendor to obtain the mode of transportation from the treating physician to authorize NEMT services and standing orders prior to rendering services.

Finding: The Plan did not ensure that a PCS form was utilized for NEMT services.

The Plan's Policy and Procedures CA OPS 130 included the requirement for the vendors to utilize the PCS form with authorization from the treating physician prior to rendering services; however, the Plan did not follow its procedures to ensure that NEMT files contained the PCS form for NEMT rendered services.

A review of 20 NEMT trips provided to members revealed that 16 were missing the required PCS form.

During the interview, the Plan stated that the transportation vendor was responsible to utilize the PCS form with approvals from the treating physician. The Plan did not ensure that its transportation vendor included the PCS form in the file. The Plan did not follow its procedures and the Contract requirements.

Without obtaining PCS forms for NEMT trips, the Plan is unable to determine the appropriate level of service for Medi-Cal members.

This is a repeat of prior year finding 3.8.1 Physician Certification Statement Form Requirement.

Recommendation: Implement policy and procedures to ensure that a PCS form is utilized when rendering NEMT services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Appropriate Action to Remedy Grievance Issues

The Plan is required to compile the systematic aggregation and analysis of grievance and appeal data and use for Quality Improvement (QI). *(Contract, Exhibit A, Attachment 14 (1) (J))*

The Plan is required to submit the written record of Grievances and Appeals (G&A) at least quarterly to the Plan's quality assurance committee for systematic aggregation and analysis for QI. G&As reviewed must include, but not limited to, those related to access to care, quality of care, and denial of services. The Plan must take appropriate action to remedy any problems identified. *(APL 21-011 which superseded 17-006, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan did not document remediation for the identified grievances related to access to specialists and PCP appointments, and balance billing.

The Plan's Policy and Procedures undated CAOPS126: *Member Appeal Grievance Policy Fair Hearing and Independent Medical Review Policy,* stated the grievance and appeal system was monitored by the Chief Executive Officer/Chief Operation Officer (CEO/COO) and Chief Medical Officer (CMO) in monthly meeting. The Plan would take appropriate action to remedy problems identified related to grievances. However, it did not document remediation for the identified grievances in accordance with its procedures and the APL requirements.

A review of G&A Reports for the 2021 quarter three and quarter four listed the following number of grievances:

- 252 in quarter three 2021 (64 billing and 24 access to services grievances)
- 323 in quarter four 2021 (49 billing and 44 access to services grievances)

Furthermore, appeal and grievance reports identified problem areas; however, there was no documentation to remedy these issues. The Service Quality Improvement Subcommittee Meeting Minutes review did not document the discussion of the identified issues and interventions to remediate the problems identified.

During the interview, the Plan stated that it performed remediation through Joint Operations Committee meetings, disciplinary action, and provider education.

However, documentation provided did not include how the Plan remediated the identified grievance issues.

Lack of appropriate action to remedy identified grievance issues may prevent the Plan from improving systemic issues, which may have a detrimental effect on members' quality of care.

This is a repeat of prior year finding 4.1.1 Appropriate Action to Remedy Identified Grievance Problems.

Recommendation: Revise and implement policy and procedures to ensure appropriate actions are taken to remedy identified grievances issues.

4.1.2 Review of Written Grievance Log

The Plan is required to comply with all existing final Policy Letters (PLs) and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2)*

The written record of grievances shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented. *(CCR, Title 28, section 1300.68 (b)(5))*

The grievance and appeal system is required to operate in accordance with all applicable federal regulations, state laws, and state regulations. The written record of G&A is required to be reviewed periodically by the governing body of the Plan, the public policy body, and by an officer of the Plan or designee. The review is required to be thoroughly documented*. (APL 21-011 which superseded APL 17-006: G&A Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan's governing body and public policy body did not review the written record of grievances on a periodic basis.

The Plan's Policy and Procedure undated CAOPS126*: Member Appeal Grievance Policy State Fair Hearing and Independent Medical Review Policy,* stated that the written record of G&As must be reviewed periodically by the Plan Board of Directors, the public policy body and by the CMO or CEO/COO. The review must be thoroughly documented. However, the Plan did not provide documentation to support the review of the written record of grievances was conducted by the governing body, and the public policy body committees during the audit period.

During the interview the Plan stated the review of the written record for grievances on a periodic basis by the governing body, and public policy body has not been implemented yet by the Plan. Only the officer of the Plan reviewed the written record.

When the written record of grievances is not reviewed by the governing body and public policy body, this may result in missed opportunities to improve quality of the grievance process.

This is a repeat of prior year finding 4.1.2 Review of the Written Record of Grievances.

Recommendation: Develop and implement policy and procedures to ensure periodic review of the written record of grievances is conducted by the governing body and public policy body.

4.1.3 Grievance Resolution Letter Decisions

The Plan is required to develop, implement, and maintain a Member Grievance System in accordance with CCR, Title 28, sections 1300.68, and 1300.68.01 and CCR, Title 22, section 53858. *(Contract, Exhibit A, Attachment 14 (1)).*

The Plan is required to establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The Plan's grievance procedure shall at minimum provide for a description of the action taken by the Plan or provider to investigate and resolve the grievance and the proposed resolution by the Plan or provider. (*CCR, Title 22, section 53858 (a))*

The Plan is required to provide subscribers and members with written responses to grievances, with a clear and concise explanation of the reason for the Plan's response. The Plan's response shall describe the criteria used and clinical reasons for its decision including all criteria and clinical reasons related to medical necessity. (*Health and Safety Code, section 1368 (5))*

The Plan's written resolution letter shall contain a clear and concise explanation of the Plan's decision. (*APL 21-011 which superseded APL 17-006: G&A Requirements, Notice and "Your Rights" Templates)*

Finding: The Plan did not send grievance resolution letters with a clear and concise explanation of its decisions to members.

The Plan's undated Policy and Procedures CAOPS126*: Member Appeal Grievance Policy State Fair Hearing and Independent Medical Review Policy*, stated written

grievance decision are issued within applicable regulatory timeframe requirements, and must include the following elements if applicable: A clear and concise explanation of the disposition APL 17-006. However, the Plan staff did not follow its procedures when sending resolution letter to members'.

A review of 61 standard grievance files revealed that 18 grievance resolution letters did not have a clear and concise explanation of the decision; for example, the letters included the following statements:

- We are unable to share our findings due to certain laws,
- State and/or federal laws prevent the result of this review from being communicated back to you, or
- No decision statement was written on the letter to address the member's complaint.

During the interview, the Plan acknowledged that the existing language in grievance resolution letters was not appropriate in all cases and did not always address the member's concerns.

Without a clear and concise written explanation of the Plan's decisions, members are not made aware if their issues are addressed and resolved.

Recommendation: Develop and implement a process to ensure that grievance resolution letters include a clear and concise explanation of the Plan's decision.