



MICHELLE BAASS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

December 15, 2022

Keisha Lewis, Director C&S Compliance
UnitedHealthcare Community Plan of California, Inc.
3215 Prospect Park Drive, Suite 1126
Rancho Cordova, CA 95670

RE: Department of Health Care Services Medical Audit

Dear Ms. Lewis:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of UnitedHealthcare Community Plan of California, Inc., a Managed Care Plan (MCP), from July 19, 2021 through July 30, 2021. The audit covered the period of June 1, 2019 through May 31, 2021.

All items have been evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report and the enclosed documents will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Oksana Meyer, MPA

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Chief, CAP Compliance & FSR Oversight Section
Managed Care Quality & Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Lyubov Poonka, Chief
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Anthony Martinez, Lead Analyst
CAP Compliance Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Tia Elliott, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form



Plan: UnitedHealthcare Community Plan of California, Inc.

Review Period: 06/01/2019 – 05/31/2021

Audit Type: Medical Audit and State Supported Services

On-site Review: 07/19/2021 – 07/30/2021

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. For policies and other documentation that have been revised, please highlight the new relevant text. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. **Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.**

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1. Utilization Management				
<p>1.1.1 Over and Under-Utilization of Health Care Services</p> <p>The Plan did not have written documentation that detects under and over-utilization of health care services.</p>	<ol style="list-style-type: none"> 1. The Plan created a workgroup to discuss monitoring and reporting 2. Develop metrics to monitor over/under utilization 3. Draft Over-Under Utilization Policy 4. Approve Over-Under Utilization Policy 5. Under Utilization Annual Report 6. Quarterly update to Over/Under Utilization workgroup 7. Quarterly update to Healthcare Quality Utilization Management Committee 8. Quarterly update to Quality Management Committee 	<ol style="list-style-type: none"> 1. QMC 9/21/2021 2. Over/Under Utilization Plan PPT 3. Over-Under Utilization Policy - draft 4. N/A 5. N/A 6. Over_Under Utilization Plan PPT 7. HQUM Q3 2021 DECK 10252021 8. QMC 9 21 2021 ppt and QMC 12 9 2021 ppt 	<ol style="list-style-type: none"> 1. 7/26/2021 2. 10/18/2021 3. 10/14/2021 4. 3/31/2022 5. 3/31/2022 6. 10/18/2021 7. 10/25/2021 8. 9/21/2021 and 12/9/2021 	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <p>- Draft Over/Under Utilization Policy was developed to describe the MCP's methods for monitoring for over/under utilization. The MCP the health plan will reviews data to identify trends in over and underutilization. Data may include a review of the following:</p> <ol style="list-style-type: none"> a. Encounters b. Establishing Care c. Blood Lead Screenings d. Fluoride Varnish e. Cervical Cancer Screenings f. Breast Cancer Screenings g. Childhood Immunizations h. Adolescent Immunizations i. Well-Child Visits j. Postpartum Care k. Bed day utilization metrics (admits/thousand (A/K), days/thousand (D/K), average length of stay (ALOS) l. ER utilization of high utilizers m. ACO performance in their specified focus areas of over/underutilization n. Gaps in care for selected HEDIS metrics, including HEDIS metrics selected by DHCS for monitoring of managed care plan quality o. Outpatient services, as needed, based on review of data p. Other measures as identified and recommended from Committees

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				<p>Over-under utilization patterns are discussed at least quarterly at the Over-Under Utilization Workgroup, HQUM, and QMC committee meetings.</p> <p>- Over-Under Utilization Monitoring policy was finalized and approved 2/7/22.</p> <p>MONITORING & OVERSIGHT</p> <p>- Quality Management Committee 9/21/21 PPT demonstrates the MCP has created a workgroup to discuss monitoring and reporting of over and under utilization. The PPT contains the MCP’s action plan of creating an under utilization work plan, work plan review within the work group and presenting data to the HQUM and QMC on a quarterly basis. PPT also contains HQUM reports from 9/1/21 and QMC minutes from 7/26/21.</p> <p>1. All members: Overall Encounters – medical visits</p> <p>New members enrolled in 120 days: Establishing care with PCP Childhood Health And eight other examples.</p> <p>- 10/25/21 HQUM meeting summary demonstrates the MCP is updating the UQUM on the development under/over UM metrics.</p> <p>- Quality Management Committee Meeting PPTs from 9/21/21 and 12/9/21 serve as evidence of the MCP updating the QMC on over/under UM metrics.</p> <p>- Over-under utilization plan contains metrics to monitor over/under utilization. Multiple measures are targeted. Each measure will be reviewed</p>

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				<p>quarterly.</p> <p>- Under/Over Utilization Annual Report 2021 from 1/31/22 confirms the MCP assesses metrics to ensure MCP compliance with over and under utilization requirements.</p> <p>The Corrective Action Plan for Finding 1.1.1 is accepted.</p>
<p>1.2.1 Prior Authorization Requirements and Preventive Health Care services</p> <p>The Plan required prior authorizations for preventive services.</p>	<p>UHC Community Plan requires prior authorization for certain preventative services, such as Low-Dose CT Lung Cancer Screening, to ensure the requested clinical study meets the criteria established by the U.S Preventative Society Task Force (USPSTF). This study is included in our prior authorization program to prevent inappropriate utilization as this scan is not medically appropriate for all members. Our process did not prevent members</p>	<p>CA DHCS Audit_Narrative_Finding 1.2.1_12.22.21</p>	<p>N/A</p>	<p>The following documentation supports the MCP's efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <p>-The MCP updated P&P to address the gap that contributed to the deficiency: The final approved copy of CAHS 041 "Preventive Care Coverage" includes that the Plan does not impose Prior Authorization requirements for UPSTF A and B recommendations. (Approved 09/09/22).</p> <p>-The MCP drafted and revised Policy, UM-022 (Draft 12/8/22) to address the exclusion of prior authorization for screenings, prevention services, or treatment of sexually transmitted diseases.</p> <p>The Corrective Action for Finding 1.2.1 is accepted.</p>

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	from receiving the appropriate lung cancer preventive screening.			
<p>1.3.1 Review of the Written Record of Appeals</p> <p>The Plan did not document the oversight of their appeals system.</p>	<p>The Plan Policy CAOPS126 Member Appeal Grievance Policy was revised to thoroughly document the periodic review of the appeals log by the Board of Directors, the Public Policy Body, and an officer of the Plan.</p> <p>Appeals log revised to include the data elements required per APL 21-011.</p> <p>Appeals log revised to remove PHI to ensure HIPAA compliance when the log is being reviewed by the Board of Directors and Public Policy Body.</p> <p>Appeals log is being revised to remove PHI while also keeping the 'Description of Acton</p>	<p>CAOPS 126 CA Member Appeal and Grievance Policy and Procedure</p>	<p>12/15/2021</p> <p>10/27/2021</p> <p>11/19/2021</p> <p>*Short-Term 1/5/21</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <ul style="list-style-type: none"> - Drafted P&P, "CAOPS126: Member Appeal and Grievance" (12/19) has been updated to include, the written record of grievances and appeals 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. (Page 6, Section e) <p>MONITORING & OVERSIGHT</p> <ul style="list-style-type: none"> - "Project Timeline_2021 CA DHCS Comp Medical Audit" shows the process & plan the MCP has in place to remediate this issue, including analysis of current systems, identify categories to add/delete from systems, training for staff of new process & ability of customizing the reports that will be output. - "Public Policy Committee Meeting Minutes" (10/12/22) demonstrate that the Public Policy Committee and an Officer of the MCP reviews and documents the review of written record of appeals. (Page 3, Section E) - "Unitedhealthcare CommunityPlan of California, Inc. Minutes of The Meeting of The Board of Directors" (07/25/22) approved by the Board (10/3/22) demonstrate review of the Appeals log by the Plan's Board of

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	<p>Taken' field.</p> <p>Appeals log is reviewed by the Plan's Board of Directors, Public Policy Body and the review is documented in meeting minutes.</p> <p>Appeals log is reviewed by Plan Officer and attestation of review is provided.</p> <p>The Plan is looking to uniformly put in classifications across multiple systems that will provide more details and comprehensive reporting to include remediation and trending of case classifications and status of remediation.</p>		<p>Q1 2022</p> <p>Q1 2022</p> <p>Long Term – Q3 2022</p>	<p>Directors and the review is documented in meeting minutes.</p> <p>The Corrective Action Plan for Finding 1.3.1 is accepted.</p>

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3. Access and Availability of Care				
<p>3.8.1 Physician Certification Statement Form Requirement</p> <p>The Plan does not complete the DHCS-approved PCS form as requirement for the provision of NEMT services.</p>	<p>1) PCS Form requirement and process for submission of form was added to new provider education/training</p> <p>2) PCS Form requirement and process was added to the provider manual</p> <p>3) PCS Forms were added to the provider and member website</p> <p>4) The Plan's transportation vendor, ModivCare, updated PCS Form SOP to include all Medi-cal programs.</p> <p>5) Plan implemented a procedure to ensure that California Medi-Cal Physician's Certification Statement</p>	<p>1) 3.8.1 PCS Form provider training deck</p> <p>2) 3.8.1 PCS Form provider manual</p> <p>3) 3.8.1 PCS Form provider website</p> <p>3.8.1 PCS Form member website</p> <p>4) California Medi-Cal Physician's Certification Statement Standard Operating Procedure #2021-003</p> <p>5) CAOPS 130 Transportation Services</p>	<p>10/26/2021</p> <p>9/8/2021</p> <p>9/21/2021</p> <p>11/30/2021</p> <p>12/1/2021</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <p>-MCP updated Provider Manual to include information on PCS form requirements for NEMT services. PCS forms were added to provider website.</p> <p>-MCP transportation vendor (Modivcare) updated their PCS Standard Operating Procedure 2021-003 that outlines Modivcare's responsibilities to obtain and report on approved, pending, and expired PCS forms.</p> <p>-Revised Policy CA OPS 130 Transportation Services (12/1/21) includes the following:</p> <p>MCP and transportation broker hold monthly JOC meetings to review reporting and service level performance. During these meetings, the MCP may identify deficiencies and/or areas for improvement that may require corrective action.</p> <p>TRAINING</p> <p>-MCP updated new provider training materials under "Transportation Benefits" to include instructions on completing PCS forms to determine mode of transportation and submission to transportation broker once completed.</p>

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	<p>Standard Operating Procedure #2021-003 PCS forms are received as required by APL 17-010. The steps, as outlined in the updated Policy and Procedure CAOPS 130 Transportation Services, is as follows:</p> <ul style="list-style-type: none"> - ModivCare sends the Plan a report listing PCS forms that have not been received - Provider advocates make 3 attempts to obtain the PCS form from the provider - If Provider Advocate is unsuccessful in obtaining form, the Provider's Contract Manager makes 3 attempts to obtain form - If Contract Manager is unsuccessful, the provider is placed on a Corrective Action Plan and/or has their 			<p>MONITORING & OVERSIGHT</p> <p>Reporting/monitoring of the following: Call received/answered Call abandonment rate Member grievances by type, volume, reason, resolution Utilization trips scheduled, canceled, completed, top service type.</p> <p>NEMT/NMT vendor to submit weekly reports listing pending PCS forms that haven't been returned to the transportation broker. Outlines MCP efforts to obtain completed PCS forms from treating providers, including escalation and potential corrective action and/or contract termination.</p> <p>Monthly JOC meeting agendas for October and December as evidence of discussion with broker about provider enrollment, the enrollment process, enrollment status, and tracker.</p> <p>MCP revised electronic PCS form to conform to DHCS requirements. PCS form addresses the four major categories needed to authorize NEMT services.</p> <p>The Corrective Action Plan for Finding 3.8.1 is accepted.</p>

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	contract terminated.			
<p>3.8.2 Medi-Cal Enrollment of NEMT and NMT Providers</p> <p>The Plan did not ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal program.</p>	<p>1) The Plan’s transportation vendor, ModivCare, updated its Provider Enrollment SOP #2021-001 to ensure compliance with DHCS requirement of NEMT/NMT provider enrollment.</p> <p>2) The Plan implemented a process whereby ModivCare provides a report of transportation providers’ enrollment status by the 5th of every month. The Plan performs a random sampling of the provider enrollment status within 15 days of receipt of report and maintains a record of the results. Any discrepancies between Plan’s findings and ModivCare’s records are immediately forwarded to ModivCare for</p>	<p>1) 20211105 Provider Enrollment SOP 2021-001</p> <p>3) CA OPS 130 Transportation Services</p>	<p>11/5/2021</p> <p>11/8/2021</p>	<p>The following additional documentation supports the MCP’s efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <p>The Plan updated P&Ps to address the gap that contributed to the deficiency:</p> <ul style="list-style-type: none"> • CA OPS 130 Transportation Services <ul style="list-style-type: none"> ○ The Plan will review vendor reports that include, but are not limited to the Enrollment of NEMT & NMT providers, including pending enrollment & the number of day’s enrollment has been pending. <p>OVERSIGHT & MONITORING</p> <p>The Plan identified, developed and deployed an internal auditing process to continuously self-monitor to detect and prevent future non-compliance:</p> <ul style="list-style-type: none"> • CA OPS 130 Transportation Services <ul style="list-style-type: none"> ○ The transportation broker submits a monthly roster of its transportation providers, including their Medi-Cal enrollment status and which providers serviced UHC members within the reporting month. [See 3.8.2 NEMT enrollment_MCQMD response 10.14.22] ○ The Plan reviews the report and verifies the provider enrollment status for a sample of the transportation providers on the report. [See 3.8.2 NEMT enrollment_MCQMD response 10.14.22] ○ The Plan & transportation broker has reoccurring monthly JOC

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	remediation. 3) The Plan updated its P&P CA OPS 130 Transportation Services to reflect the provider enrollment verification process detailed above			meetings to ensure the broker complies with all applicable state & federal laws & regulations, contractual requirements, & other requirements set forth by state regulators & will require the broker to take appropriate corrective action should the Plan identify deficiencies or areas for improvement. Results are reviewed quarterly during Service Quality Improvement Subcommittee. [Section V. – VI., pages 7-8] <ul style="list-style-type: none"> • UHC Transportation Roster <ul style="list-style-type: none"> ○ The roster demonstrates the Plan is tracking & reviewing the enrollment of NMT & NEMT providers, including pending enrollment & the number of day’s enrollment has been pending. <p>The Corrective Action Plan for Finding 3.8.2 is accepted.</p>
4. Member Rights				
4.1.1 Appropriate Action to Remedy Identified Grievance Problems The Plan did not take appropriate action to remedy problems identified related to grievances and appeals.	The Plan Policy CAOPS126 Member Appeal Grievance Policy was revised to include requirement to take actions to remedy problems identified related to appeals and grievances. The Plan Board of Directors meeting slides included remediation	CAOPS 126 CA Member Appeal and Grievance Policy and Procedure Q3 2021_for board meeting Q4 2021	12/15/2021 12/17/2021	The following additional documentation supports the MCP’s efforts to correct this finding: POLICIES & PROCEDURES <ul style="list-style-type: none"> • CAOPS126 Member Appeal & Grievance P&P <ul style="list-style-type: none"> ○ The policy states “The written record of grievances and appeals is submitted at least quarterly to the Quality Assurance Committee for systematic aggregation and analysis for quality improvement. Grievance and appeals reviewed must include, but not be limited to, those related to access to care, quality of care, and denial of services. The Plan will take appropriate action to remedy problems identified related to grievances and appeals.” (Page 5, c. & d.)

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	<p>issues and a quarter over quarter comparison of the top grievance and appeal reasons for the last year</p> <p>Meeting materials for Quality Improvement committee will include actions taken to remedy problems related to grievances and an analysis of the efficacy of those actions.</p> <p>In conjunction with findings 1.3.1 and 4.1.2, the Plan is looking to uniformly put in classifications across multiple systems that will provide more details and comprehensive reporting to include remediation and trending of case classifications and status of remediation.</p>	<p>Project Timeline_2021 CA DHCS Comprehensive Medical Audit</p>	<p>* Short-term Q1 2022</p> <p>Long Term – Q3 2022</p>	<p>TRAINING</p> <ul style="list-style-type: none"> • Service Quality Improvement Sub Committee 06232022 Slides <ul style="list-style-type: none"> ○ The meeting slides provided show that the Plan have identified issues with G&A, as well as shows updates to its process of ensuring that the proper remediation happens to any G&A identified. (Slides 14-24) ○ The slides show all items categorized by issue, root cause, & remediation & included the Plan’s analysis of how it reached the proper remediation for G&A identified. (Slides 14-24) ○ The Plan shows that it has properly taken appropriate action to remedy problems identified related to grievances & appeals. • Service Quality Improvement Sub-Committee Mtg Mins <ul style="list-style-type: none"> ○ The meeting minutes ensure the audit findings were addressed with a solution/process being implemented & specifics identified of where the majority of G&As were occurring. ○ The Plan outlines its remediation process for certain instances: <ul style="list-style-type: none"> ▪ Some of the remediation steps being taken are reaching out to providers directly to request members be seen sooner, finding other providers with better availability, authorize out of network care, and provide transportation. ▪ Another remediation step as it pertains to transportation is a member transportation VIP program. If a member continues to have challenges with a transportation provider, they will be watched closely, and extra steps will be made to make sure those members are taken care of. ▪ Part of the remediation plan has included meeting with the hospital that makes up the majority of the appeals. The ICM team is also reviewing the hospital stays greater than 5 days.

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				<p>MONITORING & OVERSIGHT</p> <ul style="list-style-type: none"> • Project Timeline_2021 CA DHCS Comp Medical Audit <ul style="list-style-type: none"> ○ Project Timeline shows the process & plan the MCP has to remediate this issue, including analysis of current systems, identify categories to add/delete from systems, training for staff of new process & ability of customizing the reports that will be output. <p>The Corrective Action Plan for Finding 4.1.1 is accepted.</p>
<p>4.1.2 Review of the Written Record of Grievances</p> <p>The Plan’s governing body, the public policy body, the officer or designee did not review and document the review of the written record of grievances and appeals.</p>	<p>The Plan Policy CAOPS126 Member Appeal Grievance Policy was revised to thoroughly document the periodic review of the appeals log by the Board of Directors, the Public Policy Body, and an officer of the Plan.</p> <p>Grievance log revised to include the data elements required per APL 21-011.</p> <p>Grievance log revised to remove PHI to ensure HIPAA compliance when the log is being reviewed by the Board of Directors</p>	<p>CAOPS 126 CA Member Appeal and Grievance Policy and Procedure</p>	<p>12/15/2021</p> <p>10/27/2021</p> <p>11/19/2021</p>	<p>The following additional documentation supports the MCP’s efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <ul style="list-style-type: none"> • CAOPS126 Member Appeal & Grievance P&P <ul style="list-style-type: none"> ○ The policy states “The written record of grievances and appeals 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.” (Page 5, Section e.) <p>MONITORING & OVERSIGHT</p> <p>- “Project Timeline_2021 CA DHCS Comp Medical Audit” shows the Plan has a process to remediate this issue, including analysis of current systems, identify categories to add/delete from systems, training for staff of new process & ability of customizing the reports.</p>

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	<p>and Public Policy Body.</p> <p>Grievance log is being revised to remove PHI while also keeping the 'Description of Action Taken' field.</p> <p>Grievance log is reviewed by the Plan's Board of Directors, Public Policy Body and the review is documented in meeting minutes.</p> <p>Grievance log is reviewed by Plan Officer and attestation of review is provided.</p> <p>The Plan is looking to uniformly put in classifications across multiple systems that will provide more details and comprehensive reporting to include remediation and trending of case classifications and status of remediation.</p>		<p>*Short Term 1/5/21</p> <p>*Q1 2022</p> <p>*Q1 2022</p> <p>Long Term – Q3 2022</p>	<p>- "Public Policy Committee Meeting Minutes" (10/12/22) demonstrate that the Public Policy Committee and an Officer of the MCP reviews and documents the review of written record of grievances. (Page 3, Section E)</p> <p>- "United Healthcare Community Plan of California, Inc. Minutes of The Meeting of The Board of Directors" (07/25/22) approved by the Board (10/3/22) demonstrate review of the Grievance log by the Plan's Board of Directors and the review is documented in meeting minutes.</p> <p>The Corrective Action Plan for Finding 4.1.2 is accepted.</p>

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5. Quality Management				
<p>5.3.1 New Provider Training Requirement</p> <p>The Plan did not ensure that all network providers conducted training for newly contracted providers within ten working days of placing them on active status.</p>	<p>1) Policy and Procedure was updated to include policy for capitated/delegated providers</p> <p>2) Training attestation form was created to track compliance with training requirement</p> <p>3) Requirement to submit provider attestations is communicated to providers during monthly meetings</p> <p>4) Completed attestations are submitted to the Provider Advocate</p>	<p>1) CA OPS 304_Provider Training and Outreach Plan</p> <p>2) Provider attestation form</p> <p>3) Monthly Service Standard Agenda</p> <p>4) UHC Attestation Example</p>	<p>10/08/2021</p> <p>7/31/2021</p> <p>8/30/2021</p> <p>9/13/2021</p>	<p>The following additional documentation supports the MCP’s efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <ul style="list-style-type: none"> - Updated P&P, “CA OPS 304: Provider Training and Outreach Plan” which has been amended to include a section on the Capitated/Delegated Training Process. The delegated group maintains a Policy and Procedure to ensure training includes the required topics and timeline of 10 business days. The Plan will review training materials on a biannual basis with the medical group and collect attestations of completed education as applicable. - “Provider Attestation Form” that is used by the MCP to have providers submit their attestation of provider training. - “Monthly Service Standard Agenda” as evidence that the MCP is reminding providers of the requirement to submit provider attestations during monthly meetings. - “UHC Attestation Example” as evidence that completed provider attestations are submitted to the MCP. - Standard Operating Procedure “Capitated/Delegated Training Process”. Medical groups under a capitation contract are delegated to conduct required new provide orientation with their newly contracted physicians and offices. The delegated group maintains a Policy and Procedure to ensure training includes the required topics and timeline of 10 business days. The plan will review training materials on a biannual basis with the medical group

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				<p>and collect attestations of completed education as applicable.</p> <p>Provider Advocates track submissions of newly contracted physicians from delegated providers via direct outreach and/or the Monthly Service Meetings.</p> <p>Process:</p> <ul style="list-style-type: none"> • On a weekly basis Check the New provider Report for any physicians loaded for delegated providers. • Reach out to direct contact at the delegated provider and request attestations for any newly contracted physicians and/or include in Monthly Service Meeting agenda. • Document the new providers in Impact and include signed attestation. • If provider training has not been completed, suppress provided from network until training is completed. Once training is completed release suppression and document in impact. <p>MONITORING & OVERSIGHT</p> <p>- Excel Spreadsheets, "Provider Training Report" (October 2021 – December 2021) as evidence that the MCP is monitoring and tracking newly contracted providers within ten working days of placing them on active status. The "Provider Name," "Training Attestation Date," "Effective Date," "Compliance," and "Follow-up on Non-Compliant Providers," are the elements being tracked in the spreadsheet.</p> <p>- Excel Spreadsheet, "New Provider Tracking 4Q21 Sample" as evidence that the MCP is monitoring and tracking newly contracted providers and</p>

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				<p>newly delegated providers within ten working days of placing them on active status. The “Provider Name,” “Provider Active Date,” “Education Completed Date,” and “Attestation Received” are the elements being tracked in the spreadsheet.</p> <p>The Corrective Action Plan for Finding 5.3.1 is accepted.</p>
6. Administrative and Organizational Capacity				
<p>6.1.1 Health Education Program Interventions</p> <p>The Plan did not offer educational interventions for unintended pregnancy, complementary care, and alternative care.</p>	<p>1. Health Education Manager to locate health education materials for Unplanned Pregnancy and Complementary & Alternative Care. 2. Health Education Manager to review and approve materials using Readability and Suitability Checklist 3. Publish materials on Health Education Resource Library</p>	<p>1. M925325 CST32412_CA21_MaternityCare_LARC-PRNC.pdf 2. CST34016_CAID21_CA-ALT_Care_Flyer_PRNC</p>	<p>1. 8/31/2021 2. 10/12/2021 3. 10/14/2021</p>	<p>The following documentation supports the MCP’s efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <p>“Q1.1CST30261_CL20_CA_VirtualHealthEdClasses_Flyer_PRNC Q1.2 M925014 CST32651 UHC CP CA21_VirtualClasses_Flyer_v2-PRNC Q 1.3 CST34016_CAID21_CA_AltCare_Flyer_PRNC are the proof of educational intervention specifically for Alternative Care. The Plan offered health education classes for Chair Yoga in 2020 and 2021 in both English and Spanish. The Plan also has developed a material on complementary and alternative medicine (CAM).</p> <p>The Plan houses health education materials on unintended pregnancy as well as complementary and alternative medicine (CAM) as part of the Health Education Resource Library on the Plan’s website. The Plan provides information on CAM services such as acupuncture and chiropractic care in the Member Handbook and Provider Handbook. The handbooks are also available on the Plan’s websites. (MCP response 01/22/22)</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				<p>- Q2.1 UHCCP CA Web Health Ed - CAM & Unintended Pregnancy</p> <p>- Q2.2 CA-Handbook-EN 2021, Pages 32,37,43</p> <p>- Q2.3 CA-Care-Provider-Manual 2021, Pages 29-30</p> <p>CAHECL-002 Health Education Program Policy was retired in 2020 and all content was integrated into CAHECL001 Health Education and Cultural and Linguistics Programs Description (HECL PD). The 2022 HECL PD has been updated to describe the health education topics included in the Plan's web-based Health Education Resource Library which align with the Contract.</p> <p>Q3.1CAHECL001_2022_HECL_PD, Page 12</p> <p>The Corrective Action Plan for Finding 6.1.1 is accepted.</p>
<p>6.2.1 Verification of Services Delivered by Network Providers</p> <p>The Plan did not implement a method to verify services delivered by network providers.</p>	<p>Upon identification the Verification of Receipt of Paid Services process had not been fully implemented in 2018, a Workplan was created to identify the root cause as to why this did not occur, Process Implementation Options, Implementation Decision, and ongoing monitoring. This updated workplan is provided as the attachment titled:</p>	<ul style="list-style-type: none"> 6.2.10_UHC_Verification_of_Services_Workplan_12222021 	<p>Short Term: 12/31/2021</p> <p>Long Term: 2/28/2022</p>	<p>The following additional documentation supports the MCP's efforts to correct this finding:</p> <p>POLICIES & PROCEDURES</p> <p>- Updated P&P, "Verification of Request of Paid Services" (08/27/21) in which the MCP will conduct verification of services activities to confirm services billed by providers were actually provided to the MCP's enrollees. These activities will be conducted via mail, telephonically or in person. Sampling shall be from claims with dates of services (DOS) from the reporting quarter and not more than 45 days from the date of payment pursuant to 42 CFR 455.20 (Verification of Receipt of Paid Services Policy & Procedure, Page 1).</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	<ul style="list-style-type: none"> 6.2.10_UHC_Verification_of_Services_Workplan_12222021 <p>UnitedHealthcare submitted the proposal for implementation of Option #1 on the above referenced workplan (outbound calls to members to verification services billed to UnitedHealthcare (UHC) were actually performed). The proposal was approved by DHCS on August 4, 2021. Documents to support this submission and its approval are provided as the attachments titled:</p> <ul style="list-style-type: none"> DHCS Proposal - Verification of Services Outbound Call Script Program Submission Review Form - Verification of Services Verification_of_Service 	<ul style="list-style-type: none"> DHCS Proposal - Verification of Services Outbound Call Script Program Submission Review Form - Verification of Services Verification_of_Services_Talking_Points DHCS Approval - Verification of Services Proposal 08042021 		<p>MONITORING & OVERSIGHT</p> <ul style="list-style-type: none"> “California C&S Compliance Work Plan Worksheet: Verification of Receipt of Paid Services” in which the MCP has created a work plan to identify the root cause as to why the verification of receipt of paid services did not occur. The work plan also covers Process Implementation Options, Implementation Decision, and ongoing monitoring (UHC_Verification_of_Services_Workplan_12222021). DHCS Verification of Services Proposal (08/04/21) as evidence that the MCP received approval from the DHCS Contract Manager to utilize their Verification of Services Talking Points to conduct 100 outbound calls per month to the MCP’s Medi-Cal members to confirm the services the MCP has been billed for were actually received by our members (DHCS Approval - Verification of Services Proposal 08042021, DHCS Proposal - Verification of Services Outbound Call Script, Verification_of_Services_Talking_Points). Excel Spreadsheet, “HARC CA VER Campaign Results” (December 2021) as evidence that the MCP has implemented a method, by telephone sampling, to verify services delivered by network providers. The “Survey Results” tab on the Excel Spreadsheet tracks the member name, DOB, Member ID, Claim #, and the question, “Did the member verify the service?” with a yes or no response (6.2.1_HARC_CA_VER Campaign_Results_DEC_2021). <p>The Corrective Action Plan for Finding 6.2.1 is accepted.</p>

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* <small>(*Short-Term, Long-Term)</small>	DHCS Comments
	<p>s_Talking_Points</p> <ul style="list-style-type: none"> DHCS Approval - Verification of Services Proposal 08042021 <p>Upon receipt of DHCS approval of the submitted proposal, the Verification of Receipt of Paid Services Policy & Procedure was updated and approved by the UnitedHealthcare Community Plan of California Health Plan (UHCCP) leadership on September 7, 2021. This policy is provided as the attachment titled:</p> <ul style="list-style-type: none"> Verification of Receipt of Paid Services Policy & Procedure <p>On July 28, 2021, a Service Readiness request was submitted to generate the California specific claims report that will be used by UHCCP's</p>	<ul style="list-style-type: none"> Verification of Receipt of Paid Services Policy & Procedure GSOR Submission 3674 - Verification of Receipt of Paid Services 07282021 		

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
	<p>HARC Team to conduct the outbound Verification of Receipt of Paid services calls.</p> <ul style="list-style-type: none"> • GSOR Submission 3674 - Verification of Receipt of Paid Services 07282021 <p>The following service types will be excluded from the Verification of Services calls</p> <ul style="list-style-type: none"> • Family Planning • Abortion • BH • HCBS/Supplies • Pharmacy • Radiology • Anesthesia • Pathology • Lab <p>At the time of this submission, the fully automated report is not yet complete; however, an interim process has been implemented and the first series of outbound calls were initiated during the</p>	<ul style="list-style-type: none"> • Confirmation of HARC performing Verification of Receipt of Paid Services Calls 12142021 		

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* <small>(*Short-Term, Long-Term)</small>	DHCS Comments
	<p>months of November and December 2021. A call completion report is expected to be received by the UHCCP Compliance Officer on or before December 31, 2021.</p> <ul style="list-style-type: none"> Confirmation of HARC performing Verification of Receipt of Paid Services Calls 12142021 			

Submitted by: Kevin Kandalaft
Title: CEO, UnitedHealthcare Community Plan of California

Date: December 30, 2021