MEDICAL REVIEW – NORTH II SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

UNITEDHEALTHCARE COMMUNITY PLAN of CALIFORNIA, INC.

Contract Number: 17-94402
17-94404

Audit Period: April 1, 2018
Through
April 30, 2019

Report Issued: October 18, 2019

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management 6
Category 3 – Access and Availability of Care 11
Category 4 – Member's Rights 15
Category 5 – Quality Management 22
Category 6 – Administrative and Organizational Capacity 25

I. INTRODUCTION

UnitedHealth Group, Inc., a publically traded company incorporated in 1977, 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 the 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 left Sacramento County at the end of October 2018. There were 3,602 Sacramento members at the end of October 2018. The Plan had no membership in Sacramento County for the period of November 1, 2018 through April 30, 2019.

As of April 2019, the Plan's total Medi-Cal membership was approximately 13,706. San Diego County had a total of 10,104 members for the audit period.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of April 1, 2018 through April 30, 2019. The onsite review was conducted from May 28, 2019 through June 7, 2019. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on September 16, 2019. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. Additional information was not submitted following the Exit Conference.

The prior DHCS medical audit for the review period of October 1, 2017 through March 31, 2018, with onsite review conducted from May 8, 2018 through May 9, 2018 identified deficiencies. The Plan addressed the deficiencies in a Corrective Action Plan (CAP). The CAP closeout letter, dated October 9, 2018, noted that all previous findings were closed. This audit examined documentation for compliance and to determine what extent the Plan has operationalized their CAP.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management & Coordination of Care, Access & Availability of Care (Access), Members' Rights, Quality Improvement (QI), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The effectiveness of the prior year's CAP was evaluated. The Plan implemented procedures to include the decision maker's complete contact information on all pharmacy notice of action letters. The Plan updated the pharmacy appeal overturn letters to include the proper attachments with the decision rationale in member grievance resolutions letters.

The Plan did not ensure that all California Children's Services (CCS) members receive medically necessary services. UM and Case Management (CM) did not coordinate CCS member services.

The Plan used non-physicians to make the final decision on the resolution of expedited appeals. Final decisions of appeals related to denial involving clinical issues must be determined by a person having clinical expertise in treating the member's condition or disease.

Category 3 – Access and Availability of Care

The Plan does not have policies and procedures to ensure non-contracting Emergency Room department services are at a minimum reimbursed at the lowest level emergency department evaluation and management Physician's Current Procedural Terminology (CPT Code). The Plan's procedure was to deny claims submitted without sufficient documentation instead of paying at the lowest CPT code for the services rendered.

Members have the right to access family planning services through any provider without prior authorization. The Plan required prior authorization for family planning claims.

Category 4 – Member's Rights

As part of the CAP, related to the prior year audit, the Plan updated the grievance resolution letters to include member rights language. The Plan established a bi-weekly random sampling of grievance cases to ensure grievance letters meet quality standards.

Non-physicians reviewed and resolved Quality of Care (QOC) grievances. The Contract requires all QOC grievances to be referred to the Plan's Medical Director.

The Plan did not ensure adequate consideration and resolution before closing the grievances and mailing resolution letters to members. The Plan mailed resolution letters to members while still investigating the grievance.

The Plan is required to notify DHCS immediately upon the discovery of a breach of unsecured Protected Health Information (PHI) and within 24 hours of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or Personal Information (PI). However, the Plan's timeline to submit reports to DHCS begins after its national privacy office receives and reviews an incident. This deviation delays reporting of potential Health Insurance Portability and Accountability Act (HIPAA) breaches to DHCS.

The Plan's policies and procedures do not contain information related to submitting a completed Privacy Incident Report (PIR) to DHCS within ten working days of the discovery of a breach or unauthorized use of PHI.

Category 5 – Quality Management

The Plan did not ensure that network providers completed the new provider training within ten working days of being added to their Medi-Cal Managed Care Network. The Contract states that the Plan must ensure that network providers receive training related to the Medi-Cal program within ten working days of being placed in the Plan's active provider network.

Category 6 – Administrative and Organizational Capacity

The Plan is out of compliance with the Contract for timely reporting of Fraud, Waste, and Abuse (FWA) incidents. The Plan does not have a written policy and procedure for timely reporting of FWA incidents to DHCS.

The Plan did not report any cases of suspected or potential FWA incidents. A review was performed on the Plan's policies and procedures for Contract compliance with Fraud and Abuse incident reporting requirements. The Plan did not follow the Contract, which requires them to promptly report to DHCS any potential FWA.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contracts.

PROCEDURE

The onsite review was conducted from May 28, 2019 through June 7, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Delegation of Utilization Management: 10 delegation of utilization management cases were reviewed to test the Plan's oversight of its delegate.

Prior Authorization Review Requirements: 38 medical and pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior Authorization Appeal Process: 21 medical and pharmacy prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services: 4 member records were reviewed to ensure the Plan's adherence to policies and procedures for identifying and referring members with CCS eligible conditions and to ensure that the Plan is in compliance with Contract requirements for monitoring the coordination of care for members.

Initial Health Assessment: 21 member records were reviewed to ensure initial health assessments were provided to members and attempts documented in members' medical records.

Complex Case Management: 15 medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Behavioral Health Therapy: Six files were reviewed for completeness and the Plan's compliance with the Contract and Memorandum of Understanding (MOU).

Non-Medical Transportation and Non-Emergency Medical Transportation: 24 member records were reviewed for completeness and compliance with the Contract to determine if the Plan has a process to provide transportation to members.

Continuity of Care: 19 case files were reviewed to ensure that the Plan's members received continuity of care services as outlined in the Contract.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the provider's directory were reviewed to determine if appointments were accurate, complete, and available. Three appointments were requested. The "third next available" appointment was used to measure access to care.

Claims: 10 emergency services and 10 family planning service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance System: 27 grievances (quality of care and quality of service) cases were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Category 5 – Quality Management

Provider Qualifications: 10 provider qualification cases and 8 provider training cases were reviewed to determine if the Plan maintained policies and procedures related to initial credentialing and re-credentialing of providers of services under the Plan, and to determine if the Plan is in compliance with the Medi-Cal Contract and their policies and procedures related to credentialing and provider training.

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: April 1, 2018 through April 30, 2019
DATE OF AUDIT: May 28, 2019 through June 7, 2019

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements…(as required by Contract)
GMC Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
GMC Contract A.5.2.G

Timeframes for Medical Authorization:
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1) or any future amendments thereto.
GMC Contract A.5.3.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
GMC Contract A.5.3.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
GMC Contract A.13.8.A

SUMMARY OF FINDING(S):

1.2.1 Ensuring California Children's Services Members Receive Medically Necessary Services

Pursuant to the Contract, Exhibit A, Attachment 11 (9)(A)(5) the Plan shall, "Ensure that once eligibility for the CCS program is established for a member, Contractor shall continue to provide all medically necessary covered services that are unrelated to the CCS eligible condition and shall monitor and ensure the coordination of services and joint case management between the primary care providers, the CCS specialty providers, and the local CCS program."

Exhibit A, Attachment 11 (9)(A)(6) "If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all medically necessary covered services to the member."

Exhibit A, Attachment 11(9)(B) "Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to members."

CCS is a State program for children with certain serious debilitating medical illnesses or diseases. It provides services to diagnose, treat, and manage medical conditions for children under the age of 21 that meet CCS criteria. Not all medically necessary services are for a CCS eligible condition and therefore would be covered by the Plan.

The Plan is responsible for providing CCS eligible members all medically necessary covered services unrelated to their CCS condition, and for monitoring and ensuring the coordination of services between their Primary Care Provider (PCP), CCS, and their CCS providers. Our review disclosed that the Plan improperly denied prior authorization requests for medically necessary services for members eligible for CCS, and did not coordinate their care.

UM did not follow up with CCS to ensure members received the requested covered services. Medical records do not demonstrate members received the requested covered services.

The Plan has UM, CM, and CCS policies and procedures. However, the policies and procedures did not address coordination between the UM and CM department regarding prior authorizations requests for potential CCS covered and non-covered services.

As a result, medically necessary covered services for CCS medical conditions and/or non-CCS related conditions were not coordinated by the CM department with the

member's PCP and CCS.

The Plan risks denying or delaying medically necessary covered services when there is no coordination between the Plan, CCS, CCS members, and the members' PCP. Delayed or denied medical care can intensify a member's condition, potentially resulting in hospitalization, and emergency treatment.

RECOMMENDATION:

1.2.1 Revise and implement UM and CM policies and procedures that ensure CCS members receive medically necessary covered services and coordination of care.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: UnitedHealthcare Community Plan of California, Inc.
AUDIT PERIOD: April 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 28, 2019 through June 7, 2019**

1.3	PRIOR AUTHORIZATION APPEAL PROCESS
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and Members. GMC Contract A.5.2.E	

SUMMARY OF FINDINGS:

1.3.1 Medical Director Responsibility of Expedited Appeal Requests

"Contractor shall have in place a system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g)), and 1300.68.01. 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision F, item 13, 42 CFR 438:402-424 and APL 17-006. Contractor shall ensure that the following requirements are met through its grievance and appeal procedures." Exhibit A, Attachment 14 (1)

"Ensure that the person making the final decision for the proposed resolution of grievances and appeals has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in a prior decision, and has clinical expertise in treating a member's condition or disease if deciding on any of the following:

1. An appeal of a denial based on lack of medical necessity,
2. A grievance regarding denial of an expedited resolution of an appeal; and
3. Any grievance or appeal involving clinical issues."

Exhibit A, Attachment 14 (1)(D)

The Contract states, "Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease." Code of Federal Regulations (CFR), Title 42,438.406 (b)(2)(ii)

The Plan used Registered Nurses (RN), known as Resolving Analysts (RA), to make clinically related decisions on the status of expedited appeal requests, as disclosed in all eight expedited appeal verification study files. In the state of California, physicians have the expertise to treat medical conditions and RNs do not. In all eight of the expedited appeals request files reviewed in the verification study, the RA determined if an appeal would be expedited.

The Plan's policy (CAOPS126) was consistent with the contract and federal regulations stating that individuals deciding the merit of expedited appeals should have expertise in treating clinical diseases. The Plan's Clinical Review Standard Operating Procedure (SOP) was not consistent with federal regulations or the contract. The SOP instructed

nurses to review expedited appeal requests against established criteria. The nurses determined whether to expedite the appeal or process the appeal.

Directing nurses to review and decide expedited status for appeals concerning clinical issues excludes a physician from participating in the clinical decision making process. This is inconsistent with federal policy and the Contract which states the decision maker must have expertise in treating the clinical condition related to the grievance.

The Plan risks adverse outcomes for members' health when it allows non-physicians to determine expedited status of members' appeals. Individuals not trained to treat medical conditions may not recognize when a member's medical condition requires immediate attention.

RECOMMENDATION:

1.3.1 Develop procedures to ensure individuals qualified to treat medical conditions make clinical decisions on expedited status for appeal requests.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthcare Community Plan of California, Inc.

AUDIT PERIOD: April 1, 2018 through April 30, 2019
DATE OF AUDIT: May 28, 2019 through June 7, 2019

3.3	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with the Contractor.
GMC Contract A.8.13

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition including Medically
Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge….
GMC Contract A.8.13.B.1

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
GMC Contract A.8.13.B.2

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D), and California Welfare and Institutions code Section 14091.3
GMC Contract A.8.13.B.3

Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1).
GMC Contract A.9.7.A

Family Planning (Claims):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
GMC Contract A.8.9

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: UnitedHealthcare Community Plan of California, Inc.
AUDIT PERIOD: April 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 28, 2019 through June 7, 2019**

3.3	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
GMC Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDING(S):

3.3.1 Payment of Emergency Room Claims

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology. Contract, Exhibit A, Attachment 8(13)(B)(2)

The Plan's policy, CA OPS 106 Pre Post-Payment Review, stipulates that the Plan will deny emergency department claims that lack documentation to support the level of service billed. The Plan does not have policies and procedures to ensure non-contracting emergency department services are reimbursed, at a minimum, the lowest level of emergency department CPT code. The Plan denied emergency room claims for the lack of documentation. The Plan did not reimburse the provider of the service as required by the Contract.

The verification study disclosed the Plan denied four claims with high level Evaluation and Management (E&M) codes. The claims were submitted with insufficient medical records to support the services provided. The Plan did not reimburse the provider at the lowest level for the service provided. Instead, the claims were denied, resubmitted, and then manually denied by the Plan's adjusters.

The Plan's claims system had an edit to deny claims with higher level E&M codes which

did not include medical records. The system is designed to deny the claims instead of reimbursing the claims at the lowest level of CPT code.

The Plan stated that the edits resulting in denials were removed April 2019. The Plan stated they are developing a process to reimburse non-contracting emergency department physicians at the lowest level of CPT code when the claim lacks documentation to support the level of service billed.

The Plan conducts weekly random claims reviews of all claims. The review was not comprehensive and the denial of the emergency room claims with high level E&M codes was not detected during the random claim review process.

The Plan determined that 12 claims were affected by the edit and would be reprocessed. The Plan stated a team is working to develop a process to adjust the claims and reimburse the denied claims by July 2019.

The Plan withheld or delayed payment to providers for services provided and put the burden on the provider to resubmit or dispute the claim.

3.3.2 Prior Authorization and Family Planning Claims

Members have the right to access family planning services through any family planning Provider without Prior Authorization. Contract, Exhibit A, Attachment 9(9)(A)

Contractor shall reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS rate. Contract, Exhibit A, Attachment 8(9)

The Plan's policy, CA OPS 030 Access to Services with Special Arrangements stated, family planning services can be provided by an out-of-network provider and without prior authorization.

The Plan improperly denied claims for family planning services for lack of prior authorization. The verification study showed that nine out of ten family planning claims were either partially or fully denied for the lack of prior authorization and were not reprocessed until April 2019.

The Plan discovered the data entry error during the pre-onsite audit documentation request. The Plan stated that the issues were corrected in April 2019.

The Plan explained that some provider types were entered into their computer system as independent physicians and were not linked to a clinic. The claims system did not recognize these providers as appropriate for family planning services and denied the claims for prior authorization.

The Plan determined 308 claims were improperly denied and stated they were sent for reprocessing. However, two claims for laboratory services, not related to the data entry error, were also denied for prior authorization. The Plan did not provide an explanation for the denials.

The Plan conducts weekly random claim reviews of the claims universe. The review was not comprehensive and the denial of family planning services lacking prior authorization was not detected.

The Plan's improper denial of claims withheld or delayed payment to providers for services provided and put the burden on the provider to resubmit or dispute the claim.

RECOMMENDATIONS:

3.3.1 Develop and implement policies and procedures to ensure emergency room claims, at a minimum, are paid at the lowest level of evaluation and management codes.

3.3.2 Implement policies and procedures to ensure all family planning services are paid without prior authorization.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: UnitedHealthcare Community Plan of California, Inc.
AUDIT PERIOD: April 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 28, 2019 through June 7, 2019**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).
GMC Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
GMC Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
GMC Contract A.14.3.A

SUMMARY OF FINDING(S):

4.1.1 Medical Director's Review of Quality of Care (QOC) Grievances

The Contract states, "Ensure that the person making the final decision for the proposed resolution of grievances and appeals has neither participated in any prior decisions related to the grievance or appeal, nor is a subordinate of someone who has participated in a prior decision, and has clinical expertise in treating a member's condition or disease if deciding on any of the following:

1. An appeal of a denial based on lack of medical necessity;
2. A grievance regarding denial of an expedited resolution of an appeal; and
3. Any grievance or appeal involving clinical issues."

Exhibit A, Attachment 14 (1)(D)

"Contractor shall maintain a full time physician as medical director, pursuant to 22 CCR 53913.5, whose responsibilities shall include, but not be limited to, the following: (E) Resolve grievances related to medical quality of care." Exhibit A, Attachment 1(6) (E),

"All grievances and appeals related to medical quality of care issues shall be immediately submitted to the MCP's medical director for action." APL 17-006

"Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to Contractor's Medical Director." Exhibit A, Attachment 14 (2)(B)(4)

The Plan did not direct all QOC grievances to the Medical Director for immediate resolution. Instead, the Plan's clinical reviewers processed the QOC grievances. Clinical reviewers (RNs are not licensed to treat medical conditions) made determinations in all twenty QOC grievance files reviewed for verification study. As a result, the Medical Director only reviewed eight of the twenty QOC grievances that the RN clinical reviewers determined to be severe.

The Plan's policy, QOC Investigation, Improvement Action Plans and Disciplinary Actions ID-5776, did not direct the clinical reviewers to send all QOC grievances to the Medical Director. Instead, the policy directed clinical reviewers to assign QOC severity grievance a level of 0-3. The policy then instructed clinical reviewers to handle grievances severity level 0 and 1 and to forward QOC grievances severity level 2 and 3 to the Medical Director.

By training its clinical reviewers to send only grievances they deemed most severe to the Medical Director, the Plan prevented the Medical Director from reviewing all QOC grievances. Allowing staff other than the Medical Director to review all QOC grievances is inconsistent with the Contract and federal regulations.

The Plan risks adverse outcomes by allowing individuals not qualified or licensed to treat medical conditions to review and decide QOC grievances. Non-physician reviewers may not appreciate complex medical issues. As a result, members may not receive timely and medically necessary care.

4.1.2 Complete Resolution of Grievances Prior to Resolution Letters

The Contract states, "Contractor shall have in place a system in accordance with 28 CCR 1300.68." Exhibit A, Attachment 14 (1)

"Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance." 28 CCR 1300.68 (a)(4)
"Resolved means that the grievance has reached a final conclusion with respect to the

beneficiary's submitted grievance as delineated in existing state regulations. The MCP shall ensure adequate consideration of Grievances and Appeals and rectification when appropriate." APL 17-006

The Plan did not ensure adequate consideration and resolution before closing the grievances and mailing resolution letters to members. The auditor's review of grievance files disclosed, eight instances where the Plan closed grievances while still waiting for the providers' response to the grievances.

The Plan's Standard Operating Procedure lacked sufficient instructions for staff processing grievances. The lack of instructions resulted in staff closing grievances prior to full resolution.

By closing grievances before full resolution, the Plan does not ensure members receive appropriate and timely medically necessary services. As a result, members' medical conditions may worsen, resulting in poor health outcomes, hospitalizations or emergency visits.

RECOMMENDATIONS:

4.1.1 Develop policies and procedures to ensure that the Medical Director reviews all QOC grievances.

4.1.2 Develop policies and procedures to ensure complete resolution of grievances before closing the grievance and mailing resolution letters.

4.3	CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:
Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316….
GMC Contract G.III.C.2

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS**. (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.
2. **Investigation and Investigation Report**. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information …to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: UnitedHealthcare Community Plan of California, Inc.
AUDIT PERIOD: April 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 28, 2019 through June 7, 2019**

4.3	CONFIDENTIALITY RIGHTS

3. **Complete Report**. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

GMC Contract G.III.J

SUMMARY OF FINDING(S):

4.3.1 HIPAA Reporting Timeline

The Contract states "notify Department of Health Care Services (DHCS) immediately upon the discovery of a breach of unsecured PHI… is reasonably believed to have been, accessed or acquired by an unauthorized person... (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement…A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate". Contract A03, Exhibit G (III)(J)(1)

The Contract states, "immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time…" Contract A03, Exhibit G (III)(J)(2)

The Contract states, "provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure". Contract A03, Exhibit G (III)(J)(3)

The Plan maintains a log to report HIPAA incidents, however the log did not have any suspected or potential HIPAA incidents to report to DHCS during the audit period. Therefore, no review was performed to determine the actual timeliness of the Plan's investigative and reporting process by means of the verification study methodology. The Plan stated that there were no incidents because their membership is less than 10,000 members. DHCS did not observe any issues with the Plan's HIPAA incident detection system.

The auditor examined the Plan's HIPAA processes by reviewing the Investigation Process for C&S CA Matters, HIPAA Policy number CA OPS 127 HP, and staff interviews to determine if the system structure complies with Contract requirements.

The Plan stated during an interview that it begins its reporting timeline to file a PIR to DHCS after the time its national privacy office receives and reviews an incident that is submitted from California staff.

The Plan's process for PIR delays reporting by requiring submission to and review by their national privacy office before reporting to DHCS.

The Contract states that the Plan is required to begin the reporting timeline on the date any employee first discovers a potential breach as stated in the following contract language:

> "A breach shall be treated as discovered by Business Associate (the Plan) as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate."

This deviation in methodology will result in potential HIPAA breaches to not be reported timely to DHCS.

The purpose of the timely reporting requirements is to help ensure patient safety and privacy. If HIPAA incidents are not reported in a timely fashion to DHCS, there could be a lapse in appropriate action to mitigate the impact of protected information breaches.

4.3.2 Missing HIPAA Breach Requirements in Policies and Procedures

Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Contract A03, Exhibit G(III)(C)(2)

The Plan's draft "HIPAA Policy" is missing the following language about submitting complete PIRs within 10 working days:

> "provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure". Contract A03, Exhibit G (III)(J)(3)

Missing HIPAA breach requirements in the Plan's policies and procedures may lead to these requirements being left out of the Plan's HIPAA system implementations and out of employee trainings.

RECOMMENDATIONS:

4.3.1 Develop and implement procedures and corrective actions to ensure compliance with HIPAA privacy incident reporting requirements.

4.3.2 Develop and implement policies and procedures to which comply with contract requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthcare Community Plan of California, Inc.

AUDIT PERIOD: April 1, 2018 through April 30, 2019
DATE OF AUDIT: May 28, 2019 through June 7, 2019

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.

Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
GMC Contract A.4.12

Provider Qualifications:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
GMC Contract A.4.12.A

Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within 10 working days after the Contractor places a newly contracted provider on active status…Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.
GMC Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
GMC Contract A.4.12.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: UnitedHealthcare Community Plan of California, Inc.
AUDIT PERIOD: April 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 28, 2019 through June 7, 2019**

5.2	PROVIDER QUALIFICATIONS

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process. GMC Contract A.4.12.D

SUMMARY OF FINDING(S):

5.2.1 New Provider Training

Contractor shall ensure that all network Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations. Contractor shall ensure that Network Provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between, Contractor, Network Provider, Member and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within 10 working days after Contractor places a newly contracted Network Provider on active status. Contractor shall ensure that Network Provider training includes, but is not limited to, information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS. Contract Exhibit A, Attachment 7 (5)

The Plan did not complete training for new providers' within10 working days of adding them to its Medi-Cal Managed Care network. DHCS reviewed the Plan's new providers Training Log and conducted a verification study of eight provider training files.

The verification study revealed none of the new provider training files reviewed had indicated training was completed within 10 working days of being placed in the active status. In addition, over 90% of the providers on the Plan's new providers log were trained beyond the 10 day requirement.

DHCS reviewed the document titled "Process for Advocate Outreach to Educate Providers for Community & State." This document states, "once new providers are identified, conduct Advocate introduction and schedule time for C&S Care Provider

training within 10 business days."

The Plan did not have documentation to show that all network providers received training regarding the Medi-Cal Managed Care program. The Plan did not know what caused the lack of compliance.

The purpose of new provider training is to ensure providers are knowledgeable about information on all member rights, clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity specific to the Medi-Cal managed care population. Members are at risk of improper treatment and infringement of their Medi-Cal rights if training is not administered in a timely fashion.

RECOMMENDATION:

5.2.1 Develop and implement a process to ensure timely training of newly contracted providers.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: UnitedHealthcare Community Plan of California, Inc.
AUDIT PERIOD: April 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 28, 2019 through June 7, 2019**

6.2	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

GMC Contract E.2.25.B

SUMMARY OF FINDING(S):

6.2.1 Fraud Reporting Timeline

The Contract states, "Prompt referral of any potential Fraud, Waste, or Abuse that Contractor identifies to the DHCS Audits and Investigations Intake Unit. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the

suspected Fraud and/or Abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity". Contract A03, Exhibit E(2)(25)(B)(7)

The Plan did not have any cases of suspected or potential fraud incidents during the audit period. Since there were no fraud incidents recorded during the audit period, there was no way to determine the actual timeliness of the investigative and reporting process using the verification study methodology. The Plan stated that there were no incidents because their membership is less than 10,000 members. DHCS did not observe any issues with the Plan's fraud detection system.

The auditor conducted interviews with the Plan's fraud and abuse staff and examined the Plan's internal documentation process to determine the Plan's compliance with the Contract.

The Plan's policies and procedures incorrectly delayed the timeline to report Fraud and Abuse incidents to DHCS. The Contract language requires the Plan to provide "Prompt referral of any potential Fraud, Waste, or Abuse that Contractor identifies to the DHCS Audits and Investigations Intake Unit. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity."

The Plan's policy is to report suspected fraud and abuse incidents to DHCS after its' national privacy office conducts their review of the incident. This process may take up to 30 days. The Plan is required to report any suspected incident the date an employee discovers the potential fraud and/or abuse, or the date the information is received by the national fraud team if it is reported by someone outside of the Plan.

This deviation in the Plan's methodology may result in potential fraud breaches being reported untimely to DHCS.

The purpose of the timely reporting requirements is to ensure fraud is promptly investigated. If fraud incidents are not reported timely to DHCS, there could be a lapse in appropriate action in preventing the loss of public funds.

6.2.2 Fraud Reporting Timeliness

The Contract states, "The procedures must include a compliance program, as set forth in 42 CFR 438.608(a), that at a minimum includes all of the following elements…Written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements". Contract A03, Exhibit E(2)(25)(B)(1)(a)

The Plan did not have a policy and procedure to document fraud and abuse reporting and related requirements. The Plan submitted the Annual Antifraud Report and the United Health Care Fraud, Waste and Abuse program 2017-2018 document. This document contains the mission statement, scope and the FWA framework, and other information about the Plan's FWA program. However, there is no mention of the Plan's contract responsibility to establish administrative procedures to report all cases of suspected fraud and/or abuse cases to DHCS.

The missing policies and procedures may lead to fraud reporting requirements being left out of the Plan's fraud and abuse system implementations and of employee trainings.

RECOMMENDATIONS:

6.2.1 Develop and implement procedures and corrective actions consistent with contractual requirements to ensure compliance with fraud reporting requirements.

6.2.2 Develop and implement policies and procedures to report all suspected fraud, waste, and abuse to DHCS as required by the Contract.

MEDICAL REVIEW – NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

UNITEDHEALTHCARE COMMUNITY PLAN of CALIFORNIA, INC.

Contract Number: 17-94403
17-94405
State Supported Services

Audit Period: April 1, 2018
Through
April 30, 2019

Report Issued: October 18, 2019

TABLE OF CONTENTS

I. INTRODUCTION 1

II. COMPLIANCE AUDIT FINDINGS 2

I. INTRODUCTION

This report presents the audit findings of United Health Care Community Plan of California, Inc. (Plan) State Supported Services Contract Numbers 17-94403 and 17-94405. The State Supported Services contracts covers contracted abortion services with the Plan.

The onsite audit was conducted from May 28, 2019 through June 7, 2019. The audit period is April 1, 2018 through April 30, 2019. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthCare Community Plan of California, Inc.

AUDIT PERIOD: April 1, 2018 through April 30, 2019
DATE OF AUDIT: May 28, 2019 through June 7, 2019

CATEGORY 1 - UTILIZATION MANAGEMENT

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDING:

SSS.1 Sensitive Service Claim Denials

Members have the right to access family planning services through any family planning Provider without Prior Authorization. Contract, Exhibit A, Attachment 9(9) (A).

Contractor shall reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal Fee for Services (FFS) rates. Contract, Exhibit A, Attachment 8(9).

The Plan denied payment of abortion claims for lack of prior authorization for services performed by out-of-network providers. The verification study shows that two of ten claims were either partially or fully denied for prior authorization.

The Plan's policy, CA OPS 030 Access to Services with Special Arrangements states, that Medi-Cal members have access to pregnancy termination services without prior authorization for outpatient services from any provider, including out-of-network providers. The Plan is not following their policies and procedures by denying family planning claims.

The Plan stated that the denials are a result of a manual computer data entry error.

Certain providers were manually classified into the system as independent physicians when they should have been linked to family planning clinics. This caused the system to incorrectly classify the abortion claims as requiring prior authorization leading to denial of claims instead of automatic approval.

The Plan discovered the data entry issue during the pre-onsite request and corrected the classification to identify and link physicians with their clinics in April 2019.

The Plan's oversight of the sensitive services claims adjudication process did not detect this error. The Plan performs weekly Random Claim Reviews; however, because of the random nature of the reviews the Plan did not catch the denials for prior authorization.

The Plan's denial of abortion claims for prior authorization lead to a withholding or delay of payments to providers for services provided. This withhold or delay of payments may cause the providers to spend more time resubmitting and disputing these claims and impair the members access to care.

RECOMMENDATION:

SSS.1 Ensure that the Plan's policies and procedures are followed and that abortion claims are paid without requiring prior authorization.