

MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE CAL MEDICONNECT AUDIT OF

**Blue Shield of California
Promise Health Plan**

2022

Contract Number: 13-90496
Cal MediConnect Three-Way
Contract

Audit Period: January 1, 2021
Through
December 31, 2021

Date of Audit: January 18, 2022
Through
January 27, 2022

Report Issued: July 13, 2022

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I. INTRODUCTION

Blue Shield of California Promise Health Plan (Plan) is a Health Maintenance Organization, wholly owned and operated by Blue Shield of California. The Plan provides Medi-Cal Managed Care services in San Diego County. Blue Shield of California is an independent member of the Blue Shield Association.

Formerly known as Care 1st Health Plan, Inc., the Plan has maintained a California full-service health plan license under the Knox-Keene Act since 1995. In June 2005, the Department of Health Care Services (DHCS) granted the Geographic Managed Care contract to the Plan to provide health care services to Medi-Cal beneficiaries in San Diego County.

In 2015, Blue Shield of California acquired Care 1st Health Plan. Effective January 1, 2019, the Plan's name was changed to Blue Shield of California Promise Health Plan.

In collaboration with the Centers for Medicare and Medicaid Services (CMS), DHCS operates a program to integrate care for beneficiaries who are eligible for both Medicare and Medi-Cal, known as Cal MediConnect (CMC). The CMC program is an alternative effort under the Coordinated Care Initiative and provides enrolled beneficiaries with a more coordinated, person-centered care experience along with access to new services.

The CMC contract is a Three-Way Contract between CMS, DHCS, and the Plan. CMC members enrolled in the Plan receive all Medicare and Medi-Cal benefits. Benefits include medical, behavioral health, long-term institutional, and home-and community-based services.

As of February 2022, the Plan served 2,697 members through the CMC line of business.

II. EXECUTIVE SUMMARY

This report presents the results of the DHCS audit of the Plan's CMC Contract for the audit period January 1, 2021 through December 31, 2021. The review was conducted from January 18, 2022 through January 27, 2022. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on June 2, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in the report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

The audit evaluated five categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

The prior DHCS CMC audit issued on July 31, 2019, for the audit period of January 1, 2018 through December 31, 2018, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP close-out letter dated November 6, 2020, documented that DHCS closed all previous findings. This year's audit included review of documents to determine implementation and the effectiveness of the Plan's CAP.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the current findings by category follows:

Category 1 – Utilization Management

Category 1 includes requirements and procedures for the UM program, including prior authorization review, and the appeal process.

The Plan must ensure that individuals who are health care professionals with clinical expertise in treating the member's condition or disease review appeals involving clinical issues. The Plan did not ensure that expedited appeals were reviewed by a health care professional with clinical expertise in treating the member's condition or disease.

For appeals resolved in favor of the member, the Plan shall ensure that the written response contains the date it was completed and a clear and concise explanation of the reason, including the reason for why the decision was overturned. The Plan's notice of appeal resolution letters did not contain the reason why the decision was overturned.

The Plan is required to obtain written consent of the member when a provider or an authorized representative requests an appeal or files a grievance on behalf of a member. The Plan did not obtain written consent from a member when a provider filed an appeal on the member's behalf.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements and procedures for Health Risk Assessment (HRA) and Individualized Care Plans (ICP).

The Plan is required to complete a HRA to assess a member's current health risk within 45-calendar-days of enrollment for those members identified through the risk stratification as higher risk, and within 90-calendar-days of coverage for those identified as lower risk. With consideration of All Plan Letter (APL) 20-011, *Governor's Executive Order N-55-20 in Response to COVID-19*, the Plan did not ensure the provision of a HRA to each new member within the required timeframes.

The Plan is required to develop ICPs within 90-calendar-days of enrollment. The Plan did not develop an ICP for each new member within 90-calendar-days of enrollment.

Category 3 – Access and Availability of Care

Category 3 includes the requirements and procedures to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not utilize the PCS forms to determine the appropriate level of service for NEMT.

The Plan is required to ensure that all NEMT services have prior authorization. The Plan did not consistently require prior authorization for NEMT services.

The Plan must ensure its transportation providers are enrolled in the Medi-Cal program. The Plan contracted with NEMT vendors not enrolled in the Medi-Cal program.

Category 4 – Member's Rights

There were no findings in this category.

Category 5 – Quality Management

There were no findings in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Medical Review Branch conducted this audit of the Plan to ascertain that Medicaid-based medical services provided to CMC members complied with federal and state laws, Medi-Cal regulations and guidelines, and the Three-Way Contract.

PROCEDURE

The review was conducted from January 18, 2022 through January 27, 2022 for the audit period January 1, 2021 through December 31, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine the effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: Ten denied medical and five denied pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: 15 medical prior authorization appeals and five expedited prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

HRA and ICP: 20 medical records were reviewed for care coordination, completeness, and timeliness.

Category 3 – Access and Availability of Care

NEMT and NMT: 15 NEMT and 15 NMT records were reviewed to confirm compliance with transportation requirements and appropriateness of services provided.

Category 4 – Member's Rights

Grievance procedures: Ten quality of care and 25 quality of service standard grievances, three exempt grievances, and ten call inquiries were reviewed for timely resolution, appropriate classification, response to complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

Category 5 – Quality Management

QI System: Five potential quality incident cases were reviewed for timely evaluation and effective action taken to address needed improvement.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Expedited Appeals

The Plan shall establish and maintain an expedited review process for appeals, when the Plan determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (*Three-Way Contract, section 2.15.3.5.1.*)

In compliance with Title 42, Code of Federal Regulations (CFR), section 438.406(b), the Plan is required to ensure that decision makers on Appeals are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply: a denial of an appeal based on lack of medical necessity; a grievance regarding denial of expedited resolution of an appeal; or any appeal involving clinical issues. (*Three-Way Contract, section 2.15.3.3.6.*)

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated as part of the Plan's formal appeal system, the decision-maker shall be a health care professional with clinical expertise in treating the member's condition or disease if the following applied:

- An appeal of an Adverse Benefit Determination (ABD) that is based on lack of medical necessity
- A grievance regarding denial of an expedited resolution of an appeal
- Any grievance or appeal involving clinical issues

Furthermore, the policy stated if the appeal is for a clinically urgent situation, the appeal and grievance Coordinator will immediately forward the case to the assigned Registered Nurse (RN) or Licensed Vocational Nurse (LVN) for review. The assigned nurse will then request an immediate review by the Medical Director for a clinical review.

Finding: The Plan did not ensure that expedited appeals were reviewed by a health care professional with clinical expertise in treating the member's condition or disease.

The verification study found two of eight expedited appeal cases were downgraded to standard by non-qualified staff.

- One case was downgraded by a LVN.
- Another case was downgraded by an Intake Coordinator.

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In both cases, the non-qualified staff did not consider that taking the time for a standard resolution could jeopardize the members' life, physical or mental health, or ability to attain, maintain, or regain maximum function.

In addition to Plan policy 10.19.5, *Beneficiary Grievance Management System*, the Plan's Desktop Procedure, *Blue Shield Promise_Medi-Cal and CMC Grievance and Appeals* (effective December 2020), stated a member may request to file an expedited appeal should the member believe their request is urgent. When a member requests to file an expedited appeal, the Customer Care Representative should inform the member that the Medical Director will review the case to determine if it meets the expedited criteria. However, the Plan confirmed nurses downgraded expedited appeals without a Medical Director review.

If the Plan does not ensure expedited appeals are reviewed by health care professionals with clinical expertise in treating the member's condition or disease, members may not receive necessary services timely, which could result in poor health outcomes.

Recommendation: Implement policies and procedures to ensure that expedited appeals are reviewed by a health care professional with clinical expertise in treating the member's condition or disease.

1.3.2 Notice of Appeal Resolution Letters for Overturned Appeals

Regarding enrollee appeals, Integrated Notice of Action, the notice must explain the action the Plan has taken or intends to take; and the reasons for the action, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's ABD. Such information shall include medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (*Three-Way Contract, sections 2.15.1.1.1 and 2.15.1.1.2*)

The Plan's resolution, containing a written response to the grievance shall contain a clear and concise explanation of the Plan's decision. (*California Code of Regulations (CCR), Title 28, section 1300.68(d)(3)*)

For appeals resolved in favor of the member, the Plan shall ensure that the written response contains the date it was completed and a clear and concise explanation of the reason, including the reason for why the decision was overturned. (*APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates, issued August 31, 2021*)

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Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated that for overturned decisions, appeals resolved in favor of the member, written notice to the member shall include the results of the resolution and the date it was completed. The written response shall contain a clear and concise explanation of the reason, including the reason for why the decision was overturned.

Finding: The Plan's Notice of Appeal Resolution letters did not contain the reason why the decisions were overturned.

The verification study showed that for all ten overturned appeal cases, the resolution letters did not include the reason why the decisions were overturned.

Plan policy 10.19.5, *Beneficiary Grievance Management System*, stated that upon receipt of the completed appeal review from the physician, the appeals and grievances RN/LVN will work with the Case Coordinator to finalize the case. The Case Coordinator verifies that the following elements are included in the system of record: closed case date, physician reviewer's name, determination disposition, physician reviewer's comments, and actions taken. However, the policy did not describe the process for ensuring all the elements of the Notice of Appeal Resolution were included in the letters. The Plan's oversight process was insufficient to detect non-compliance with the format of Notice of Appeal Resolution letters. Further, the Plan stated that its policy and procedure did not state to reference criteria utilized for an overturned appeal.

Omission of the reason or criteria the Plan used to overturn the initial decision did not give providers and members the opportunity to understand why the requests for services are ultimately approved. Effective communication between the health plan, members, and providers is imperative in order to pursue the most appropriate treatment plan covered by the Plan.

Recommendation: Implement policies and procedures to ensure Notice of Appeal Resolution letters include the reasons why the decisions are overturned.

1.3.3 Member's Written Consent for Appeals Filed by a Provider

The Plan shall maintain beneficiary protections for appeals regarding Medi-Cal services; members, members' authorized representative, or a provider with the member's written consent may file the oral or written appeal with the Plan within 60-calendar-days after the Integrated Notice of Action. (*Three-Way Contract, Section 2.15.3.2.*)

If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance on behalf of an enrollee. (*CFR, Title 42, Section 438.402(c)(1)(ii)*)

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Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary. Managed Care Plans (MCP) shall continue to comply with this existing requirement in accordance with the DHCS contract and federal regulations. (*APL 21-011, Grievance and Appeals Requirements, Notice and “Your Rights” Templates, issued August 31, 2021*)

Plan policy 10.19.5, *Beneficiary Grievance Management System* (revised October 2021), stated that an enrollee or their representative may file an appeal of an ABD of a grievance in writing with the Plan within 60-calendar-days after the date of the ABD.

Finding: The Plan did not obtain written consent from a member when a provider filed an appeal on the member’s behalf.

The verification study found that 12 appeals filed by a provider on the member’s behalf did not include written consent from the member.

Plan policy 10.19.5, *Beneficiary Grievance Management System*, did not mention the specific requirement to obtain written consent when the person filing the appeal is the provider. The Plan stated it considered the written consent met when the member agreed to treatment by a provider.

Not obtaining written consent from a member when a provider files an appeal on their behalf may interfere with patient autonomy, which is the right of patients to make decisions about their medical care without their health care provider’s influence.

Recommendation: Revise and implement policies and procedures to ensure that written consent is obtained when a provider files an appeal on the member’s behalf.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	HEALTH RISK ASSESSMENT AND INDIVIDUALIZED CARE PLANS
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2.1.1 Health Risk Assessment

The Plan will complete HRAs for all members. A HRA is an assessment tool which identifies member health needs. The Plan is required to develop a HRA to assess a member's current health risk within 45-calendar-days of enrollment for those members identified through the risk stratification as higher risk, and within 90-calendar-days of coverage for those identified as lower risk. The Plan shall notify Primary Care Physicians (PCPs) of enrollment of any new member who has not completed a HRA within the time period and whom the Plan has been unable to contact. The Plan shall encourage PCPs to conduct outreach to their members. (*Three-Way Contract, section 2.8.2*)

Medicare-Medicaid Plans (MMPs) are required to document and report their outreach efforts to enrollees related to HRAs, including telephone attempts, mailing dates of the HRA, enrollee refusals to participate in the HRA process, requests for in-person HRAs, and other outreach efforts, as determined by DHCS.

The following process applies to enrollees who are categorized as higher risk and must be completed by the MMP within 45-calendar-days of enrollment:

- Day 1 to Day 30 – MMP attempts at least five phone calls (two within ten-business-days of the enrollment date).
- Day 31 to Day 40 – If the MMP is unable to complete the HRA by the 30th calendar day, it must mail the HRA to the enrollee by the next business day.
- Day 41 and Day 45 – If the enrollee has not completed a HRA, the MMP must attempt another phone call.
- Six Months After Enrollment – If the MMP is unable to complete the HRA due to a lack of response from the enrollee, the MMP must mail a HRA to the enrollee.

(*Dual Plan Letter (DPL) 17-001, Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect, issued July 11, 2017*)

On April 22, 2020, the Governor of the State of California issued Executive Order (EO) N-55-20. The EO provided for various flexibilities in relation to State statutes and regulations, thereby allowing DHCS to take appropriate actions to mitigate the effects of the COVID-19 Public Health Emergency (PHE). Pursuant to this EO authority, DHCS issued the following temporary flexibilities: DHCS extended the timeframes for completing HRA surveys in an effort to ensure staff time and resources are directed to

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urgent care needs. For the duration of the PHE, MCPs must conduct a HRA survey to comprehensively assess each newly enrolled member's current health risk. For members identified as high risk, completion must be within 135 days of enrollment and 195 days for those identified as low risk. On June 30, 2021, the flexibilities provided in EO N-55-20 terminated. Therefore, effective July 1, 2021, HRAs for any newly enrolled members must be completed in alignment with the standard timeframes in place prior to EO, as required by State law. HRAs related to enrollment that occurred on or before June 30, 2021, will remain subject to extended timeframes. (*APL 20-011, Governor's Executive Order N-55-20 in Response to COVID-19, revised July 8, 2021*)

Plan policy 90.4.3, *Risk Stratification and Health Risk Assessment* (revised March 2020), stated that the Plan will provide an initial HRA to all higher risk members within 45-calendar-days of enrollment and to lower risk members within 90-calendar-days of enrollment.

Plan policy 10.4.4, *Health Risk Stratification and Assessment Process* (revised January 2021), stated that the Plan contracted with a vendor to conduct the HRA process. The vendor is to complete all member files within 45 days of enrollment. The Plan provides the vendor with one distinct data file on a monthly basis containing current member eligibility. The vendor will then conduct HRAs telephonically from the vendor's centralized call center. The vendor will conduct HRA in 2 phases:

- Phase 1: Three telephonic attempts within a seven-day period
- Phase 2: Two additional telephonic attempts. If unsuccessful, the HRA is mailed. Phase 2 occurs within a seven-day period immediately following Phase 1.

Finding: The Plan did not ensure the provision of a HRA to each member within the required timeframes.

The verification study found 12 of 20 member HRA records were not completed timely.

- Members with enrollment on or before June 30, 2021:
 - Three members identified as high risk had a HRA completed between 152 and 284 days of enrollment.
 - Three members identified as low risk had a HRA completed between 212 and 298 days of enrollment.
- Members with enrollment after June 30, 2021:
 - Six members identified as high risk had a HRA completed between 70 to 105 days of enrollment.

As part of the prior CAP, the Plan implemented a monitoring tool to ensure HRA completion. Since implementation of the monitoring tool, the Plan stated it transitioned to a new prospective audit tool that is more comprehensive. The new audit tool helps maintain compliance with HRA/ICP population and includes all members, specific time

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periods, effective dates, and calls made. However, the transition to the new audit tool began in October 2021.

In addition to the monitoring tool, the Plan dedicated a Program Manager to assist with all escalations and monitoring of the vendor's process. The Plan stated it contracted with an outside vendor to complete HRA outreach attempts. Vendor outreach attempts such as phone calls and mailings were documented within the records reviewed by the audit team, however, outreach was not done within the required timeframes as stipulated in DPL 17-001. The Plan did not ensure that its vendor outreach mechanism was effective, which resulted in untimely HRAs to members.

Failure to provide timely HRA to members can increase the risk of an adverse health outcome. The Plan may be unable to identify members' health care needs, which has the potential to delay appropriate referrals for services necessary for their medical conditions.

This is a repeat finding of the prior audit (2019) – CC.1a Health Risk Assessment.

Recommendation: Revise and implement policies and procedures to ensure the provision of a HRA to each member within the required timeframes.

2.1.2 Individualized Care Plan

The HRA will serve as the starting point for the development of the ICP. The Plan will develop a comprehensive, person-centered ICP for each member that includes goals and preferences, measurable objectives, and timetables to meet medical, behavioral health, and Long-Term Services and Support needs. The ICP must be completed within 90-calendar-days of enrollment. The Plan will provide the ICP to members no less than annually. (*Three-Way Contract, section 2.8.3*)

Plan policy 90.4.2, *Individual Care Plan* (revised March 2020), stated that the Plan will develop an ICP for each member initially, at least annually thereafter, and when a significant change in condition occurs.

Finding: The Plan did not develop an ICP for each new member within 90-calendar-days of enrollment.

The verification study found for five of 20 member HRA records, the Plan developed ICPs between 91 and 301 days of enrollment.

As part of the prior CAP, the Plan addressed the finding by sending members a follow-up letter, utilizing monitoring reports to track timelines, and updating its policies.

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However, the updated Plan policy 90.4.2, *Individualized Care Plan*, did not state the Plan will develop ICPs within 90-calendar-days of enrollment.

Failure to timely develop an ICP may result in the Plan's inability to identify whether members' health care needs are addressed, met, or in need of reassessment in order for the member to improve or maintain their current health status.

This is a repeat finding of the prior audit (2019) – CC.1b Individualized Care Plan.

Recommendation: Revise and implement policies and procedures to ensure the provision of an ICP to each new member within 90-calendar-days of enrollment.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8

NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement

The Plan shall provide services to enrollees that include NMT and NEMT benefits. The Plan must provide transportation services to beneficiaries for medically necessary services. The Plan must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare and Institutions Code 14132(ad) and the requirements in applicable current and future DPLs. (*Three-Way Contract, Appendix A: Covered Services, section A.3.2*)

NEMT services are subject to prior authorization. MMPs and transportation brokers are required to use a DHCS-approved PCS form to determine the appropriate level of service for MMP members. (*DPL 18-001, Non-Emergency Medical and Non-Medical Transportation Services, issued April 26, 2018*)

Plan policy 70.2.100, *Non-Emergency Medical Transportation Services* (revised November 2021), stated that a Request for NEMT – PCS form must be completed and submitted before NEMT services can be authorized and provided to the member. The PCS form certifies the medical necessity to determine the type of transportation being requested. The Plan’s NEMT oversight team is responsible for monitoring the monthly compliance of authorizations issued and rides occurring with the Request for NEMT – PCS forms.

Finding: The Plan did not utilize the required DHCS-approved PCS forms to determine the appropriate level of service for Medi-Cal members.

The verification study found that eight of 15 sample records did not utilize a PCS form. Selected cases for review were reflective of the entire audit period.

The Plan confirmed their UM team did not ensure that PCS forms and Treatment Authorization Requests (TAR) were received before issuing authorizations. The Plan stated to address these deficiencies and simplify the authorization process, the PCS and TAR have been consolidated into a one page form. However, the form was not approved until September 2021.

If the Plan does not utilize PCS forms, members may not receive the appropriate level of service necessary for their medical condition.

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Recommendation: Implement policies and procedures to ensure that all NEMT requests include a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members.

3.8.2 Treatment Authorization Request

The Plan shall provide services to enrollees that include NMT and NEMT benefits. The Plan must provide transportation services to beneficiaries for medically necessary services. The Plan must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare and Institutions Code 14132(ad) and the requirements in applicable current and future DPLs. (*Three-Way Contract, Appendix A: Covered Services, section A.3.2*)

The Plan is required to ensure that all NEMT services have prior authorization. (*CCR, Title 22, section 51323*)

NEMT services are subject to a prior authorization, except when a member is transferred from an acute level of care, to a skilled nursing facility or intermediate care facility licensed pursuant to Health and Safety Code, Section 1250. (*DPL 18-001, Non-Emergency Medical and Non-Medical Transportation Services, issued April 26, 2018*)

Plan policy 10.3.21, *Non-Emergency Transportation* (revised February 2021), stated that NEMT requests require a TAR and PCS.

Finding: The Plan did not consistently require prior authorization for NEMT services.

The verification study found that eight of 15 sample records did not include a TAR, none of which were exceptions as stated in DPL 18-001. Selected cases for review were reflective of the entire audit period.

The Plan confirmed their UM team did not ensure that PCS forms and TARs were received before issuing authorizations. The Plan stated to address these deficiencies and simplify the authorization process, the PCS and TAR have been consolidated into a one page form. However, the form was not approved until September 2021.

If the Plan does not utilize a TAR, members may not receive the transportation method necessary for their medical condition.

Recommendation: Implement policies and procedures to ensure that all NEMT requests include prior authorization.

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3.8.3 Non-Enrolled NEMT Transportation Providers

The Plan must ensure that all network providers and subcontractors are enrolled in the Medi-Cal program. (*CFR, Title 42, section 438.602(b)*)

MCP may enter into subcontracts with other entities in order to fulfill the obligations of the Contract... shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 422.504(i), 423.505(i), 438.230(b)(3), (4) and 22 CCR Section 53867. (Three-Way Contract, section 2.9.10.2)

All MCP network providers must enroll in the Medi-Cal program. MCPs have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL or they may direct their network providers to enroll through DHCS. (*APL 19-004, Provider Credentialing / Recredentialing and Screening / Enrollment, issued June 12, 2019*)

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. MCP will remain contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the subcontracted functions. (*APL 19-004*)

Finding: The Plan did not ensure contracted NEMT providers were enrolled in the Medi-Cal program.

The Plan utilizes a subcontracted vendor to assist in providing ground transportation services to members. The Plan did not have a process in place to ensure its subcontracted transportation vendor complied with Medi-Cal enrollment requirements during the review period.

The verification study found that four of 19 transportation providers were not enrolled in the Medi-Cal program.

The broker delegated the NEMT services to their subcontractors. The Plan's agreement with its transportation broker stated the broker's scope of work includes subcontractor credentialing, as well as ensuring all delegated entities and subcontractors meet requirements set forth by the Plan and DHCS where applicable.

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The Plan stated subcontractor information was annually requested to verify enrollment in the Medi-Cal program. The audit team reviewed the Plan's monitoring report, dated October 2021, and found the Plan did not completely and accurately ensure subcontractors were enrolled. The report identified one non-enrolled subcontractor as enrolled and one enrolled subcontractor as not enrolled in Medi-Cal.

If the Plan contracts with transportation providers not enrolled in the Medi-Cal program, it cannot ensure that members receive adequate and safe transportation services.

Recommendation: Implement policies and procedures to ensure NEMT providers are enrolled in the Medi-Cal program.