DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

REPORT ON THE FOCUSED AUDIT OF INLAND EMPIRE HEALTH PLAN 2023

Contract Number: 04-35765

Audit Period: August 1, 2022 Through July 31, 2023

Dates of Audit: September 18, 2023 Through September 29, 2023

Report Issued: August 30, 2024

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I. INTRODUCTION

Background

In accordance with California Welfare and Institutions Code section 14456, the Department of Health Care Services (DHCS) may conduct additional reviews outside of the annual medical audit when DHCS determines there is good cause.

DHCS directed the Contract and Enrollment Review Division to conduct focused audits of all contracting Medi-Cal Managed Care Plans (Plans) to evaluate the current Plans' performance in the areas of Behavioral Health and Transportation services.

These focused audits differ from DHCS' regular annual medical audits in scope and depth. The annual medical audits evaluate the Plan's organizational structures, policies and procedures, and systems for compliance with contractual requirements. The focused audits examined the operational issues that may hinder appropriate and timely member access to medically necessary care. The focused audit engagement formally commenced in January 2023, through December 2023.

For the Behavioral Health section, the focused audit evaluated the Plan's monitoring activities of specific areas such as Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorder Services (SUDS). The focused audit also reviewed potential issues that may contribute to the lack of member access and oversight for SMHS, NSMHS, and SUDS.

The focused audit conducted a more in-depth look at current Plan operations/practices for executing the delivery of transportation services. The audit examined potential causes for the systemic issues surrounding the Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services, specifically when transportation is delegated to a transportation broker.

Inland Empire Health Plan (Plan) was established on July 26, 1994, as the local initiative Medi-Cal Managed Care Health Plan in the Inland Empire region. The Plan received its Knox-Keene license on July 22, 1996, and commenced operations on September 1, 1996, in Riverside and San Bernardino counties.

The Plan provides managed care health services to Medi-Cal beneficiaries under the provisions of W&I Code section 14087.3. The Plan is a public entity, formed as a Joint Powers Agency, and a not-for-profit health plan. The Plan is headquartered in Rancho Cucamonga, California, created by Riverside and San Bernardino Counties as a Two-Plan Medi-Cal Managed Care model.

The Plan provides health care coverage to eligible members in San Bernardino and Riverside Counties as a mixed model Health Maintenance Organization. The Plan's contracted provider network consists of approximately seven Independent Physician Associations (IPAs) and 34 hospitals. The Plan also directly contracts with 1,381 primary care physicians and 2,595 specialists.

During the audit period, the Plan delegated transportation services to Call-the-Car, a transportation broker.

As of July 31, 2023, the Plan's enrollment for the Medi-Cal line of business was 1,685,464 members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS focused audit for the period August 1, 2022, through July 31, 2023. The review was conducted from September 18, 2023, through September 29, 2023. The audit consisted of document review, surveys, verification studies, interviews and file reviews with the Plan representatives.

An Exit Conference with the Plan was held on July 1, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The focused audit evaluated the areas of performance for Behavioral Health and Transportation services.

The summary of findings by performance area follows:

Performance Area: Behavioral Health

Category 2 – Case Management and Coordination of Care:

- Specialty Mental Health Services
- Non-Specialty Mental Health Services
- Substance Use Disorder Services Category 3 – Access and Availability of Care

The Plan is responsible for the appropriate management of members' mental and physical health care, including mental health services, both within and outside the Plan's provider network. The Plan is required to coordinate care with the appropriate county Mental Health Plan (MHP) for members' mental and physical health care. The Plan did not ensure the provision of coordination of care to deliver mental health care services to members.

The Plan is required to coordinate with county MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to SMHS providers and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. The Plan did not ensure the referral loop was closed and the new provider accepted the care of members transitioning from NSMHS to SMHS and vice versa.

The Plan is required to arrange for member referrals to the county department responsible for substance use treatment, or other community resources when services are not available through counties, for members identified as requiring alcohol or

substance use disorder (SUD) treatment services. The Plan is required to make good faith efforts to confirm whether members receive referred treatments, document when and where treatments were received, and any next steps following treatment. If a member does not receive referred treatments, the Plan must follow up with the member to understand barriers and adjust the referrals if warranted. The Plan did not make good faith efforts to confirm whether members received referred treatments for SUD. The Plan did not follow up with members who did not receive referred treatment to understand barriers and make subsequent adjustments to referrals.

Performance Area: Transportation

Category 3 – Access and Availability of Care

- Non-Emergency Medical Transportation
- Non-Medical Transportation

The Plan is required to have a direct line to the Plan's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT and receive status updates on the NEMT rides. The Plan did not have a direct line to the Plan's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT and receive status updates on the NEMT rides.

The Plan is required to provide NEMT ambulance services, litter van services, wheelchair van services, and NEMT services by air under certain conditions. The Plan did not have policies and procedures for these NEMT modalities.

The Plan is required to ensure that a copy of the Physician Certification Statement (PCS) form is on file for all members receiving NEMT services and that all fields are filled out by the provider. The Plan did not ensure that all fields of the PCS form are filled out by the provider, specifically the prescriber's signature and/or information.

The Plan is required to provide NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care. The Plan did not ensure the delegate, Call-the-Car, provided the appropriate level of service for members requiring ambulatory door-to-door service.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

On November 3, 2022, DHCS informed Plans that it would conduct focused audits to assess the performance in certain identified high-risk areas. The focused audit was concurrently scheduled with the annual medical audit. The audit scope encompassed the following sections:

- Behavioral Health - SMHS, NSMHS, and SUDS
- Transportation – NEMT and NMT services

The audit was conducted from September 18, 2023, through September 29, 2023. 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 2 – Case Management and Coordination of Care

SMHS: Ten samples were reviewed, six from San Bernardino County and four from Riverside County, to evaluate whether there was member care coordination between the Plan and county MHPs, as well as compliance with All Plan Letter (APL) requirements.

NSMHS: Ten samples were reviewed, five each from San Bernardino and Riverside Counties, to evaluate compliance with APL requirements.

SUDS: Ten samples from Riverside County were reviewed to evaluate compliance with APL requirements.

Concurrent SMHS and NSMHS: Ten samples were reviewed, five each from San Bernardino and Riverside Counties, to evaluate compliance with APL requirements.

Category 3 – Access and Availability of Care

NEMT: Ten samples were reviewed, seven from Riverside County and three from San Bernardino County, to evaluate compliance with APL requirements.

NMT: Ten samples were reviewed, six from San Bernardino County and four from Riverside County, to evaluate compliance with APL requirements.

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

COMPLIANCE AUDIT FINDINGS

Performance Area: Behavioral Health – SMHS, NSMHS, and SUDS

Category 2 – Case Management and Coordination of Care

2.1 Case Management and Care Coordination

The Plan is required to coordinate care with the county MHP. The Plan is responsible for the appropriate management of a member's mental and physical health care, which includes, but is not limited to, medication reconciliation and coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health services, both within and outside the Plan's provider network. (APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services)

Plan policy, 12.K.1 Behavioral Health Services (revised January 1, 2023), states that SMHS are organized through the county MHPs. The Plan, IPAs, and providers remain responsible for all necessary physical health care. The Plan and county MHPs provide medically necessary behavioral health interventions. The Plan maintains a Memorandum of Understanding (MOU) with both county MHPs which outlines care management and coordination.

The Plan's MOU with the county MHPs states the Plan will case manage the physical health of the member and coordinate service with the mental health provider. The county MHP will accept referrals from the Plan for determination of medical necessity and provide appropriate mental health specialty evaluation services. The Plan will accept referrals from the county MHP for assessment, makes a determination of medical necessity for outpatient services, and provide referrals within the Plan's mental health provider network. The Plan will arrange and pay for appropriate medical assessments of members to identify co-morbid physical and mental/behavioral health conditions. The Plan will coordinate with the county MHP in conducting outreach efforts. The Plan and county MHP will be responsible for conducting a multidisciplinary clinical team oversight process for clinical operations to include screening, assessment, referrals, care management, care coordination, and exchange of medical information. As part of quarterly Joint Operations Meetings, the Plan and county MHPs will review referral, care coordination and information exchange protocols and processes and monitor member engagement and utilization.

Finding: The Plan did not ensure the provision of care coordination to deliver mental health care services to members.

A verification study of ten members with a referral for SMHS revealed the following:

- Four members did not have documented evidence that they received services.
- Three members did not have documented evidence that showed the Plan followed up to ensure they received services.
- Three members did not have documented evidence that the Plan followed up to ensure they received services within the audit period. The Plan followed up after DHCS requested the member records, which was approximately five to ten months after the referrals were made.

Although the Plan's policy required the Plan to coordinate care with the county MHPs, the policy did not have procedures on how the Plan will monitor and ensure members received referred services with the county MHPs.

The Plan's, Referral to SMHS Workflow (revised July 20, 2023), showed processes related to intake, crisis situations, and referral to the county MHP. However, the Plan's Workflow did not include a process for follow up to ensure that the member actually received the referred SMHS.

The Plan did not provide monitoring reports requested by DHCS. In a narrative response, the Plan stated it is not responsible for monitoring accessibility to SMHS as these services are carved out to the county MHPs.

Members may not receive medically necessary health care if the Plan does not adequately coordinate care with the county MHPs.

Recommendations: Develop and implement policies and procedures to ensure that the Plan coordinates care with the county MHPs for the appropriate management of members' mental and physical health care.

2.2 Referral Loop Closure

The Plan must coordinate with the county MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to SMHS providers and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. (APL 22-005 No Wrong Door for Mental Health Services Policy).

Plan policy, 12.K.1 Behavioral Health Services (revised January 1, 2023), states that the Plan coordinates with the county MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa. When

the Plan refers members to the county MHP, it ensures that the referral process has been completed, the member has been connected with a provider in the new system, the new provider accepts the care of the member, and medically necessary services have been made available to the member.

Finding: The Plan did not ensure that the referral loop was closed, and that the new provider accepted the care of members receiving NSMHS to SMHS or vice versa.

A verification study of ten members with a referral to transition from NSMHS to SMHS, or vice versa, revealed the following:

- Eight members did not have any documentation demonstrating that they received services.
- Six members did not have any documentation that showed that the Plan followed up with them to ensure that they received services.
- One member did not have any documentation that the Plan followed up to ensure that they received services within the audit period. The Plan followed up after DHCS requested member records, approximately five months after the referral was made.

Although the Plan's policy requires the Plan to ensure that the referral process has been completed, the Plan failed to do so. Additionally, the Plan did not have procedures in place to monitor referrals for members who transition from NSMHS to SMHS and vice versa.

The Plan's, Referral to SMHS Workflow (revised July 20, 2023) and Referral to NSMHS Workflow (revised July 11, 2023), did not include a process for member follow up to ensure referred services were rendered.

The Plan did not provide monitoring reports of the referral process as requested. Additionally, in a narrative response, the Plan stated it is not responsible for monitoring accessibility to SMHS as these services are carved out to the county MHPs.

Without ensuring that the referral loop is closed, and the new provider accepts care of the member, the member may not receive medically necessary services.

Recommendations: Revise and implement policies and procedures to ensure that the referral loop is closed, and the new provider accepts care of the member. Develop and implement policies and procedures to monitor the transition of care for members.

2.3 Substance Use Disorder Services- Good Faith Effort to Confirm Treatment

The Plan must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. (APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions, Referral, and Treatment)

Plan policy, 12.K.2 Substance Use Treatment Services (revised January 1, 2023), states that the Plan, IPAs, and providers identify members requiring SUD treatment services and arrange for the referral to the County Behavioral Health Department for substance use treatment, or other community resources.

Plan policy, 10.B Adult Preventive Services (revised January 1, 2023), states that the Plan will make a good faith effort to confirm whether members receive referred treatments and document when, where, and any next steps following treatment.

Plan policy, 10.C.1 Pediatric Preventive Services (revised January 1, 2023), states that the Plan will make a good faith effort to confirm whether members receive referred treatments and document when, where, and any next steps following treatment.

Finding: The Plan did not make good faith efforts to confirm whether members received referred treatments for SUD and did not document when, where, and any next steps following treatment.

A verification of ten members with a referral for SUDS revealed the following:

- Nine members did not have any documentation demonstrating that they received services.
- Eight members did not have any documentation demonstrating that the Plan followed up with them to ensure that they received the referred services.
- Two members did not have any documentation demonstrating that the Plan followed up with them to ensure that they received the referred services within the audit period. The Plan followed up after member records were requested and four to eight months after the referrals were made.

Although the Plan's policy required the Plan to make a good faith effort to confirm whether members received referred treatments and document when, where, and any next steps following treatment. The Plan did not make a good faith effort to confirm next steps following treatment. Additionally, the Plan did not have procedures in place to monitor and ensure members received referred SUDS.

The Plan's, Referral to SUDS Workflow (revised July 11, 2023), did not include a process to follow up with members to ensure that the referred SUDS were actually received.

The Plan did not have monitoring reports for SUDS. In a narrative response, the Plan stated it is not responsible for monitoring accessibility to SUDS as these services are carved out to county MHPs.

Without good faith efforts from the Plan to ensure referred treatment was received by the member, or documentation of when, where, and any next steps following treatment, the member may not receive medically necessary services.

Recommendations: Revise and implement policies and procedures to ensure that the Plan makes good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. Develop and implement policies and procedures to ensure appropriate management and monitoring of SUDS.

2.4 Substance Use Disorder Services Follow Up to Understand Barriers

If a member does not receive referred treatments, the Plan must follow up with the member to understand barriers and make adjustments to the referrals, if warranted. The Plan should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to necessary treatment. (APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions, Referral, and Treatment)

Plan policy, 12.K.2 Substance Use Treatment Services (revised January 1, 2023), states that the Plan, IPAs, and providers identify members requiring SUD treatment services and arrange for the referral to the County Behavioral Health Department for substance use treatment, or other community resources.

Plan policy, 10.B Adult Preventive Services (revised January 1, 2023), states that if a member does not receive referred treatments, the Plan will follow up with the member to understand barriers and make adjustments to the referrals as needed.

Plan policy, 10.C.1 Pediatric Preventive Services (revised January 1, 2023), states that if a member does not receive referred treatments, the Plan will follow up with the member to understand barriers and make adjustments to the referrals as needed.

Finding: The Plan did not have a process in place to follow up with members, understand barriers, and make subsequent adjustments to referrals, if members did not receive referred treatments.

A verification study of ten members with a referral for SUDS revealed the following:

- Nine members did not have any documentation demonstrating that they received services.
- Eight members did not have any documentation demonstrating that the Plan followed up with them to ensure that they received the referred services.
- Two members did not have any documentation demonstrating that the Plan followed up with them to ensure that they received the referred services within the audit period. The Plan followed up after records were requested and four to eight months after the referrals were made.

Although the Plan's policy required the Plan to follow up with the member to understand barriers and make adjustments to the referrals as needed, the Plan did not follow up with the member to understand barriers and make adjustments to the referrals. Additionally, the Plan did not have procedures in place to monitor and ensure that members receive referred SUDS.

The Plan's, Referral to SUDS Workflow (revised July 11, 2023), did not include a process to follow up with members to ensure that the referred SUDS were received.

The Plan did not have monitoring reports for SUDS. In a narrative response, the Plan stated it is not responsible for monitoring accessibility to SUDS as these services are carved out to county MHPs.

If there is no follow up with the member to understand barriers and make adjustments as warranted, the member may not receive medically necessary services.

Recommendations: Revise and implement policies and procedures to ensure that if a member does not receive referred treatment, the Plan must follow up with the member to understand barriers and make adjustments to the referrals, if warranted. Develop and implement policies and procedures to ensure appropriate management and monitoring of SUDS.

COMPLIANCE AUDIT FINDINGS

Performance Area: Transportation – NEMT and NMT

Category 3 – Access and Availability of Care

3.1 Direct Line to Transportation Liaison

The Plan must have a direct line to the Plan's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT and receive status updates on their NEMT rides. (APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)

Plan policy, MC_09C Access Standards Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (revised January 1, 2023), and the Provider Policy and Procedure Manual Medi-Cal, both state under Plan Responsibilities: The Plan has designated the Manager of Transportation Services as the Plan's transportation liaison, who ensures that authorizations are processed during and after business hours. Providers and members may call, request, and schedule urgent and non-urgent NEMT and receive status updates on their NEMT rides through the following avenues, calls and requests will be routed directly to the Plan's transportation liaison, as appropriate:

1. For providers - Provider Call Center at (866) 223-4347; and

2. For members - Member Services Department at (800) 440-4347/ (800) 718-4347 (TTY).

Finding: The Plan did not have a direct line to the Plan's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT and receive status updates on their NEMT rides.

The Plan's policies and procedures identifies its Manager of Transportation Services as the transportation liaison. Members and providers are instructed to access the transportation liaison through the Transportation Services Call Center (for members) and Provider Call Center (for providers) However, the policy does not state the direct line to the transportation liaison. Instead, members and providers are instructed to call a call center number. These call centers will then contact the Plan's transportation liaison to request and schedule urgent and non-urgent transportation and receive status updates on rides.

The Plan stated in the Focused Audit Questionnaire that the transportation liaison's process to ensure that authorizations PCS are being processed during and after business hours is as follows: during normal business hours members have direct access to the member call center, who will then transfer the member to the transportation liaison for assistance. During the interview, the Plan confirmed that there is no direct line to the transportation liaison.

If the Plan does not have a direct line to the transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT and receive status updates on their NEMT rides, this may lead to unnecessary delays in obtaining the rides needed, resulting in poor health outcomes.

Recommendation: Revise and implement policies and procedures to have a direct line to the transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT and receive status updates on their NEMT rides.

3.2 Policies and Procedures for Non-Emergency Medical Transportation Modalities

NEMT Modalities

The Plan must provide NEMT ambulance services for:

- Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
- Transfers from an acute care facility to another acute care facility.
- Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
- Transport for members with chronic conditions who require oxygen if monitoring is required.

The Plan must provide litter van services when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:

- Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
- Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs or other forms of public conveyance.

The Plan must provide wheelchair van services when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:

- Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
- Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs or other forms of public conveyance.

The Plan must provide NEMT by air only under the following conditions:

- When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible.

(APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)

Plan policy, MC_09C Access Standards Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (revised January 1, 2023), states the Plan provides NEMT and NMT services for all prior authorized services and Medi-Cal covered services and related travel expenses.

Finding: The Plan did not have policies and procedures for NEMT modalities regarding NEMT ambulance services, litter van services, wheelchair van services, and NEMT services by air.

Review of the Plan's website, Evidence of Coverage (EOC), Provider Manual, and other documents did not reveal any mention of the NEMT modalities regarding NEMT ambulance services, litter van services, and NEMT services by air. Only the EOC included two of the three wheelchair van services modalities.

While the Plan has transportation Policy MC_09C, Access Standards Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (revised January 1, 2023), it does not contain the APL criteria about the Plan's requirement to detail NEMT modalities regarding NEMT ambulance services, litter van services, wheelchair van services, and NEMT services by air.

If the Plan does not clearly detail the requirements for the different types of NEMT services, members may be denied of transportation services to obtain necessary medical assistance, which may affect the member's health.

Recommendation: Revise and implement policies and procedures to clearly detail the requirements for NEMT ambulance services, litter van services, wheelchair van services, and NEMT services by air.

3.3 Prescriber's Signature and/or Information on Physician Certification Statement Form

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, SUD provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx.

NEMT services are subject to prior authorization. The member must have an approved PCS form authorizing NEMT by the provider.

The Plan must ensure that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. (APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)

Plan policy, MC_09C Access Standards Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (revised January 1, 2023), states in part under prior authorization:

- The Plan ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. Additionally, the Plan has developed a mechanism to capture data from the PCS form and report to DHCS, as required.

Finding: The Plan did not ensure that all fields of the PCS form are filled out by the provider, specifically the prescriber's signature and/or information.

In three of ten cases reviewed, the Plan did not ensure the PCS form was signed by the prescribing provider and/or had the prescriber's information.

During the review of verification study files, the Plan stated that PCS forms are completed through the provider portal, there are two options to fill out the form, and providers certify and attest the PCS form through the portal.

The auditor requested the PCS form for one of the samples. The Plan resubmitted the PCS form sent with the original file submission which did not include the name of the prescribing provider, only the name of the health care center.

The Plan stated that the monitoring process to ensure a PCS form is received, prior to services being rendered is as follows: the Plan requires a review of system alerts to ensure PCS forms are received prior to services being rendered. In the event that a PCS form is not on file, the transportation broker, the Plan's Provider Relations, and the Plan's Transportation Services work together to obtain the PCS form. The transportation broker will make up to three outreach attempts to the member's primary care provider to obtain the PCS form, and also educates the member about this requirement. After all efforts are exhausted, the transportation broker refers to the Plan's Transportation Services to provide support. The Plan's Transportation Services reviews the list of members and sends it to the Plan's Provider Relations for provider outreach. However, given the findings from the verification study samples, the Plan did not consistently follow through with the monitoring process of the PCS form to ensure all fields are filled out by the provider.

If the Plan does not ensure that the prescriber's signature and/or information is reflected on the form, the Plan might be providing services to members that might not qualify for the services or members may not receive the appropriate level of service which may result in member harm.

Recommendation: The Plan must consistently implement existing policies and procedures to ensure that all fields on the PCS form are filled out by the provider including the prescriber's information and signature.

3.4 Ambulatory Door-to-Door

The Plan must provide NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care.

The Plan or its transportation brokers must arrange or provide the modality of transportation prescribed in the PCS form and cannot triage the member's need to assess for the most appropriate level of NEMT service. The Plan is required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. Transportation brokers cannot downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services. (APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)

Plan policy, MC_09C Access Standards Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (revised January 1, 2023), states under the NMT section that the Plan does not require prior authorization for NMT services. These services are a covered Medi-Cal benefit when a member needs to obtain medically necessary services, including those not covered by the health plan, such as, but not limited to, specialty mental health, SUD, dental, and other benefits delivered through the Medi-Cal Fee-for-Service delivery system, including pharmacy services.

Finding: The Plan did not ensure the delegate, Call-the-Car, provided the appropriate level of service for members requiring ambulatory door-to-door service.

Plan policy, MC_09C did not include any information regarding the Plan's requirement that transportation brokers cannot downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.

The Delegation Agreement between the Plan and Call-the-Car states that Medi-Cal NMT modes of transportation covered include ambulatory curb to curb (Transportation Network Companies/Rideshare), ambulatory door-to-door, and bus pass under the screening criteria section of the Scope of Work. The Plan is required to provide NEMT to members needing ambulatory assistance. The Plan incorrectly allows for the delegate to schedule ambulatory door-to-door services as NMT.

The NMT data universe included 287,953 trips of which 32,751 trips were listed as ambulatory, door-to-door. In addition, the NMT seniors and persons with disabilities data universe included 136,146 trips of which 20,609 trips were listed as ambulatory, door-to-door.

A verification study of ten NMT samples revealed that five services were listed as ambulatory door-to-door, all five samples were either a no show or missed trip.

When the delegate does not provide the required NEMT modality for door-to-door assistance, members may not receive the appropriate level of care, which may result in adverse impacts on member health.

Recommendation: Develop and implement policies and procedures to ensure the delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.