DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF SOLANO COUNTY BEHAVIORAL HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 22-20138

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2022 — June 30, 2023

Dates of Audit: December 16, 2024 — December 27, 2024

Report Issued: April 3, 2025

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I. INTRODUCTION

The Solano County Behavioral Health Plan (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing mental health services to county residents.

Solano County is located in Northern California. The Plan provides services within the unincorporated county and in seven cities: Benicia, Dixon, Fairfield, Rio Vista, Suisun City, Vacaville, and Vallejo.

As of December 2024, the Plan had a total of 4,588 members receiving services and a total of 32 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2022, through June 30, 2023. The audit was conducted from December 16, 2024, through December 27, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 19, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 1, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, Access and Information Requirements, Coverage and Authorization of Services, Member Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2017, through June 30, 2020, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was closed at the time of onsite. This year's audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

The summary of the findings by category follows:

Category 2 – Care Coordination and Continuity of Care

There were no findings noted for this category during the audit period.

Category 3 – Quality Assurance and Performance Improvement

There were no findings noted for this category during the audit period.

Category 4 – Access and Information Requirements

There were no findings noted for this category during the audit period.

Category 5 – Coverage and Authorization of Services

The Plan is required to provide or arrange and pay for medically necessary covered SMHS, including Adult Residential Treatment Services (ARTS), for members who meet access criteria. The Plan did not ensure the provision of ARTS for members who met access criteria for this service.

The Plan's Utilization Management Program is required to implement mechanisms to assure authorization decision standards are met and conduct concurrent review for psychiatric inpatient hospital and Psychiatric Health Facility (PHF) services. The Plan did not conduct concurrent review authorization for all psychiatric inpatient hospital and PHF services for its members.

Category 6 – Members Rights and Protection

There were no findings noted for this category during the audit period.

Category 7 – Program Integrity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medically necessary services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Specialty Mental Health Services Contract.

PROCEDURE

DHCS conducted an audit of the Plan from December 16, 2024, through December 27, 2024, for the audit period of July 1, 2022, through June 30, 2023. The audit included a review of the Plan's policies for providing services, procedures to implement these policies, and the process to determine whether these policies were effective. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and ten member referrals from the MHP to MCP were reviewed for evidence of referrals, initial assessments, progress notes of treatment planning, and follow-up care between the MCP and the MHP.

Category 3 – Quality Assurance and Performance Improvement

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

There were no verification studies conducted for the audit review.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Ten member files were reviewed for evidence of appropriate service authorization.

Treatment Authorizations: Ten member files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Category 6 – Members Rights and Protection

Grievance Procedures: Ten grievances were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Appeal Procedures: Five appeals were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 MEMBERS ACCESS TO SPECIALTY MENTAL HEALTH SERVICES

5.2.1 PROVISION OF ADULT RESIDENTIAL TREATMENT SERVICES

The Plan is required to provide or arrange and pay for medically necessary covered Specialty Mental Health Services, including but not limited to ARTS, for members who meet access criteria. *(Contract, Exhibit A, Attachment 2, section (2)(A)(7))*

Plan policy *AAA224, Concurrent Service Authorization for Inpatient and Crisis Residential Services (revised May 25, 2020)* stated that it is the Plan's policy to implement a consistent process of service authorization to manage the care and service utilization of members in Adult Residential settings. The policy also stated that the Plan does not require prior authorization for Adult Residential treatment and that it conducts concurrent review for ARTS.

Finding: The Plan did not ensure the provision of ARTS for members who met access criteria.

Although the Plan policy *AAA224* stated that its protocol is to implement a consistent service authorization process to manage member access to ARTS, it did not detail the process for ARTS assessment or availability of services.

DHCS requested sample ARTS authorizations and utilization management tools, which the Plan was unable to provide. As a result, DHCS was not able to conduct a verification study.

During an interview, the Plan stated that they were unaware of the requirement to provide ARTS. In a written narrative, the Plan stated that it had not implemented an ARTS program that meets the certification and service model requirements and that it did not provide the service to its members.

The review of Plan documents showed that ARTS was not provided by the Plan between 2022 through 2024 in spite of having established policies and procedures for the program.

When the Plan does not ensure members who meet access criteria receive covered services, such as ARTS, members may not receive medically necessary services.

Recommendation: Revise policies and implement procedures for members to receive appropriate access to SMHS, including Adult Residential Treatment Services as required by the Plan's contract.

5.2.2 CONCURRENT REVIEW OF PSYCHIATRIC SERVICES

The Plan is required to comply with all state and federal statutes and regulations, the terms of the contract, with Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract, Exhibit E, section (6)(B))*

The Plan's Utilization Management Program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization review procedures. The concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and PHFs certified by DHCS as Medi-Cal providers of inpatient hospital services. (*BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services)*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; Title 42 of Code of Federal Regulations section 438.230(b)(1))*

Plan policy *AAA224, Concurrent Service Authorization for Inpatient and Crisis Residential Services (revised 5/25/2020)* stated that it is the Plan's policy to conduct concurrent review and authorization for all psychiatric inpatient hospital services and PHF services.

Finding: The Plan did not conduct concurrent review for all psychiatric inpatient hospital and PHF services.

In a verification study, four of ten member records revealed that the Plan did not conduct concurrent review. Instead, the Plan conducted retrospective review that occurred the day of discharge and between 28 and 49 days after discharge.

During an interview, and in a written narrative, the Plan attributed the noncompliance with concurrent review requirements to the transition from in-house authorizations to the delegation to a subcontractor. The Plan claimed that during this transition period, the hospitals and PHFs were in the learning phase, which contributed to their failure to meet the requirements. The Plan failed to provide evidence that it adequately developed corrective action to address authorization processing errors or non-compliant authorizations.

When the Plan does not ensure timely evaluation of members medical necessity and appropriateness of psychiatric inpatient services, the Plan cannot ensure members are receiving medically necessary services.

Recommendation: Implement Plan's written policies and procedures for concurrent review of psychiatric inpatient hospital and PHF services.