DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SANTA ANA SECTION

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

Contract Number: 22-20104

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: May 5, 2025 — May 16, 2025

Report Issued: October 14, 2025

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I. INTRODUCTION

Imperial County Behavioral Health Services (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.

Imperial County is located in the far southeast of California, bordering both Arizona and Mexico. The Plan provides services within the unincorporated county and in four cities: Brawley, Calexico, El Centro, and Winterhaven.

As of June 2024, the Plan had a total of 7,401 members receiving Specialty Mental Health Services (SMHS) services and a total of 263 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from May 5, 2025, through May 16, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on September 16, 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 September 17, 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: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2020, through June 30, 2021, identified deficiencies incorporated in the Corrective Action Plan (CAP), which were later closed out. This year's audit included a review of the Plan's compliance with its DHCS Contract and assessed its implementation of the prior year's CAP.

The summary of the findings by category is as follows:

Category 1 – Network Adequacy and Availability of Services

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

Category 2 – Care Coordination and Continuity of Care

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

Category 4 – Access and Information Requirements

The Plan is required to provide a member who is blind or visually impaired and other individuals with disabilities with communication materials in the individual's requested formats, including Braille. The standard alternative formats options are large print, audio compact disk (CD), data CD, and Braille. Finding 4.1.1: The Plan did not ensure that alternative communication material in Braille was available to its members.

The Plan is required to obtain verbal or written consent from members for the use of telehealth in the delivery of services. Finding 4.4.1: The Plan did not ensure providers obtained verbal or written member consent for telehealth services.

Category 5 – Coverage and Authorization of Services

The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services and shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Finding 5.2.1: The Plan did not implement a concurrent review process to ensure timely authorization of psychiatric inpatient hospital services.

Category 6 – Beneficiary 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 SMHS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from May 5, 2025, through May 16, 2025, for the audit period of July 1, 2023, through June 30, 2024. 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 the Plan's representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Mobile Crisis Services: Fifteen medical records were reviewed for appropriate services, which include coordination of care, crisis assessment, follow-up treatment, safety plans and evidence of warm hand off.

Category 2 – Care Coordination and Continuity of Care

There were no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

Telehealth Services: Fifteen medical records were reviewed to confirm compliant member consent for telehealth services.

Category 5 – Coverage and Authorization of Services

Treatment Authorization (TA): Fifteen medical records were reviewed for appropriate services authorization processes including concurrent review.

Crisis Residential Treatment (CRT): Ten medical records were reviewed for appropriate service authorization processes including Service Authorization Request (SAR) concurrent review.

Adult Residential Treatment (ART): Nine medical records were reviewed for appropriate service authorization processes including SAR concurrent review.

Category 6 – Beneficiary Rights and Protection

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

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 Language and Format Requirements

4.1.1 Member Materials in Braille

Medi-Cal Behavioral Health delivery systems (Mental Health Plans (MHP), Drug Medi-Cal-Organized Delivery System counties, and Drug Medi-Cal counties), and their subcontractors must provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individuals requested standard and non-standard alternative format(s). The standard alternative format options are large print, audio CD, data CD, and Braille. *(Behavioral Health Information Notice (BHIN) 24-007, Effective Communication, Including Alternative Formats, for* Individuals with Disabilities)

Plan policy, *PL01 09-20 Written Materials-Language and Format Requirements* (effective 01/30/2024), states the following: The Plan shall provide alternative format materials to aid members with disabilities including those who are visually impaired. Alternative format materials for all written materials for beneficiaries and potential beneficiaries in an easily understood language and format, utilizing a font size no smaller than 12 points. Any large print document must be printed in a font size no smaller than 20 points. Written materials are also to be available through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of beneficiaries or potential beneficiaries with disabilities or limited English proficiency.

Plan policy, PL01 09-20 states that the Plan shall provide alternative format materials to aid members who are visually impaired. However, this policy does not state that the Plan will make available alternative format materials in Braille.

Finding: The Plan did not ensure the availability of the Braille format as an alternative communication material to SMHS members.

During the interview, the Plan stated that currently they do not have a process in place for providing information in a Braille format. The Plan confirmed Braille has never been requested by members. The Plan intends to develop the translation of documents into Braille and is reaching out to other counties to find options or available vendors to address this issue.

When the Plan does not provide alternative formats to members, such as Braille, it limits member accessibility, preventing the member from having adequate knowledge to make informed decisions. This can result in poor mental health outcomes due to missed or delayed access to necessary behavioral health services.

Recommendation: Revise and implement policies and procedures to ensure the availability of the Braille format as an alternative communication material to members.

4.4 Telehealth

4.4.1 Consent of Telehealth Services

Prior to initial delivery of covered services via telehealth, providers are required to obtain the beneficiaries' verbal or written consent for the use of telehealth as an acceptable mode of delivery services, and must explain the following to beneficiaries:

- The beneficiary has a right to access covered services in-person.
- Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
- Non-Medical Transportation (NMT) benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable. *(BHIN 23-018 Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)*

Plan policy, *PL02-01-117 Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment* (effective 01/01/2024), is applicable to telehealth. The policy states the following: Prior to initial telehealth service delivery, the Plan requires providers to obtain and document in the beneficiary's Electronic Health Records (EHR) their informed consent using the Consent for Telehealth form:

- The beneficiary has a right to access covered services in person.
- The use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
- Non-medical transportation and nonemergency medical transportation benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

If the beneficiary is not able to sign the Consent for Telehealth, providers will document the beneficiary's informed consent in the beneficiary's EHR and efforts will be made to obtain the signed Consent for Telehealth at the next visit. To preserve the beneficiary's right to access covered services in-person, the Plan's provider furnishing services through telehealth must do one of the following:

1. Offer those same services in-person (face-to-face); or
2. Arrange for referral and facilitation of in-person care that does not require a beneficiary to independently contact a different provider to arrange for that care.

Finding: The Plan did not obtain consent before rendering telehealth services and did not ensure all required elements were included in collected telehealth consents.

In a verification study of 15 medical records, the Plan did not meet all telehealth consent requirements as noted below:

- Four out of 15 marked as telehealth in the medical records, were in-person visits and were included in the telehealth universe sample.
- Nine out of 15 did not have consent prior to delivery of service via telehealth as required.
- Three out of 15 medical records have consent, but the provider did not explain to the beneficiary, as required, the right to access covered services in-person.
- Three out of 15 medical records have obtained consent, but the provider did not explain to the beneficiary, as required, that use of telehealth is voluntary, and consent can be withdrawn at any time.
- Four out of 15 medical records have obtained consent, but the provider did not explain to the beneficiary, as required, that NMT benefits are available for in-person visits.
- One out of 15 medical records have obtained consent, but the provider did not explain to the beneficiary, as required, any potential limitations or risks related to receiving services via telehealth as compared to an in-person visit.

The Plan has an established process to monitor telehealth consent compliance through chart reviews. However, the Plan did not document CAPs to address five of five incomplete telehealth consents identified during its chart review. These consent forms did not inform members of the NMT benefits.

During an interview, the Plan acknowledged that consents were not obtained from some members prior to receiving telehealth services. The Plan stated that providers were educated on the need for all members who received telehealth services to have verbal

or written consent obtained and documented beforehand. In spite of the Plan's education efforts, non-compliance in meeting telehealth consent requirements was identified during the audit period.

When the Plan does not ensure that all subcontracted providers are appropriately obtaining and documenting verbal or written telehealth consent that explains all required elements as outlined in BHIN 23-018 prior to initial delivery of covered services via telehealth, this can result in members making uninformed health decisions due to lack of adequate knowledge about treatment options.

Recommendation: Develop and implement policies and procedures to accurately reflect the Plan has an established process to monitor telehealth compliance.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 Concurrent Review and Prior Authorization Requirements

5.2.1 Concurrent Review and Authorization Requirements

The Plan shall establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with *BHIN 22-017 Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services* and shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. *(BHIN 22-017 Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services).*

The MHP shall decide whether to grant, modify or deny the hospital or Psychiatric Health Facilities (PHFs) initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in BHIN 22-017. The MHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services *(BHIN 22-017 Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services).*

When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay-authorization request for a specified number of days to the responsible county MHP. The responsible county MHP shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24 hours of receipt of the request and all information reasonably necessary to make a determination *(BHIN 22-017 Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*).

Plan policy, *PL02-11-07 Concurrent Review Standards for Psychiatric Inpatient Level of Care Services* (effective 12/23/2024), states the following: Upon notification of admission of an Imperial County Medi-Cal beneficiary to a hospital or PHF, the MHP shall review the beneficiary's admission orders, initial plan of care, request to authorize the beneficiary's treatment, and completed face sheet, as provided by the hospital or PHF,

to decide whether to grant, modify, or deny the initial treatment authorization request. The MHP shall make an expedited authorization decision and communicate the decision to the requesting hospital or PHF as expeditiously as the beneficiary's health condition requires and not later than 72 hours after receipt of the request for services.

If a continued stay authorization request is submitted by the hospital or PHF, the MHP shall issue a decision on the request within 24 hours of receipt of the request and all information reasonably necessary to make a determination.

Finding: The Plan did not implement a concurrent review process to ensure timely authorization of psychiatric inpatient hospital services.

For the verification study, all fifteen SMHS members were missing evidence to support that concurrent review was conducted in a manner consistent with BHIN 22-017. Specifically, the documentation did not include:

1. Confirmation and authorization decisions from the MHP within 72 hours of initial notification of hospital admission
2. Concurrent authorization decisions by the MHP within 24 hours of the hospital's request for continued stay services.

In an interview, the Plan stated that one way it conducts its concurrent authorization is through informal phone calls and email correspondence; however, the Plan did not submit evidence of concurrent review email and phone correspondence. Therefore, the Plan did not adhere to its policy since there is no documentation to demonstrate the implementation of a concurrent review process during the audit period.

When the Plan does not ensure and document timely concurrent review procedures for the authorization of psychiatric inpatient hospital services, the Plan cannot ensure the provision of medically necessary and appropriate level of care.

Recommendation: Implement policy and procedure to conduct concurrent review for timely authorization of psychiatric inpatient hospital services.