DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

CENTRAL SECTION

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF KERN COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES FISCAL YEAR 2024-25

Contract Number: 22-20106

Contract Type: Specialty Mental Health Services

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

Dates of Audit: June 17, 2025 — June 27, 2025

Report Issued: September 24, 2025

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I. INTRODUCTION

Kern County Behavioral Health and Recovery Services (BHRS) (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.

Kern County BHRS is located in Bakersfield, California, which is part of the San Joaquin Valley. The Plan provides services within nine cities and 28 unincorporated cities. The nine cities include: Tehachapi, Lake Isabella, Mojave, Taft, Ridgecrest, Bakersfield, Lamont, Wasco, and Frazier Park.

As of June 30, 2024, the Plan had a total of 4,479 members receiving services and a total of 903 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from June 17, 2025, through June 27, 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 4, 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 19, 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 seven categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, 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, 2018, through June 30, 2021, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was closed at the time of the onsite.

The summary of the finding by category 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 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 utilize concurrent review for all Adult Residential Treatment (ART) Services. The Plan must reauthorize medically necessary ART services, as appropriate, concurrently with the members' stay and based on the members' continued need for services. Finding 5.2.1: the Plan did not conduct concurrent reviews to authorize or re-authorize medically necessary ART 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 Specialty Mental Health Services Contract.

PROCEDURE

DHCS conducted an audit of the Plan from June 17, 2025, through June 27, 2025, for the audit period of July 1, 2023, through June 30, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Mobile Crisis Service Encounters: Ten member files were reviewed for evidence of response, assessment, planning, and treatment.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member files were reviewed for evidence of referrals from a Managed Care Plan (MCP) to Mental Health Plan (MHP), and ten member referrals from MHP to MCP were reviewed for evidence of coordination of care.

Category 3 – Quality Assurance and Improvement

There were no verification studies conducted for this audit.

Category 4 – Access and Information Requirements

Telehealth Services: Ten member files were reviewed for evidence of telehealth consent and required elements.

Category 5 – Coverage and Authorization of Services

Authorizations: Five Treatment Authorization Requests (TAR) from a contracted facility, five TARs out of network facility, ten Crisis Residential Treatments, and five Adult Residential Treatment Authorization requests were reviewed for evidence of an appropriate authorization treatment process, including the concurrent review process.

Category 6 – Beneficiary Rights and Protection

Grievances and Appeals: 15 grievances of quality of service, five grievances of quality of care, and five appeals were reviewed for a timely resolution, appropriate response to the complaint, and submission to the appropriate level for review.

Category 7 – Program Integrity

There were no verification studies conducted for this audit.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 CONCURRENT REVIEW AND AUTHORIZATION REQUIREMENTS

5.2.1 Concurrent Review of Adult Residential Treatment (ART)

The Plan's Utilization Management program is responsible for evaluating medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively or retrospectively. *(MHP Contract 22-20106 A1, Exhibit A, Attachment 6.1.B)*

The Plan shall implement mechanisms to assure authorization decision standards and written policies and procedures for processing requests for initial and continuing authorizations of services in accordance with Behavioral Health Information Notice *(BHIN) 22-016, Authorization of Outpatient Specialty Mental Health Services (SMHS). (MHP Contract 22-20106 A1, Exhibit A, Attachment 6.2.A and 6.2.A.1)*

The Plan must utilize referral and/or concurrent review and authorization for all ART services. If the Plan refers a member to a facility for ART, the referral may serve as the initial authorization, as long as the Plan specifies the parameters (e.g., number of days authorized) of the authorization. The Plan must then reauthorize medically necessary ART services, as appropriate, concurrently with the members' stay and based on the members' continued need for services. *(BHIN 22-016, Authorization of Outpatient Specialty Mental Health Services (revised April 15, 2022))*

Plan policy, *5.1.19, Authorization Requests for Inpatient Psychiatric, Crisis Residential and Adult Residential Services, (Revision Date: 6/8/22)*, stated that the Plan shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions. The Plan must utilize referral and/or concurrent review and authorization for all Adult Residential Treatment Services. Furthermore, the Plan policy stated reauthorization of medically necessary ART services as appropriate, concurrently with the member's stay and based on the member's continued need for services.

Finding: The Plan did not conduct concurrent reviews to authorize or re-authorize medically necessary ART services.

In a verification study, two out of five samples that required reauthorizations, the Plan did not conduct a concurrent review ranging from 77 to 123 days. In addition, the

Plan provided no evidence demonstrating the ART concurrent reauthorization process.

In an interview, the Plan acknowledged it does not have a mechanism to ensure authorization standards and specific procedures for ART authorization and reauthorization services.

Although the Plan has a policy requiring concurrent reviews and authorization of all medically necessary ART services, the Plan did not have a procedure to ensure the concurrent reviews were completed for its members.

When the Plan does not conduct a concurrent review for reauthorization of medically necessary ART services, the Plan cannot ensure appropriateness of level of care, nor can it determine the medical necessity of continued institutional stay. This can lead to ineffective resource utilization and can negatively impact a member's ability to receive timely ART services.

Recommendation: Revise and implement policies and procedures to ensure a concurrent review for authorization and reauthorization of medically necessary ART services.