DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

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

Contract Number: 22-20111

Contract Type: Specialty Mental Health Services

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

Dates of Audit: October 29, 2024 — November 8 , 2024

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I. INTRODUCTION

Madera 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.

Madera County is located in the Central Valley of California. The Plan provides services within the unincorporated county and in three cities: Madera, Chowchilla, and Oakhurst.

As of November 2024, the Plan had a total of 2,232 members receiving services and a total of 80 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 October 29, 2024, through November 8, 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 February 12, 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 February 27, 2025, the Plan submitted a response that it agrees with all the findings. The report reflects the evaluation of all relevant information during the audit.

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, Member Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2021, through June 30, 2022, identified deficiencies incorporated in the Correction Action Plan. This year's audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

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

The summary of the findings 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

The Plan is required to coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a Non-Specialty Mental Health Services (NSMHS) provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. The Plan did not coordinate with MCPs to facilitate care transitions and guide referrals for all members transitioning to the managed care delivery system.

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 Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). The Plan did not have a concurrent review process for authorization of all CRTS and ARTS.

The Plan is required to provide timely Notice of an Adverse Benefit Determination (NOABD) before the date of action to its members. The Plan did not provide Notices of Adverse Benefit Determination at least ten days before the date of action to its members.

Category 6 – Member 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 October 29, 2024, through November 8, 2024, 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 Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Intensive Care Coordination (ICC)/Intensive Home-Based Services (IHBS) Determination of Services: Ten children and youth files were reviewed for assessment criteria and service determination.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: 14 member files were reviewed for evidence of referrals from a Managed Care Plan (MCP) to the Mental Health Plan (MHP), initial assessments, and 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

Access Line Test Calls: Five test calls requesting information about SMHS and how to treat an urgent condition were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements; two test calls requesting

information about the member problem resolution and fair hearing processes were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements.

Access Test Call Log: Five required test calls were made and review of Plan's call log to ensure logging of each test call and confirm the log contained all required components.

Category 5 – Coverage and Authorization of Services

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

NOABD Requirements: Eight member files were reviewed for evidence of appropriate documentation and completeness of required NOABDs.

Category 6 – Member Rights and Protection

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

Appeal Procedures: Four 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 2 – Care Coordination and Continuity of Care

2.1 COORDINATION OF CARE REQUIREMENTS

2.1.1 Coordination of Services with Managed Care Organizations

The Plan must coordinate the services it furnishes to the members with the services the members receive from any other managed care organization (MCO), in Fee-For-Service (FFS) Medicaid, from community and social support providers, and other human services agencies used by its members. *(Contract, Exhibit A, Attachment 10, section 1(A)(2))*

The Plan agrees to comply with all applicable federal and state law including applicable Behavioral Health Information Notices (BHINs). (*Contract, Exhibit E (6)(B))*

The Plan is required to provide or arrange for the provision of medically necessary SMHS for members in their counties who meet access criteria for SMHS. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MHPs and MCPs to ensure member choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. (*BHIN No. 22-011, No Wrong Door for Mental Health Services Policy* (revised March 31, 2022))

Plan policy *MHP 69.00, Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (*approved January 31, 2023*)*, provided guidance to MHPs on standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of Adult and Youth members to the appropriate Medi-Cal mental health delivery system and ensure that members requiring transition between delivery systems receive coordinated care. If the Plan refers members to MCPs, the Plan will coordinate these referrals with MCPs or directly to MCP providers delivering NSMHS. The policy also mentions that the Plan will coordinate member care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the member has been connected with a

provider in the new system, and the new provider accepts the care of the member and medically necessary services have been made available to the member.

The Plan has Memorandums of Understanding (MOUs) with Anthem Blue Cross (dated May 14, 2013) and with Fresno-Kings-Madera Regional Health Authority dba CalViva Health (dated January 10, 2012) for coordination of services. The MOU mentioned that the Plan will coordinate with the MCP Customer Care Center and/or the MCP to facilitate appointment and referral verification assistance as needed. The MCP will coordinate and assist the Plan and the member to keep their appointments and referrals back to their primary care provider (PCP) as appropriate for all other services not covered by the Plan.

Finding: The Plan did not coordinate with MCPs to facilitate care transitions and guide referrals for all members transitioning to the managed care delivery system.

In a verification study, 14 member records revealed the following:

- 12 of 14 records did not contain evidence that the new provider accepted the care of the members. For five records, there is no documentation that the MCP contacted members or scheduled an appointment; and for seven, there was no evidence that the MCP communicated with the Plan, or that Plan attempted to follow-up after referral.
- In addition, for six of the 12 samples, the Plan provided evidence of referral to the MCP, including the screening tool; however, the records did not include evidence of any follow-up attempts made by the Plan or communication from the MCP.
- Also, for two of the 12 samples, the Plan's documents showed large gaps in coordination since the MCP contacted the Plan 30 and 77 calendar days after referral. For both samples the Plan did not provide evidence of any follow-up attempt.

During interviews and in a written narrative, the Plan stated that its process, when referring members to MCPs, included the following:

1. The Plan completes the Medi-Cal Screening Tool and referral documents and sends them to the MCP, which is expected to provide a status update on the transition of care.
2. If MCP does not provide a response within this timeframe, the Plan will proactively reach out.

3. Once the MCP confirms that the client has transitioned to its care and has a scheduled appointment, the Plan will finalize the process in its Access to Service documentation and update its referral tracking system.

However, the verification study results did not support the Plan's described process.

The Plan stated that its team conducted daily tracking and monitoring of its access to service tracking system, which contained data pulled from electronic health records (EHR), to ensure that their clients are aligned with the appropriate services and that all necessary follow-ups are completed. However, review of the Plan's reports and monitoring data revealed significant variances and missing relevant information such as transition of care, bidirectional contact between the organizations, date of screening, assessment date, and timeliness on both reports. An example of a lack of coordination is noted in one sample with an *Access to Services* form showing case closure on July 25, 2023; however, the same case was referred to the MCP on August 10, 2023. This did not demonstrate the Plan followed its procedures to close a referral only after the referral loop was completed.

If the Plan does not ensure care coordination with MCPs, this can affect the facilitation of member transitions and referrals resulting in delays or missed referrals for medically necessary services.

Recommendation: Implement policies and procedures to coordinate with MCPs to facilitate transitions and guide referrals for all members referred to the managed care delivery system.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUIREMENTS

5.2.1 Concurrent Review of Adult Residential Treatment (ART) and Crisis Residential Treatment (CRT)

The Plan is required to operate a utilization management (UM) program that ensures members have appropriate access to SMHS. The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal members prospectively or retrospectively. (*Contract, Exhibit A, Attachment 6, section (1)(A) -(B)*)

The Plan agrees to comply with all applicable federal and state law including applicable BHINs. (*Contract, Exhibit E (6)(B))*

The Plan must utilize referral and/or concurrent review and authorization for all CRTS and ARTS. If the Plan refers a member to a facility for CRTS or ARTS, 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 CRTS and ARTS services, as appropriate, concurrently with the member's stay and based on member's continued need for services. *(BHIN No. 22-016* (revised April 15, 2022))

Plan policy *MHP 18.00, Authorization of Specialty Mental Health Services* (revised January 31, 2022), stated that the Plan will utilize referral and/or concurrent review and authorization for all CRTS and ARTS and will not require an initial prior authorization. All referrals will include a specified number of days being authorized. All referrals made by collaborative county partners will include a specified number of days being authorized not to exceed five days. Prior authorization is required for referrals from non-collaborative counties. The Plan will reauthorize medically necessary CRTS and ARTS, as appropriate, concurrently with the member's stay and based on member's continued need for services.

Finding: The Plan did not conduct a concurrent review for authorization of all CRTS and ARTS.

In a verification study, six of six member records included referral forms and progress notes for stays of two to 33 days in CRT facilities. However, the six records did not contain evidence of concurrent review for treatment authorization.

In an interview, the Plan stated that during the audit period, there was no concurrent review conducted for ARTS and CRTS due to staff shortage. The Plan stated that it provided ARTS but did not conduct concurrent review for these services. However, the Plan did not provide a universe of members receiving ARTS.

In a written narrative, the Plan stated that a meeting had been scheduled with the Crisis Residential Unit to re-establish the concurrent review process and ensure a clear referral process is followed and monitored by the Plan. However, the Plan did not provide any evidence to support the re-establishment of the concurrent review process or the monitoring process.

If the Plan does not utilize or implement concurrent review and authorization of all CRTS and ARTS, members' ability to receive medically necessary services can be negatively impacted.

Recommendation: Implement Plan's written procedures for concurrent review and authorization of all CRTS and ARTS.

5.4 NOTICE OF ADVERSE BENEFIT DETERMINATION REQUIREMENTS

5.4.1 Provision of Notice of Adverse Benefit Determination

The Plan must provide timely and adequate NOABD at least ten days before the date of action to its members. The Plan must provide NOABD in writing when the Plan denies or limit authorization of a requested services, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; also, when the Plan reduces, suspends, or terminates a previously authorized service, and when the Plan fails to provide services in a timely manner, as defined by the Department. *(Contract, Exhibit A, Attachment 12, section (10)(A)(1)-(6), Code of Federal Regulations (CFR), Title 42, Sections 431.211, 431.213, 438.10 and 438.404*)

Plan policy *MHP 21.00, NOABD & Notice Templates* (revised July 1, 2018), stated that the Plan will provide members a NOABD in accordance with the stated Contract requirements and within the timeframes for sending the NOABD. For termination, suspension, or reduction of a previously authorized SMHS, at least ten days before the date of action.

Finding: The Plan did not provide Notices of Adverse Benefit Determination at least ten days before the date of action to its members.

A verification study was conducted to verify compliance with NOABD requirements. The review found that for all the eight sampled members, the Plan provided the notice 14 days after the determination.

The Plan submitted a NOABDs data universe that revealed the Plan's provision of all types of NOABDs were sent 14 days after a determination.

As a Corrective Action Plan to address the Fiscal Year 2021-2022 deficiency of non-timeline NOABDs, the Plan implemented remedial activities on October 31, 2022. The Plan developed a dynamic form in the Plan's EHR system, named *Access to Services*, to track and monitor urgent and non-urgent requests, including psychiatric service requests timeliness data. In addition, daily monitoring of *Access to Services* entries and weekly export of *Access to Services* data for analysis gave the Plan the ability to track and ensure the provision of appropriate and timely NOABDs. However, review of data from the Plan's *Members Access to Services* database showed gaps of 16 days to 222 days between members' initial date of contact and the NOABD requested/action dates indicating the Plan's non-implementation of its policies and procedures to comply with NOABD's timeliness requirements.

If the Plan does not provide timely NOABDs to its members, these members may miss opportunities for filing an appeal or a grievance and receiving mental health services timely.

This is a repeat of the 2021-2022 audit finding – Notice of Adverse Benefit Determination Requirements

Recommendation: Revise and implement the Plan's written policies and procedures to ensure that the Plan provides timely NOABDs at least 10 days before the date of action to its members.