DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number(s): 22-20144

Contract Type: Specialty Mental Health Services

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

Dates of Audit: September 10, 2024 — September 20, 2024

Report Issued: January 31, 2025

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I. INTRODUCTION

Tulare County Behavioral Health (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.

Tulare County is located in the Central Valley of California's San Joaquin Valley. The Plan provides services within the unincorporated county and in eight cities: Visalia, Tulare, Porterville, Three Rivers, Springville, Dinuba, Exeter, and Farmersville.

As of June 2024, the Plan had a total of 15,871 members receiving SMHS services and a total of 61 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 September 10, 2024, through September 20, 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 January 15, 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 January 22, 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, 2020, through June 30, 2021, identified deficiencies incorporated in the Correction Action Plan (CAP), which were later closed out on July 11, 2023. 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.

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

The Plan must provide or arrange and pay for medically necessary covered SMHS to beneficiaries who meet access criteria for receiving the SMHS Adult Residential Treatment Services (ARTS). The Plan did not ensure the provision of ARTS for members who met criteria.

The Plan is required to establish mechanisms to ensure that network providers comply with the timely access requirements, monitor network providers regularly to determine compliance, and take corrective action if a network provider fails to comply

with timely access requirements. The Plan did not take corrective action when its network providers failed to comply with timely access requirements.

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

The Plan must ensure its Medi-Cal Behavioral Health delivery systems and their subcontractor can provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individuals' requested alternative format(s). The standard alternative formats options are large print, audio CD, data CD, and Braille. The Plan did not ensure the availability of the braille format as an alternative communication material to members.

The Plan is required to obtain verbal or written consent from members for the use of telehealth in the delivery of services. 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 operate a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. The UM 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. If the Plan delegates duties and obligations to subcontracting entities, the Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department. The Plan did not have a UM program with a process to determine whether its subcontractor, Keystone Peer Review Organization, Inc. (KEPRO), is able to adequately perform the delegated duty of concurrent review.

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 September 10, 2024, through September 20, 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 Base Services (IHBS) Determination of Services: Ten children and youth files were reviewed for assessment criteria, service determination, and provision of services.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Nine 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

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 beneficiary 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 Line Test Call Log: The Plan's call log was reviewed to ensure all required log components were documented for four test calls made to the Plan.

Telehealth Services: Ten member files were reviewed to confirm compliant member consent for telehealth services.

Category 5 – Coverage and Authorization of Services

Authorizations: Ten members files were reviewed for appropriate services authorization processes including concurrent review

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

Category 6 – Beneficiary Rights and Protection

Grievances Procedures: 11 grievances were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Appeals Procedures: Three 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 1 – Network Adequacy and Availability of Services

1.1 Availability of Specialty Mental Health Services

1.1.1 Provision of Adult Residential Treatment Services (ARTS)

The Plan must provide or arrange, and pay for, the following medically necessary covered SMHS to beneficiaries who meet access criteria for receiving the SMHS: Adult Residential Treatment Services (ARTS) *(Plan Contract, Exhibit A, Attachment 2 section (A)(7))*.

Plan Policy *04-010, Specialty Mental Health Services (effective 01/15/2024)* stated the Plan provides covered services to members who meet medical necessity and access criteria for SMHS. Covered services include Adult Residential Treatment Services (ARTS), including Adult Residential Treatment Services (ARTS). The policy states all services provided shall be documented in accordance with established documentation requirements and standards.

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

A universe of Treatment Authorization Requests (TARs) to review ARTS was requested from the Plan. However, there was no evidence of the Plan's authorization for ARTS. Therefore, a verification study was not feasible.

In an interview, the Plan stated it does not offer ARTS as a service to its members and that it did not receive requests from providers to place members in ARTS. However, there is no formal assessment and authorization process specifically for ARTS.

In a written narrative, the Plan also confirmed ARTS is not an available service and has not made any efforts to implement this service for its members.

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

Recommendation: Implement policies and procedures to ensure members who meet criteria have access to covered services, such as ARTS.

1.1 Availability of Specialty Mental Health Services

1.1.2 Timely Access Requirements

The Plan shall establish mechanisms to ensure that network providers comply with the timely access requirements in accordance with Title 42 of Code of Federal Regulations (CFR) section 438.206(c)(1)(iv). The MHP shall monitor network providers regularly to determine compliance with timely access requirements and take corrective action if a network provider fails to comply with timely access requirements. *(Contract, Exhibit A, Attachment 8, section (4)(A)(5)-(7))*

Plan policy *00-68, Timely Access (effective Date 11/01/2019)* stated the Quality Improvement (QI) Unit will monitor network providers to ensure compliance with timely access requirements and take corrective action for non-compliance. For example, appointment dates for behavioral health services within the required ten business days of their request as required by the Plan's policy 00-68.

Finding: The Plan did not take corrective action when its network providers failed to comply with timely access requirements.

Although the Plan's policy 00-68 stated that it will develop a corrective action for non-compliance with timeliness standards, it did not demonstrate implementation of its policies and procedures. The Plan's "Timely Access Documents for FY 23-24" report identified 51 out of 102 members who did not receive an initial appointment date for behavioral health services within the required ten business days of their request as required by the Plan's policy 00-68. The initial service appointments were delayed due to "no available provider" and ranged from 12 days to 117 days of the referral/contact, as indicated on the Plan's report. However, a review of the Plan's Quality Improvement Committee (QIC) meeting minutes indicated the Plan did not discuss timely access or CAP development for non-compliant network providers.

In a narrative, the Plan confirmed that they do not currently implement a Policy and Procedure detailing the CAP process for non-compliant providers.

When the Plan does not address timely access requirements for non-compliant providers via corrective actions, members access to care may be hindered, which can lead to delayed medical interventions and possible poor health outcomes.

Recommendation: Revise and implement policies and procedures that outline timely access requirements and the corrective action process for non-compliant providers.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.1 Language and Format Requirement

4.1.1 Member Materials in Braille

Medi-Cal Behavioral Health delivery systems (Plans, 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 alternative format(s). The standard alternative formats 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 *04-005, Information Requirement (effective 03/01/2024)* described the Plan's guidelines for language and formatting for Medi-Cal members with impaired sensory, manual, or speaking skills upon request and free of charge. The Plan has the following alternative formats: Braille, audio format, large print, and accessible electronic formats (such as a data CD).

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

In an interview, the Plan stated that its Community Outreach Team is responsible for developing and providing members with materials in alternative formats. During the audit period, the Plan did not develop braille materials since there was no member request for materials in braille.

In a written narrative, the Plan stated it currently does not implement a process to translate information into braille.

When the Plan does not provide all required alternative formats of communication materials, it limits the member's accessibility to information and may prevent them from having adequate knowledge to make informed decisions about their health care. This can result in poor mental health outcomes due to missed or delayed access to medically necessary behavioral health services.

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

4.4 Telehealth

4.4.1 Telehealth Consent

Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering 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 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)

Unless specifically prohibited by this contract or by federal or state law, 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 Mental Health Plan may have with any subcontractor. *(Plan Contract, Exhibit A, Attachment 1, section 3; 42 CFR section 438.230(b)(1).)*

Plan policy *10-16, Telehealth Services (10/01/2022)* stated members must provide consent verbally or in writing prior to initiating telehealth services and must be documented in the member medical record. In addition, the consent must include the right to access covered services in person; telehealth is voluntary, members can withdraw consent at any time without affecting their ability to access covered services in the future; non-medical transportation services are available to in-person visits; and potentials limitation or risks of receiving services through telehealth compared to in person-visit.

Finding: The Plan did not ensure providers obtained verbal or written member consent for telehealth services.

The verification study identified one of ten cases that did not include documentation indicating member consent for telehealth prior to the delivery of services.

In an interview, the Plan stated clinicians document the member's consent for telehealth in SmartCare and that verbal consent can also be documented in the progress note of the member's medical chart. The Plan stated member consent was not included in its chart utilization review tool used by the clinicians, and it did not have a monitoring mechanism to ensure clinicians were in compliance with the telehealth consent requirement. In addition, member consent was not identified as an aspect of Quality Assurance Performance Improvement monitoring by the Plan.

In a written narrative, the Plan reiterated it did not have a process in place for monitoring member consent for telehealth. The Plan stated it will implement monitoring measures moving forward by developing a report in the member's Electronic Health Record to verify telehealth consent forms are completed prior to the delivery of services. The Plan also updated its chart utilization review tool to include verification of compliance with telehealth consent documentation during its monthly utilization chart reviews moving forward.

When the Plan does not ensure providers obtain member consent for receiving services via telehealth, members may not have adequate knowledge about treatment and service delivery options to best meet their healthcare needs.

Recommendation: Develop policies and procedures, including staff training, to ensure providers obtain members' consent for telehealth prior to the delivery of services.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 Concurrent Review and Authorization Requirements

5.2.1 Concurrent Review and Authorization Requirements

Plans are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. The UM 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. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services; California Code of Regulations, Title 9, section 1810.440(b); 42 CFR sections 438.210 (a)(4), (b)(1), (2)).*

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 Mental Health Plan may have with any subcontractor. *(Plan Contract, Exhibit A, Attachment 1, section 3; 42 CFR section 438.230(b)(1))*

Plan Policy *04-012, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services (effective 01/15/2024)* included Attachment A from its subcontracted provider which outlined how the Plan must operate a UM program that ensures members have appropriate access to SMHS. The policy stated the UM program evaluates medical necessity, appropriateness and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures.

Plan contract *1129-PICR-2022-TUC, Keystone Peer Review Organization, Inc. (KEPRO) California Mental Health Services Authority ("CalMHSA") (01/01/23 – 12/31/2024)* described how the subcontracted provider will conduct concurrent review and authorization for all psychiatric inpatient hospital and psychiatric health facility services on behalf of the Plan.

Finding: The Plan did not have a UM program with a process to determine whether its subcontractor, Keystone Peer Review Organization, Inc. (KEPRO), is able to adequately perform the delegated duty of concurrent review.

The Plan's Policy *04-012* stated that it will conduct concurrent authorization review procedures. The Plan contract *1129-PICR-2022-TUC* stated that the UM duty for concurrent review will be performed by KEPRO. However, the Plan lacks policies and procedures on how it will determine whether its subcontractor is able to adequately perform the delegated duty of concurrent review.

The Plan contract *1129-PICR-2022-TUC* does not state how the Plan will conduct oversight of delegated UM duties, such as concurrent review.

In an interview, the Plan stated it does not have a monitoring practice in place to ensure appropriate authorizations are being conducted by the subcontractor and has not met with the subcontractor to review authorizations it conducts.

The Plan provided a KEPRO quarterly utilization report of processed payments; however, the report does not demonstrate the Plan's monitoring and determination if inpatient concurrent review authorizations were appropriately adjudicated by the Plan's subcontractor.

When the Plan's UM program lacks a process to determine that its subcontractors are able to adequately perform delegated UM duties, there is a risk of over- and underutilization of services, which may result in waste of resources and negative health outcomes for members.

Recommendation: Develop and implement policies and procedures to ensure the Plan's UM program establishes a process to determine that its subcontractors are able to adequately perform delegated UM duties.