DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SUBSTANCE USE DISORDER REVIEW SECTION

REPORT ON THE SUBSTANCE USE DISORDER (SUD) AUDIT OF INYO COUNTY BEHAVIORAL HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 23-30092

Contract Type: Drug Medi-Cal Services (DMC)

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

Dates of Audit: September 24, 2024 — October 4, 2024

Report Issued: February 28, 2025

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I. INTRODUCTION

Inyo 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 substance use disorder services to county residents.

Inyo County, in the Eastern Sierra, is located in east-central California. The Plan provides services within the unincorporated county and particularly in Bishop city.

As of October 2024, the Plan had a total of 176 members receiving services and a total of 16 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 24, 2024, through October 4, 2024. The audit consisted of documentation review, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on February 6, 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 21, 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 five categories of performance: Availability of Drug Medi-Cal Services (DMC) Services, Quality Assurance and Performance Improvement, Access and Information Requirements, 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). The prior year CAP was completely closed at the time of onsite. Therefore, this year's audit included a review of documents to ensure that its 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 – Availability of Drug Medi-Cal Services

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 is required to provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individuals'

requested alternative formats. The Plan did not ensure that alternative communication material in braille was available to its members.

Category 6 – Beneficiary Rights and Protection

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

Category 7 – Program Integrity

The Plan is responsible for verifying the Medi-Cal eligibility of each month of services prior to billing for DMC services to that client for that month. Medi-Cal eligibility verification shall be performed prior to rendering service, in accordance with and as described in DHCS' DMC Provider Billing Manual. The Plan did not verify Medi-Cal eligibility of services prior to billing for the DMC services.

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 DMC Contract.

PROCEDURE

DHCS conducted an audit of the Plan from September 24, 2024, through October 4, 2024, for the audit period 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 – Availability of Drug Medi-Cal Services

There was no verification studies conducted for the audit review.

Category 3 – Quality Assurance and Performance Improvement

There was no verification studies conducted for the audit review.

Category 4 – Access and Information Requirements

There was no verification studies conducted for the audit review.

Category 6 – Beneficiary Rights and Protection

There was no verification studies conducted for the audit review.

Category 7 – Program Integrity

There was 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 FORMAT REQUIREMENTS FOR BRAILLE

The Plan is required to comply with all State and federal statutes and regulations, BHINs, and any other applicable authorities. *(Contract, Exhibit A, Attachment I, Part I, Section 1(B))*

The Plan is required to provide interpretive services and make member information available in the following alternative formats: braille, audio format, large print, and accessible electronic format. *(Contract, Ex. A, Att. I, Pt II, Sec. S(6)(c))*

The Plan is required to provide a member who is blind or visually impaired, and other individuals with disabilities, with communication materials in the individuals' requested alternative formats. 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, (Jan. 2024), p.2, 5.)*

Finding: The Plan did not ensure that alternative communication material in braille was available to its members.

The Plan policy *Language, Culture, and Other Special Communications Needs (revised 11/29/2023)* described procedures for accommodating individuals with various language, cultural, and special communication needs. This policy listed resources for the hearing-impaired but did not include a process to provide the braille format for members who requested it.

In an interview, the Plan acknowledged that it focused more on providing communication materials for hearing-impaired than that of visual-impaired members.

When the Plan does not provide alternative formats to members, such as braille, it limits their accessibility preventing them 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: Develop and implement policies and procedures to ensure alternative formats, including braille, are available to members upon request.

COMPLIANCE AUDIT FINDINGS

Category 7 – Program Integrity

7.1 MEDI-CAL ELIGIBILITY

7.1.1 VERIFICATION OF MEDI-CAL ELIGIBILITY

The Plan is responsible for verifying the Medi-Cal eligibility of each month of services prior to billing for DMC services to that member for that month. Medi-Cal eligibility verification shall be performed prior to rendering service, in accordance with and as described in DHCS' DMC Provider Billing Manual. *(Contract, Ex. A, Att. I, Pt. III, Sec. B)*

Finding: The Plan did not demonstrate and ensure verification of members' Medi-Cal eligibility monthly prior to rendering services or prior to billing for DMC services.

Following repeated requests, the plan did not provide documentation demonstrating compliance with the requirement to verify members' Medi-Cal eligibility prior to rendering service or prior to billing for DMC services.

The Plan did not provide a policy or procedure demonstrating it established a process to verify members' Medi-Cal eligibility monthly prior to rendering services or billing for DMC services.

During the interview, the Plan stated their front office staff ran Medi-Cal eligibility verifications each month prior to billing for each member. However, the Plan did not submit evidence of this eligibility determination process.

When the Plan fails to verify members' eligibility of services, monthly, prior to rendering and billing for DMC services, it may compromise the Medi-Cal program's integrity and Medi-Cal's process for detecting and preventing fraud, waste, and abuse.

Recommendation: Develop and implement procedures ensuring the Plan verifies the Medi-Cal eligibility of each month of services prior to rendering and billing for DMC services to that member.