DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20105

Contract Type: Specialty Mental Health Services

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 mental health 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, verification studies, 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 six 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, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2017, through June 30, 2020, identified deficiencies incorporated in the Correction Action Plan (CAP). The prior year CAP was completely closed at the time of onsite. 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

The Plan has an affirmative responsibility to determine if children and youth who meet criteria for members' access to SMHS need Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). The Plan did not ensure the assessment for the need of ICC and IHBS services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

Category 2 – Care Coordination and Continuity of Care

The Plan is required to coordinate the services the Plan furnishes to a member with the services the member receives from any other managed care plans (MCP). The Plan did not ensure service coordination for members eligible for MCP referrals.

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.

The Plan is required to have an affirmative responsibility to obtain member consent prior to initial delivery of covered service via telehealth. The Plan did not ensure that all providers obtained and documented verbal or written consent from members prior to the initial delivery of covered services via telehealth.

Category 5 – Coverage and Authorization of Services

The Plan is required to establish and implement written policies and procedures to address the authorization of SMHS in accordance with Behavioral Health Information Notice (BHIN) 22-016. The Plan did not ensure to provide or arrange, and pay for medically necessary covered SMHS, including Adult Residential Treatment Services and Crisis Residential Treatment Services.

The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services; and required to have mechanism in effect to ensure consistent application of review criteria for authorization decisions in accordance with BHIN No. 22-017. The Plan did not conduct concurrent authorization review procedures for psychiatric inpatient hospital services to its members.

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 medical 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 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 – Network Adequacy and Availability of Services

ICC/IHBS Determination: Five children and youth member files were reviewed for the provision of ICC and IHBH services.

ICC/IHBS Provision of Services: Eight samples were reviewed for criteria and service determination.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten member files were reviewed for evidence of referrals from the Mental Health Plan (MHP) to Managed Care Plan (MCP), 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 was 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 Line Test Call Log: The Plan's call log was reviewed to ensure all required log components were documented for five test calls made to the Plan.

Category 5 – Coverage and Authorization of Services

Service Authorizations: Ten member files were reviewed for evidence of appropriate service authorization request.

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

Category 7 – Program Integrity

There was no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 1 – Network Adequacy and Availability of Services

1.2 CHILDREN'S SERVICES

1.2.1 ASSESSMENT OF THE NEED OF ICC AND IHBS

The Plan is required to provide or arrange, and pay for, ICC and IHBS services for members under the age of 21. *(Contract, Exhibit A, Attachment 2, Section 2(A)(11)(12))*

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need ICC and IHBS. *(BHIN 21-073; Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries (3rd ed., Jan. 2018), pp.9.)*

Finding: The Plan did not ensure the assessment for the need for ICC and IHBS services for all children and youth who met beneficiary access and medical necessity criteria for SMHS.

The verification study revealed inconsistency in documenting the determination for the need of ICC and IHBS for eligible children and youth. However, evidence of this determination must be present for all children and youth whether these services were provided or not.

- In one medical record, the member's condition met the criteria for ICC/IHBS, and the Plan documented the need for ICC/IHBS.
- Four medical records included assessments that did not meet the criteria for ICC/IHBS but there was no record of the Plan's determination that ICC/IHBS was not needed.

Review of Plan documents showed that although the Plan had policies to assess for the need SHMS including IHBS, it lacked a policy to access for the need of ICC services. Furthermore, there was no formal process of documenting the ICC/IHBS determination in the members' medical records, and the monitoring process.

In an interview, the Plan acknowledged that there was an inconsistency in documenting ICC/IHBS determination in its members' medical records. The Plan would only document the determination for ICC/IHBS services that were recommended by the clinician in the electronic health record of its members. In the narrative, the Plan

confirmed that there were no formal procedures to outline the requirement of documenting all ICC/IHBS cases for members.

When the Plan does not document the determinations of need for ICC and IHBS services, the Plan cannot ensure all children and youth receive medically necessary behavioral health services.

This is Repeat Finding of the 2020-2021 Review – Network Adequacy and Availability of Services.

Recommendation: Update and implement policies and procedures to ensure all children and youth who meet beneficiary access criteria for SMHS are assessed to determine if ICC and IHBS services are needed

COMPLIANCE AUDIT FINDINGS

Category 2 – Care Coordination and Continuity of Care

2.1 COORDINATION OF CARE REQUIREMENTS

2.1.1 COORDINATION OF MCP REFERRALS

The Plan shall coordinate the services the Plan furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. *(Contract, Ex. A, Att.10, sec.1(A)(2); 42 CFR. § 438.208(b)(2)(i)-(iv); CCR, tit. 9, § 1810.415.)*

The Plan shall be responsible for providing or arranging and paying for SMHS for Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to SHMS. (*CCR, tit. 9, § 1810.228)* The Contractor shall accept these individuals in the order in which they are referred (including self-referral) without restriction (unless authorized by Centers for Medicare and Medicaid Services), up to the limits set under this Contract. *(Contract, Ex. A, Att. 7(1)(B); CFR, tit. 42, § 438.3(d)(1))*

The *Memorandums of Understanding (MOUs), Care Coordination with Anthem Blue Cross of California Partnership Plan, Inc. (executed 2014)* and *California Health and Wellness Plan (executed 2017)* detailed the expectations and delegated activities between the Plan and MCPs. The MOUs addressed shared responsibilities, requirements for program oversight, assessment and referral procedures, and protocols for the beneficiaries' transition, and coordination of care. The MOUs stated that the Plan will accept and track MCPs referrals.

Plan policy *Continuity and Coordination of Care (effective 4/07/2022)* outlined the procedures and responsibilities for ensuring continuous and coordinated care for beneficiaries receiving behavioral health services. The policy stated collaboration among managed care organizations, Fee-For-Service (FFS) Medicaid programs, community support providers, and other human services agencies, fostering a more integrated approach to behavioral health care.

Finding: The Plan did not ensure service coordination for members eligible for MCP referrals.

A verification study showed no evidence that a referral process was conducted. Utilization of the Plan's screening tool, *Adult Screening Tool for Medi-Cal Mental Health Services,* concluded that nine members were appropriate for MCP referral. However, there was no evidence that these nine members were referred to the MCP. In one case, a statement was documented that the Plan spoke with the member and her Ombudsman and explained that she can request mental health services through her MCP. However, there was no documentation that the member was ultimately referred to and received mental health services from the MCP.

The Plan policy *Continuity and Coordination of Care* described how it would provide coordination of care. However, this policy did not include a referral process when a MCP referral was appropriate for a member.

In an interview, the Plan stated the recent change in management contributed to the delay in developing and updating the Plan's policies and procedures.

When the Plan does not effectively coordinate services and refer members to MCPs, it can result in fragmented care, negatively impacting the health outcomes of beneficiaries.

Recommendation: Revise and implement policies and procedures to ensure members receive care of coordination.

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, the term of this Agreement, BHINs, and any other applicable authorities. *(Contract, Ex. E, Sec. 6(H))*

The Plan is required to provide all written materials for beneficiaries in easily understood language, format, and alternative format that take into consideration the special needs of beneficiaries. (*Contract, Ex. A, Att.11, sec.1(A); 42 CFR. § 438.10(d)(6))*.

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. *(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.

4.4 TELEHEALTH REQUIREMENTS

4.4.1 TELEHEALTH MEMBER CONSENT

The Plan has an affirmative responsibility to obtain beneficiary 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; and 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, (April 2023))*.

Plan policy *Criteria for Access to SMHS – Medical Necessity and other Coverage Requirements (effective 5/25/22)* stated the Plan's responsibility to obtain beneficiary consent before delivering telehealth services. Providers must obtain verbal or written consent and inform beneficiaries of their right to access services in person, clarify that telehealth is voluntary, and that consent could be withdrawn without affecting future access to Medi-Cal services. Providers were required to explain the availability of Medi-Cal coverage for transportation to in-person visits after other resources are exhausted and discuss any potential limitations or risks associated with telehealth. This consent process and the beneficiary's acknowledgment must be documented in the patient record.

Finding: The Plan did not ensure that all providers obtained and documented verbal or written consent from members prior to the initial delivery of covered services via telehealth.

The verification study revealed that zero of the ten members receiving telehealth services included documentation of telehealth consent.

In an interview, the Plan stated that the absence of an updated policy and consent form to reflect the requirements of BHIN 23-018 was due to the loss of the Deputy Director, which resulted in gaps in oversight and communication regarding the consent process. The Plan acknowledged it did not implement necessary updates or training for staff for telehealth consent, leading to inconsistencies in how consent

was obtained and documented.

In a narrative, the Plan acknowledged that the failure to ensure consistent documentation of beneficiary consent for telehealth services was a critical issue that must be addressed. Recent leadership turnover had a significant effect on the oversight and execution of essential policies and procedures. Consequently, this resulted in unclear expectations for obtaining and documenting consent before delivering services.

When the Plan does not ensure beneficiary consent are monitored before the initial delivery of covered services via telehealth, it can result in beneficiaries not having adequate knowledge about treatment options.

Recommendation: Revise and implement policies and procedures to ensure the Plan's beneficiary consents are being monitored if they are obtained before initials delivery of covered service via telehealth.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization Services

5.1 SERVICE AUTHORIZATION REQUEST

5.1.1 AUTHORIZATION OF CRISIS RESIDENTIAL TREATMENT SERVICES (CRTS) AND ADULT RESIDENTIAL TREATMENT SERVICES (ARTS)

The Plan is required to comply with all state and federal statutes and regulations, the term of this Agreement, BHINs, and any other applicable authorities. *(Contract, Ex. E, Sec. 6(H))*

The Plan shall provide or arrange and pay for medically necessary covered SMHS to members who meet access criteria for receiving SMHS:

- Adult Residential Treatment Services
- Crisis Residential Treatment Services

(Contract, Ex. A, Att. 2, Sec. 2(A))

The Plan is required to establish and implement written policies and procedures to address the authorization of Special Mental Health Services (SMHS) in accordance with BHIN 22-016 regarding a decision to modify an authorization request in which shall be provided to the treating provider. *(BHIN 22-016; Authorization of Outpatient Specialty Mental Health Services, (April 2022))*

Finding: The Plan did not ensure to provide or arrange, and pay for medically necessary covered SMHS, including ARTS and CRTS.

The Plan did not have policies and procedures to address and ensure the process of authorization for CRTS and ARTS.

In an interview, the Plan stated that it currently did not have written policies and procedures for authorizing outpatient CRTS and ARTS services.

In a narrative, the Plan stated that it had no out-of-county CRTS/ARTS subcontractors since these subcontractors did not renew their contract with the Plan. Hence, the Plan authorized CRTS and ARTS on a case-by-case basis.

When the Plan does not have policies and procedure for authorization process of CRTS and ARTS, this can limit access to medically necessary SMHS.

Recommendation: Develop and implement policies and procedures related to service authorization requests for CRTs and ARTs

5.2 CONCURRENT REVIEW AND PRIOR AUTHORIZATION REQUEST

5.2.1 CONCURRENT REVIEW

The Plan is required to comply with all state and federal statutes and regulations, the term of this Agreement, BHINs, and any other applicable authorities. *(Contract, Ex. E, Sec. 6(H))*

The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017. The Plan shall have 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; 42 CFR section 438.210(b)(1); 42 CFR section 438.210(b)(2)(i-ii))*

The concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and psychiatric health facilities certified by DHCS as Medi-Cal providers of inpatient hospital services. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services*)

Finding: The Plan did not conduct concurrent authorization review procedures for psychiatric inpatient hospital services to its members.

A verification study revealed zero of the ten-member psychiatric inpatient hospitalizations had evidence of concurrent review as required in BHIN 22-017.

A review of the Plan documents showed a lack of policies and procedures to conduct concurrent authorization review procedures for psychiatric inpatient hospital services to its members.

In an interview, the Plan stated that it did not have written policies and procedures to conduct concurrent review process to its members for psychiatric inpatient hospital stays.

When the Plan does not ensure the concurrent review procedures for the authorization of psychiatric inpatient hospital services, it may impact a member's ability to receive appropriate medically necessary services.

Recommendation: Develop and implement the policies and procedures to ensure the Plan to conduct concurrent review for inpatient psychiatric hospital services in a timely manner.