DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

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

Contract Number: 22-20117

Contract Type: Specialty Mental Health Services

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

Dates of Audit: August 20, 2024 — August 30, 2024

Report Issued: December 23, 2024

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I. INTRODUCTION

Mono County Behavioral Health Services (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.

Plan The is located in the East Central portion of California. The Plan provides services throughout Mono County which serves the four Tribal communities consisting of Bridgeport Indian Colony, Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation, Mono Lake, and Antelope Valley Indian Community.

As of June 2024, the Plan had a total of 202 Medi-Cal members, of which 157 members accessed specialty mental health services.

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 August 20, 2024, through August 30, 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 December 3, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On December 18, 2024, 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, 2017, through June 30, 2020, identified deficiencies incorporated in the Corrective Action Plan (CAP). This year's audit included a review of the Plan's compliance with its DHCS Contract and assessed its implementation of the prior audit 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

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 services furnished to beneficiaries with services the beneficiary receives from any other managed care organization (MCO) used by its beneficiaries. The Plan did not ensure to coordinate services furnished to beneficiaries with its managed care organizations.

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 statewide, toll-free telephone number 24 hours a day, seven days per week, that provides information about services needed to treat a member's urgent condition. The Plan did not ensure its 24/7 Access Line provided required information regarding how to treat a member's urgent condition.

Category 5 – Coverage and Authorization of Services

The Plan is required to have concurrent review authorization process for all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals, and psychiatric health facilities. The Plan did not conduct concurrent review of beneficiaries' psychiatric inpatient hospital stays.

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 (SMHS) Contract.

PROCEDURE

DHCS conducted an audit of the Plan from August 20, 2024, through August 30, 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

There were no verification studies conducted for the audit review.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: The Plan did not have any evidence of referrals from MCPs to the Mental Health Plan (MHP) or referrals from the MHP to the MCP. No evidence of initial assessments, progress notes of treatment planning, and follow-up care between the MCPs and the MHP was provided.

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 access 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.

Category 5 – Coverage and Authorization of Services

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

Authorizations: The Plan did not have any service authorization requests during the audit period.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Eight grievances were reviewed for timely resolution, appropriate response to 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 Care

The Plan is required to coordinate services furnished to beneficiaries with services the beneficiary receives from any other managed care organization (MCO), in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. *(Contract, Exhibit A, Attachment 10(1)(A)(2))*

The Plan shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries. The Contractor shall ensure the components of the MOU comply with guidance issued by DHCS regarding MOU requirements. The MOU shall address how to ensure Medically Necessary Non specialty mental health service (NSMHS) and specialty mental health service (SMHS) provided concurrently are coordinated and non-duplicative. The Mental Health Plan (MHP) shall monitor the effectiveness of its MOU with Medi-Cal managed care plans. Should a conflict arise between the parties to the MOU, the Contractor shall abide by the requirements in BHIN 21-034. (California Code of Regulations (CCR), Title 9, section 1810.370.) *(Contract, Exhibit A, Attachment 10(1)(E))*

The *Memorandum of Understanding (MOU) for Coordination of Services (executed 2014 and 2018)* detailed the expectations and delegated activities between the Plan and the MCOs. The MOU addressed shared responsibilities, requirements for program oversight, assessment and referral procedures, protocols for the beneficiary's transition, and coordination of care. In addition, it states that the Plan will accept and track MCOs referrals. The Plan in conjunction with MCOs will hold regular meetings to review the referral and care coordination to improve quality of care and will develop reports that track cross-system referrals and beneficiary engagement.

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. *(Plan Contract, Exhibit A, Attachment 10, section (1)(A)(2); Code of Federal Regulations (CFR), Title. 42, section 438.208(b)(2)(i)-(iv); California Code of Regulations (CCR), Title 9, section 1810.415)*

Plan policy *21-018, Coordination with Physical Health Care Providers (revised 08/06/2021)* stated the Plan enters into a Memoranda of Understanding (MOU) with each MCP that enrolls members served by Plan. The MOU addresses the referral protocol between the Plan and MCP, including:

- How Plan will provide a referral to the MCP when Plan determines that the member's mental illness would be responsive to physical health care-based treatment.
- How the MCP will provide a referral to Plan when the MCP determines SMHS covered by Plan may be required.

Finding: The Plan did not ensure to coordinate services furnished to beneficiaries with its managed care organizations.

Although the MOU addressed requirements for program oversight and referral procedures, the Plan did not implement its responsibility to coordinate care for referrals to MCOs. The Plan did not maintain a log of referrals to MCOs. There was no evidence that the Plan conducted meetings with the MCOs to conduct collaboration, oversight and review the effectiveness of the MOU, that includes ensuring referrals are processed for medically necessary services.

In the interview, the Plan stated it experiences communication challenges with its MCOs due to frequent changes in their representatives, which impacts its ability to develop consistent referral processes. Additionally, the MCOs lacked in county facilities and services to refer members who met mild to moderate treatment criteria. The lack of services from the MCOs resulted in the Plan continuing treatment for members that should have been referred to the MCOs.

In a written narrative, the Plan also confirmed that it treated members with mild to moderate symptoms to keep them out of the local crisis systems such as to prevent their symptoms from increasing, preventing loss of function, and citing the lack of local MCOs resources. The Plan was looking at ways it may be able to contract with the MCOs to provide Non-Specialty Mental Health Services (NSMHS) for Medi-Cal members.

When the Plan does not fully implement its MOU by not coordinating referrals to MCOs, this can lead to poor coordination of care that may result in poor health outcomes if the provision of behavioral health services is missed or delayed.

Recommendation: Ensure the Plan is complying with the Contract and MOU requirements in providing coordination of care to beneficiaries.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.2: 24/7 Access Line and Written Log of Requests for SMHS
4.2.1 24/7 Access Line

The Plan shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week, that provides language capabilities in all languages spoken by beneficiaries of the county; provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met; services needed to treat a beneficiary's urgent condition; and how to use the beneficiary problem resolution and fair hearing processes. *CCR, Title 9, Chapter 11, sections 1810.405(d) and 1810.410(e)(1))*

Plan policy *22-013, 24/7 Toll-Free Access Line (revised 05/12/2022)* established guidelines for Medi-Cal members to provide statewide toll-free telephone number 24 hours a day seven days per week, with language capabilities in all languages spoken by members in the county, provide information to members on how to access specialty mental health services, and information on how to treat a member's urgent condition.

Finding: The Plan did not ensure its 24/7 Access Line provided required information regarding how to treat a member's urgent condition.

The Plan has policy *22-013*, *Toll-Free Access Line;* however, the Plan staff did not follow the process related to treating members' urgent condition through its 24/7 Access line.

The verification study identified four out of five DHCS test calls in which the Plan did not provide information about how to treat a member's urgent condition.

A review of the Plan's quarterly test call reports indicated that the Plan did not consistently assess the provision of required information regarding how to treat a member's urgent condition.

In an interview, the Plan stated that front office staff operate the 24/7 Access Line by utilizing a shared cellular phone. The Plan acknowledged it has concerns with the effectiveness of its one-time training for its Access Line operators. The low volume of

Access Line calls limits the staff from gaining sufficient experience providing members with the required information. The Plan stated it conducts a limited number of test calls per quarter due to challenges getting people to perform the test calls.

When the Plan staff does not provide members with information about how to treat an urgent condition, it could lead to delays in receiving necessary urgent medical treatment.

This is a repeat of the 2020-2021 audit finding – Access and Information Requirements.

Recommendation: Implement and train staff on policies and procedures to ensure the Plan's 24/7 access line system provides required information regarding how to treat a member's urgent condition.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2: Concurrent Review and Prior Authorization Requirements
5.2.1 Concurrent Review

The Plan is required to comply with all state and federal statutes and regulations, the terms of this Agreement, Behavioral Health Information Notices (BHINs), and any other applicable authorities. *(Contract, Exhibit E, section (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*)

Plan policy *21-005*, *Concurrent Review and Authorization of Specialty Mental Health Services (revised 04/24/2023)* described procedures for the authorization and concurrent review of psychiatric inpatient hospital services.

Finding: The Plan did not conduct concurrent review of members for psychiatric inpatient hospital services.

Plan has policy 21-005, *Concurrent Review and Authorization of Specialty Mental Health Services;* however, it lacks proactive monitoring mechanism for the authorization of psychiatric inpatient hospital services.

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

In the interview, the Plan stated that concurrent review for inpatient psychiatric services was not conducted because hospitals did not provide necessary

documentation to the Plan on a periodic basis. The Plan stated it had made repeated requests to the hospitals regarding the authorization process including providing hospitals the Plan's 24/7 phone number for member admissions. However, the Plan staff did not ensure to verify with the hospital to inquire about the psychiatric inpatient hospital stay on a periodic basis.

When the Plan does not conduct concurrent review, it may impact beneficiaries' ability to receive appropriate medically necessary services.

Recommendation: Revise and implement policies and procedures to ensure that the Plan conducts concurrent review by implementing an effective communication process with psychiatric inpatient hospitals on a periodic basis.