DHCS REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF:

Modoc County Behavioral Health
2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
BEHAVIORAL HEALTH REVIEW BRANCH

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF

Modoc County Mental Health Plan

2024

Contract Number:	22-20116
Audit Period:	July 1, 2022 through June 30, 2023
Dates of Audit:	June 4, 2024 through June 21, 2024
Report Issued:	September 27, 2024

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I. INTRODUCTION

Modoc County Behavioral Health Services (Plan) provides a variety of Specialty Mental Health Services (SMHS) for county residents. The Plan is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of supporting the mental health needs of the community.

Modoc County is located in the northeast corner of California. The Plan provides services throughout Modoc County, which consists of 19 cities, communities, and Native American reservations, with Alturas being the only incorporated city in the County.

In the fiscal year 2022-2023, the Plan served 499 members (325 adults/174 youth) and had a total of 15 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS SMHS audit for the period of July 1, 2022, through June 30, 2023. The audit was conducted from June 4, 2024, through June 21, 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 September 18, 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 September 26, 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 five categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, and Program Integrity.

The prior DHCS triennial compliance review (covering fiscal years 2017 through 2020), identified deficiencies incorporated in the Corrective Action Plan (CAP). This year's audit included a review of documents to determine 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 beneficiary access to SMHS need Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). The Plan did not ensure children and youth were assessed for the need for ICC and IHBS.

The Plan is required to provide necessary Therapeutic Foster Care (TFC) services for children and youth who meet beneficiary access criteria for SMHS. The Plan did not ensure the provision of TFC services through a network of appropriate TFC providers.

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. The Plan did not ensure the assessment for the need of TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

The Plan shall certify, or use another Plan's certification documents to certify, the organizational providers that subcontract with the Plan to provide SMHS. The Plan did

not ensure certification of its providers in a timely manner that subcontract with the Plan to provide SMHS.

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

Category 3 was not evaluated as part of this year's audit.

Category 4 – Access and Information Requirement

The Plan is required to maintain a written log of the initial requests for SMHS and services needed to treat a beneficiary's urgent condition. The Plan did not log all calls requesting SMHS or treatment of a beneficiary's urgent condition.

Category 5 – Coverage and Authorization of Services

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

Category 6 – Beneficiary Rights and Protection

Category 6 was not evaluated as part of this year's audit.

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 this audit of the Plan to ascertain that medically necessary services provided to beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the state's SMH(S) Contract.

PROCEDURE

DHCS conducted an audit of the Plan from June 4, 2024, through June 21, 2024, for the audit period of July 1, 2022, through June 30, 2023. 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 study was conducted for this audit:

Category 1 – Network Adequacy and Availability of Services

ICC, IHBS, and TFC Determination: Ten children and youth record files were reviewed for criteria and service determination.

ICC and IHBS Provision of Services: Ten children and youth medical records were reviewed for the provision of ICC and/or IHBS services.

Category 2 – Care Coordination and Continuity of Care

There were no verification studies conducted for the audit review.

Category 4 – 24/7 Access Line and Written Log of Requests for SMHS

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: Five required test calls were made as well as review of the 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

No verification study was conducted.

Category 7 – Program Integrity

No verification study was conducted.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: MODOC COUNTY MENTAL HEALTH PLAN

AUDIT PERIOD: July 1, 2022, through June 30, 2023
DATES OF AUDIT: June 4, 2024, through June 21, 2024

CATEGORY 1 – NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1.2	Children's Services

1.2.1 Medical Necessity Determination for ICC and IHBS

The Plan is required to provide or arrange, and pay for, medically necessary covered specialty mental health services, including ICC and IHBS to beneficiaries under the age of 21. *(Contract, Ex. A, Att. 2, §2(A)(10) and (11))*

The Plan has an affirmative responsibility to determine if children and youth who meet criteria for beneficiary access to SMHS need ICC and IHBS. *(Behavioral Health Information Notice (BHIN) 21-073: Criteria for beneficiary access to SMHS, medical necessity and other coverage requirements; Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3rd edition, January 2018), p. 9.)*

Plan policy *147, Pathways to Well-Being/Intensive Services for Medi-Cal Youth* (*revised 7/22/2021*) outlined requirements for making ICC and IHBS determinations. The policy delineates that the Plan will determine eligibility for ICC and IHBS services and document the determination in the initial assessment. Determinations are repeated every 90 days by an ICC coordinator and in a Child and Family Team meeting, which is documented in the client's chart.

Finding: The Plan did not ensure the determinations for ICC and IHBS for children and youth who meet criteria for beneficiary access to SMHS.

A verification study identified eight of ten children and youth beneficiary files did not contain evidence of medical necessity determinations for ICC and IHBS.

During the interview, the Plan stated that the ICC or IHBS determination was documented in the beneficiary file only when it became a recommended service for the respective beneficiary during weekly team reviews. The Plan stated the determination sometimes was documented in meeting minutes; however, the Plan acknowledged its process can be streamlined to improve effectiveness.

The Plan was unable to locate or provide any additional documentation for the children and youth identified in the verification study. The Plan provided a written narrative stating it will be implementing a new ICC and IHBS assessment process which will include an ICC and IHBS determination form starting July 1, 2024.

When the Plan does not determine the need for ICC and IHBS services, children and youth may not receive necessary behavioral health services and resources.

This is a repeat of the 2020-2021 audit finding – Network Adequacy and Availability of Services.

Recommendation: Implement the Plan's policy and procedure to ensure documentation of ICC and IHBS determination for eligible children and youth beneficiaries.

1.2.2 Provision TFC Services

The Plan is required to provide or arrange, and pay for, medically necessary covered specialty mental health services, including TFC to beneficiaries under the age of 21. *(Contract, Ex. A, Att. 2, §2(A)(13))*

The Plan must provide TFC services to all children and youth who meet beneficiary access criteria for SMHS as medically necessary. *(BHIN 21-073: Criteria for beneficiary access to SMHS, medical necessity and other coverage requirements; Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3rd edition, January 2018), p. 34.)*

Plan policy *147, Pathways to Well-Being/Intensive Services for Medi-Cal Youth* (revised 7/22/2021) described requirements for service planning and delivery for children/youth with TFC services. The policy acknowledges commitment to service delivery of TFC and includes language identifying that TFC is not available in Modoc county and will attempt to contract TFC services contingent on medical necessity and feasibility.

Finding: The Plan did not ensure the provision of TFC services to children and youth.

In an interview, the Plan stated it currently does not provide TFC services and explained there are a very limited number of foster care homes in the area and TFC is not an interest to foster care families, noting foster families have expressed that TFC would be difficult for single or elderly foster parents. To meet the needs of foster youth with intensive needs the Plan utilizes urgent Child and Family Team meetings and provides intensive case management in collaboration with Modoc County Child Welfare Services; however, the Plan acknowledged TFC is a contractual requirement.

During the audit period the Plan did not disseminate any requests for proposals to solicit TFC service providers. The Plan stated it had discussed the need for TFC services during the Modoc County Interagency Leadership Team (ILT) meetings with partnering

agencies; however, the Plan only submitted ILT meeting minutes for meetings that occurred outside the audit period.

When the Plan does not provide TFC services it may impact the ability to serve youth beneficiaries. Youth in need of TFC services may not receive the treatment needed to adequately address their mental health.

This is a repeat of the 2020-2021 audit finding – Network Adequacy and Availability of Services

Recommendation: Engage with providers that are willing to provide TFC services.

1.2.3 Medical Necessity Assessment for TFC

The Plan is required to provide or arrange, and pay for, medically necessary covered specialty mental health services, including TFC to beneficiaries under the age of 21. *(Contract, Ex. A, Att. 2, §2(A)(13))*

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. *(BHIN 21-073: Criteria for beneficiary access to SMHS, medical necessity and other coverage requirements; Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (3rd edition, January 2018), p. 11.)*

Plan policy *147, Pathways to Well-Being/Intensive Services for Medi-Cal Youth* (*revised 7/22/2021*) outlined requirements for service planning and delivery for children/youth with TFC services. The policy states that determination of eligibility for TFC is conducted and documented via the initial assessment.

Finding: The Plan did not ensure determinations of TFC for child and youth who meet criteria for beneficiary access for SMHS.

In an interview, the Plan stated is does not perform TFC determinations and has not implemented tools for the assessment for the need of this service. The Plan cited the lack of TFC providers as the reason for not assessing for TFC. If a beneficiary or their family was interested in a TFC assessment the Plan would provide CFT meetings and intensive case management. In the written the narrative, the Plan acknowledged the need for TFC services and, again, cited the lack of available services.

When the Plan does not assess whether eligible beneficiaries need TFC services, it may impact its ability to serve youth beneficiaries. Youth in need of TFC services may not receive the treatment needed to adequately address their mental health.

This is a repeat of the 2020-2021 audit finding – Network Adequacy and Availability of Services.

Recommendation: Establish policies and procedures to assess children and youth for the need of TFC services.

1.4	Provider Selection and Monitoring

1.4.1 Certification of Organizational Providers

The Plan shall certify, or use another Plan's certification documents to certify, the organizational providers that subcontract with the Plan to provide SMHS, in accordance with California Code of Regulations (CCR), title 9, §1810.435. *(Contract, Ex. A, Att. 8, §8(D))*

Plan policy *177, Medi-Cal Certification and Recertification of Organizational Mental Health Providers* (*revised 2/16/2023*) included procedures for the certification and recertification of organizational providers. The Plan holds the sole responsibility for selecting, certifying, recertifying, and monitoring all of its contracted providers. Each Medi-Cal site must be recertified every three years. The recertification process includes a site review, completion of a recertification transmittal form, update of fire clearance, and submitting the transmittal to DHCS for approval.

Finding: The Plan did not ensure the certification and recertification of organizational providers that subcontract with the Plan to provide SMHS.

The DHCS Provider Monitoring Report revealed five of five provider sites were overdue for re-certification.

In an interview, the Plan stated it was aware of the overdue providers. The lapse in the recertification process was due to turnover for the staff position responsible for tracking provider certifications. The Plan stated the position has recently been filled and submitted a narrative post interview outlining its plan to implement a new procedure for tracking certifications.

When the Plan does not certify providers rendering SMHS, the Plan cannot ensure that SMHS is provided by qualified practitioners which may result in poor mental health outcomes for the beneficiaries.

This is a repeat of the 2020-2021 audit finding – Network Adequacy and Availability of Services.

Recommendation: Implement procedures to ensure monitoring and timely providers recertification.

CATEGORY 4 – ACCESS AND INFORMATION REQUIREMENTS

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

4.2.1 Access Call Log

The Plan shall maintain a written log of the initial requests for SMHS from beneficiaries. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request. Beneficiary calls requesting information about SMHS access and services needed to treat a beneficiary's urgent condition are required to be logged. *(CCR, Tit 9, chap 11, §1810.405(f))*

Plan policy *163, 24/7 Access Line and Log; Availability of 24/7 Services* (*revised 9/20/2021*) outlined the procedures for logging information and staff training related to the 24/7 Access Line. All requests for SMHS received through the Access Line, in person, or in writing must be documented in a detailed Access Log. This log includes mandatory information including the caller's name, date of request, and initial disposition, among other relevant details. Clerical staff handle logging during business hours, while after-hours calls are managed by a contractor that logs the information through a secure site.

Finding: The Plan did not log any beneficiary calls requesting access to specialty mental health and urgent condition services.

A verification study revealed that none of five DHCS test calls were logged. Three call requests were made during normal business hours and two call requests were made during after-hours.

In an interview, the Plan stated that staffing shortages and key personnel being absent may have contributed to the calls not being logged during business hours. Its after-hours contractor, which operates the line Monday through Wednesday from 6:00 p.m. to 8:00 a.m. and Thursday at 5:00 p.m. through Monday at 8:00 a.m., transmits its call log to the Plan daily and the Plan transcribes the calls to its Access log. The Plan stated the individual in charge of transcribing the calls has been on leave, which may have contributed to the after-hours calls not being logged correctly.

The Plan was provided the opportunity to find the missing DHCS tests. Post interview, the Plan submitted a written narrative stating it was unable to locate the calls citing staff turnover and training as the cause. The Plan stated it would address this deficiency

moving forward by improving internal training processes and utilizing its test calls to provide feedback to internal staff and to contractor staff who operate the Access Line.

When the Plan does not track beneficiary SMHS call requests, it may have a detrimental impact on the Plan's ability to ensure that beneficiaries receive services in a timely manner.

This is a repeat of the 2020-2021 audit finding – Access Call Log.

Recommendation: Revise and implement policies and procedures to ensure that all SMHS call requests are properly tracked, monitored, and properly recorded.