DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

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

Contract Number: 22-20134

Contract Type: Specialty Mental Health Services

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

Dates of Audit: July 16, 2024 – July 26, 2024

Report Issued: November 5, 2024

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I. INTRODUCTION

Santa Clara 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.

Santa Clara County is located on the southern coast of San Francisco Bay. The Plan provides services within the unincorporated county and in 15 cities: Campbell, Cupertino, Gilroy, Los Altos, Los Altos Hills, Los Gatos, Milpitas, Monte Sereno, Morgan Hill, Mountain View, Palo Alto, San Jose, Santa Clara, Saratoga, and Sunnyvale.

As of August 2024, the Plan had a total of 43,677 members receiving services and a total of 116 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 July 16, 2024, through July 26, 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 October 17, 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 November 1, 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 six categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care; 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 the State's Specialty Mental Health Services (SMHS) Contract and assessed the 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:

Performance Area:

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

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 Requirements

The Plan is required to provide a statewide, 24/7 toll-free telephone number that provides information to members about how to use the beneficiary problem resolution and fair hearing processes. The Plan did not ensure the 24/7 toll-free telephone number provided the required information for the beneficiary problem resolution and fair hearing processes.

The Plan is required to ensure all providers obtain and document the members' consent prior to the initial delivery of telehealth services and inform members that Non-Medical Transportation (NMT) services are available for in-person visits. The Plan did not ensure all providers obtained and documented the members' consent prior to the initial delivery of telehealth services or informed the members that NMT services were available for in-person visits.

Category 5 – Coverage and Authorization of Services

The Plan is required to utilize or implement concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). The Plan did not utilize or implement concurrent review and authorization for all CRTS and ARTS.

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 this audit of the Plan to ascertain that medically necessary services provided to members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's SMHS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from July 16, 2024, through July 26, 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 for this audit:

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: Five member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and five 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 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 five test calls made to the Plan.

Category 5 – Coverage and Authorization of Services

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

Category 6 – Beneficiary Rights and Protection

Grievances Procedures: 20 grievances 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

Performance Area

Category 4 – Access and Information Requirements

4.2 24/7 Access Line and Written Log of Request

4.2.1 Access Line Information

The Plan shall provide a statewide, toll-free telephone number 24 hours a day, seven days a week, that provides language capabilities in languages spoken by beneficiaries of the county; provides information to beneficiaries about how to access SMHS, including SMHS 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. *(California Code of Regulations, Title 9, chapter 11, section 1810.405(d); and section 1810.410(e)(1))*

Plan policy, *ADM-007 Access and Availability of Behavioral Health Services* (revised 08/23/2022), established guidelines for Medi-Cal beneficiaries to receive timely and accessible behavioral health services. Call center responsibilities include: a statewide toll-free phone line available 24/7 for beneficiaries, providing 24/7 telephone screening, information, and referral services to beneficiaries, including weekends and holidays; facilitating referrals based on needs; coordinating out-of-area authorizations; utilizing DHCS screening and transition of care tools to guide SMHS referrals.

Finding: The Plan did not ensure the 24/7 access line provided the required information regarding beneficiary problem resolution and fair hearing processes 24 hours a day.

A verification study identified two of two test calls requesting information regarding beneficiary problem resolution and fair hearing processes went to voicemail and the callers were not provided the required information.

In an interview, the Plan acknowledged that the 24/7 access line system for members seeking information regarding the problem resolution and fair hearing processes may be ineffective when the call is not routed to a live representative. The Plan stated that there were instances of calls outside of business hours going to voicemail, with no live staff present. Further, the Plan expressed plans to review the 24/7 access line process to explore solutions to divert the caller to a live representative.

When the Plan does not provide members with information regarding problem resolution and fair hearing processes, it may limit the members' ability to file a grievance or appeal the Plan's decisions regarding services.

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

Recommendation: Implement policies and procedures to ensure the Plan's 24/7 access line system provides required information regarding the problem resolution and fair hearing processes 24 hours a day.

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; NMT 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. *(Behavioral Health Information Notice (BHIN) 23-018, Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal*)

Plan policy, *4600 Telehealth Policy for Psychiatry (Outpatient Service*s) (revised 01/31/2020), outlined the requirement to obtain and document consent for telepsychiatry services; the consent must state the beneficiary has decided to receive telepsychiatry services rather than alternatives; the beneficiaries must be clearly informed about the risks, benefits, and consequences of telehealth; and the right to withdraw from telepsychiatry services at any time.

Plan policy, *4601 Telehealth Policy for Outpatient Therapy (Outpatient Services)* (issued 03/16/2020), outlined the requirement to obtain and document explicit informed consent for telehealth services; consent for treatment must be obtained for telehealth encounters; verbal consent shall be documented in the beneficiaries' medical record and be available upon request; beneficiary will be informed of risks, benefits, and consequences of telehealth; and the beneficiary's right to withdraw from telepsychiatry services at any time.

Finding: The Plan did not ensure all providers obtained and documented the members' consent prior to the initial delivery of telehealth services or informed the member that NMT services are available for in-person visits.

In an interview, the Plan stated that an internal review showed deficiencies in documenting the member consent for telehealth services. The Plan stated that some instances of consent were recorded generically in chart notes without detailing all required elements outlined in BHIN 23-018. The Plan acknowledged that the current policies for telehealth were out of date and that the Plan was in the process of revising and updating the policies to be in compliance with the requirement.

The Plan submitted policy, *SDM-009 Telehealth Policy (draft),* which is currently in the process of being developed and is anticipated to supersede the current telehealth policies for psychiatry and outpatient therapy. The policy has not been approved and does not reflect governing policies during the audit period.

When the Plan does not ensure that all providers obtain and document members' consent prior to the initial delivery of telehealth services, members are not fully informed about their options or rights related to telehealth services.

Recommendation: Update the telehealth policies and consent forms to explicitly include all required elements, such as the member's right to access in-person services, the voluntary nature of telehealth, the option to withdraw consent without affecting future access to Medi-Cal services, NMT benefits, and any potential limitations or risks of telehealth compared to in-person visits.

COMPLIANCE AUDIT FINDINGS

Performance Area

Category 5 – Coverage and Authorization of Services

5.3 Concurrent Review and Prior Authorization Requirements

5.3.1 Crisis Residential Treatment Services and Adult Residential Treatment Services

The Plan must utilize the referral and/or concurrent review and authorization for all CRTS and ARTS. The Plan may not require prior authorization.

1. If the Plan refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization only if the Plan specifies the parameters (e.g., number of days authorized) of the authorization.
2. The Plan must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.
   (BHIN 22-016, Authorization of Outpatient Specialty Mental Health Services)

Plan policy, *UMR-001 Authorization of Outpatient Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services* (approved 10/24/2023), outlined the authorization process for outpatient SMHS and DMC-ODS services within the Plan. The policy states that all authorization decisions follow Medi-Cal medical necessity criteria and clinical best practices. The policy identifies that the ARTS and CRTS do not require prior authorization.

Finding: The Plan did not utilize or implement concurrent review and authorization for all CRTS and ARTS.

A verification study revealed six of six authorizations for CRTS did not include parameters (e.g., number of days authorized) or evidence of concurrent review.

In an interview, the Plan stated CRTS are available; however, the Plan is not currently conducting concurrent review for the service. The Plan stated the CRTS providers were resistant to concurrent review. The Plan stated that it is modifying the CRTS contracts in Fiscal Year 2024-2025 to establish the required authorization process and will include additional training and guidance. In addition, the Plan submitted a narrative confirming concurrent review of CRTS was not in place during the audit period and reiterated

efforts to implement the process next fiscal year citing update to the providers' contracts and implementing new policies.

Further, the Plan stated it is not currently providing ARTS. The Plan disseminated a Request for Proposal (RFP) for ARTS, which resulted in a contract with a provider who was not a licensed ARTS provider. This led the Plan to establish an Enhanced Adult Residential program in lieu of an ARTS. The Plan has also disseminated a Request for Statement of Qualifications (RFSQ) to continuously engage providers for this service. The Plan submitted the RFP, RFSQ, and a narrative reiterating the licensing challenges of current providers.

When the Plan does not utilize or implement concurrent review and authorization for all CRTS and ARTS, a member's ability to receive medically necessary services can be negatively impacted.

This is Repeat Finding of the 2020-2021 Review – Concurrent Review and Prior Authorization Requirements

Recommendation: Develop and implement policies and procedures related to the service authorization requests and concurrent review processes for CRTS and ARTS.