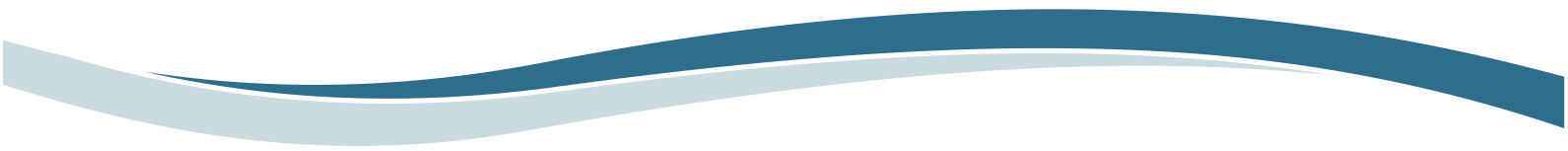
DHCS REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF: SUTTER-YUBA

2023



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

Sutter-Yuba County Mental Health Plan

2023

Contract Number:	22-20141
Audit Period:	July 1, 2022 Through June 30, 2023
Dates of Audit:	July 11, 2023 Through July 20, 2023
Report Issued:	December 05, 2023

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I. INTRODUCTION

The bi-county structure for Sutter-Yuba Behavioral Health (Plan) provides mental health services to residents of both Sutter County and Yuba County through a Joint Power Agreement established in 1969. The Plan is unique because it is the only bi-county behavioral health organization in the State of California. The Plan oversees the full range of clinical operations of specialty mental health and crisis services.

The Plan provides a broad continuum of prevention, early intervention, and service needs for mental health services as well as the necessary infrastructure, technology, and training elements that support this system for both counties.

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 July 11, 2023 through July 20, 2023. The audit consisted of document review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on November 14, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. On November 28, 2023, the Plan submitted a response. DHCS' evaluation of the Plan's responses is 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.

DHCS issued the prior SMHS Finding Report for Fiscal Year 2019/2020 on January 24, 2020, for the review period of July 1, 2017, through June 30, 2020. This current compliance audit examined the Plan's compliance with its DHCS Contract and implementation of its Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Network Adequacy and Availability of Services

The Plan is required to maintain and assess its provider network to ensure adequate access for all contracted services. The Plan did not monitor and maintain an adequate provider network as it did not establish contracts with Therapeutic Foster Care providers (TFC) for the provision of TFC services.

The Plan is required to ensure provision of TFC services when medically necessary. The Plan did not determine the need for TFC services in order to provide the services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

Category 2 – Care Coordination and Continuity of Care

No findings were noted for the audit period.

Category 3 – Quality Assurance and Performance Improvement

No findings were noted for the audit period.

Category 4 – Access and Information Requirements

No findings were noted for the audit period.

Category 5 – Coverage and Authorization of Services

No findings were noted for the audit period.

Category 6 – Beneficiary Rights and Protections

The Plan is required to have an appeal system in place to handle appeals of adverse benefit determinations. The Plan did not ensure that financial liability disputes, which are adverse benefit determinations, were classified as appeals.

The Plan is required to provide a beneficiary with a Notice of Adverse Benefit Determination (NOABD) upon denial of a beneficiary's request to dispute a financial liability. The Plan did not provide beneficiaries a NOABD upon denial of requests to dispute financial liability.

Category 7 – Program Integrity

No findings were noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Contract and Enrollment Review Division to ascertain that the SMHS services provided to Plan beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

The audit was conducted from July 11, 2023, through July 20, 2023. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Children's Services: Ten medical records were provided to review Intensive Care Coordinator (ICC) and Intensive Home Based Services (IHBS) level services.

Category 2 – Care Coordination and Continuity of Care

No verification study was conducted.

Category 3 – Quality Assurance and Performance Improvement

No verification study was conducted.

Category 4 – Access and Information Requirements

24/7 Access Line: Seven test calls were conducted both during business hours and after hours.

Category 5 – Coverage and Authorization of Services

Concurrent Request: 12 medical concurrent were reviewed for timeliness, consistent application of criteria, and appropriate review.

Category 6 – Beneficiary Rights and Protections

Grievance procedures: 31 standard grievances, that included six quality of care and 25 qualities of service, were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in beneficiary's preferred language.

Category 7 – Program Integrity

No verification study was conducted.

A description of the findings for each category is contained in the following section.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Sutter-Yuba Mental Health Plan
AUDIT PERIOD: July 1, 2022 through June 30, 2023 **DATES OF AUDIT:** July 11, 2023 through July 20, 2023

CATEGORY 1 - Network Adequacy and Availability of Services

1.2	Children's Services

1.2.1 Network Adequacy Requirements

The Plan must maintain a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services cover under this contract for all beneficiaries. *(Contract, Exhibit A, Attachment 8, (3)(B))*

The Plan shall implement mechanisms to assess the capacity of service delivery of its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Plan's delivery system. *(Contract, Exhibit A, Attachment 8, (2)(A))*

Finding: The Plan did not maintain and monitor to ensure that its network's capacity supported access to TFC services for all beneficiaries under 21 years of age.

Plan policy *Monitoring Network Adequacy (effective 4/20/2020),* states that the Plan will maintain and monitor to ensure that its network's capacity supported providers within the network. However, this policy does not describe how it will provide adequate access to TFC services.

The Plan did not document or provide the requested evidence of efforts to establish subcontracts with TFC providers.

In a written response, the Plan stated that currently there is no contract with any TFC providers to offer TFC services to children and youth within the county.

When the Plan does not maintain and monitor for adequate provider network in the provision of TFC services, beneficiaries cannot obtain medically necessary services, and this can result in severe impacts on behavioral health.

Recommendation: Develop policies and procedures to meet network adequacy standards and to ensure access to TFC services.

1.2.2 Therapeutic Foster Care Services

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. The Plan must provide TFC services to all children and youth who meet beneficiary access and medical necessity criteria for SMHS. *(Behavioral Health Information Notice (BHIN) 21-073, Criteria for Beneficiary Access to SMHS, Medical Necessity and other Coverage Requirements; 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. 11 & 34.)*

Plan policy *Therapeutic Foster Care Services (revised 9/25/2019),* stated that the Plan will work closely with TFC agencies and TFC families to provide TFC services for children and youth identified as needing such services. Plan development for children receiving TFC services will be developed by the Child Family Team (CFT). The Plan may participate in a CFT for children receiving TFC services and follow-up CFT meetings will occur at least every 90 days. The Quality Assurance (QA) staff analyst will review the progress of TFC services in CFT meetings at least every three months.

Finding: The Plan did not ensure the provision of TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

Plan policy *Therapeutic Foster Care Services (revised 9/25/2019)* does not describe how the Plan conducts screenings for the need of TFC services.

TFC is included in SMHS children's services, along with IHBS and ICC. In a verification study based on requested TFC, IHBS, and ICC records, ten of ten records documented the Plan's assessment for the need and the provision of IHBS and ICC services. However, there was no documentation of screenings to assess the need and provision of TFC services.

The Plan did not submit documents supporting compliance with requirements for need determination and provision of TFC services. There was no submission of assessment forms with individualized TFC need screenings, CFT meeting notes addressing TFC, and quarterly QA staff analyst review of the progress of TFC meetings.

When the Plan does not screen for TFC needs and provide TFC services, this can lead to non-identification of TFC needs and delays in accessing medically necessary services resulting in poor health outcomes for SMHS eligible children and youth.

Recommendation: Revise and implement policies and procedures to ensure that the Plan screens for TFC needs and provides medically necessary TFC for SMHS eligible children and youth beneficiaries.

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CATEGORY 6 - Beneficiary Rights and Protections

6.1	Grievance and Appeal System

6.1.1 Adverse Benefit Determination Classification

The Plan's beneficiary problem solution process shall have an appeal system in place to handle appeal of adverse benefit determinations. *(Contract, Exhibit A, Attachment 12)*

Appeal means a review by a Managed Care Organization of an adverse benefit determination. *(Code of Federal Regulations (CFR), Title 42, section 438.400)*

An adverse benefit determination includes the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. *(CFR, Title 42, section 438.400)*

If a Plan or a network provider of the Plan receives a complaint pertaining to an adverse benefit determination, as defined under CFR, Title 42, section 438.400, the complaint is not considered a grievance. *(Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No: 18-010E Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates)*

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. *(CFR, Title 42, section 438.400)*

The Plan shall ensure that each beneficiary has adequate information about its problem resolution processes by explaining the availability of State Hearings after the exhaustion of an appeal in accordance with CFR, Title 42, sections 438.402(c)(1) and 438.408 (c)(3). *(Contract, Exhibit A, Attachment 12 (1)(B)(4))*

The Plan's Beneficiary Handbook states that following an adverse benefit determination, such as a denial of a request to dispute financial liability, the Plan will send a letter or a NOABD that informs beneficiaries of their appeal rights.

Finding: The Plan did not ensure that financial liability disputes, which are adverse benefit determinations, were classified as appeals.

Plan policy *Grievance and Appeal Procedures (effective 6/13/2023),* states that its QA staff analyst is responsible for classifying grievance and appeal cases. This policy does not state that complaints pertaining to adverse benefit determinations are classified as appeals.

In a verification study, the Plan misclassified and processed eight beneficiary requests to

dispute financial liability. These requests were classified as grievances and not as appeal cases.

In an interview, the Plan explained that the appeal misclassification error was due to the QA staffs' lack of knowledge related to financial liability, and adverse benefit determinations that must be classified as appeals.

When appeals are misclassified as grievances, beneficiaries can miss deadlines and may not be able to exercise their rights to appeal disputes by requesting a State Fair Hearing.

Recommendation: Revise and implement policies and procedures to ensure adverse benefit determinations with financial liability are classified as appeals.

6.2	Handling Grievance and Appeals

6.2.1 Written Notice of Adverse Benefit Determination (NOABD) Requirements

The Plan is required to provide a beneficiary with a NOABD upon denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial liabilities. *(Contract, Exhibit A, Attachment 12, (10)(A))*

In accordance with the federal requirements, Plans must use the DHCS' uniform notice templates when providing beneficiaries with a written NOABD for adverse benefit determinations that include the dispute of financial liability. *(MHSUDS Information Notice No: 18-010E Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates)*

The Plan shall ensure that each beneficiary has adequate information about its problem resolution processes by explaining the availability of State Hearings after the exhaustion of an appeal in accordance with CFR, Title 42, sections 438.402(c)(1)(i)(A) and 438.408 (c)(3). *(Contract, Exhibit A, Attachment 12 (1)(B)(4))*

The Plan's Beneficiary Handbook states that following an adverse benefit determination, such as a denial of a request to dispute financial liability, the Plan will send a written notice to advise Medi-Cal beneficiaries of their appeal rights and provides guidance regarding the State Hearing process.

Finding: The Plan did not provide beneficiaries a NOABD upon denial of requests to dispute a financial liability.

In a verification study, the Plan did not send the NOABD Financial Liability Notice to

eight beneficiary requests disputing financial liability.

Plan policy *#09-003 Notice of Adverse Benefit Determination (NOABD) (effective 9/18/2019),* states that the Business Office is responsible for issuing the NOABD dispute of financial liability. The Plan did not follow its policy and procedures to provide notification letters to inform the beneficiaries of the reasons for denial, and their rights to file a State Fair Hearing.

In an interview, the Plan stated that there were issues with inadequate QA staffing and its QA staff did not receive training to ensure adverse benefit determinations with financial liability are classified as appeals.

When the Plan does not send beneficiaries a required written NOABD upon denial of requests to dispute financial liability, beneficiaries may not receive critical information necessary to exercise their rights to appeal disputes by requesting a State Fair Hearing.

Recommendation: Revise and implement policies and procedures to ensure NOABDs are sent to beneficiaries upon denial of requests to dispute a financial liability.