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

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

Contra Costa County Mental Health Plan

2023

Contract Number:	22-20098
Audit Period:	July 1, 2022 Through June 30, 2023
Dates of Audit:	September 12, 2023 Through September 22, 2023
Report Issued:	February 15, 2024

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I. INTRODUCTION

Contra Costa County Behavioral Health Services (Plan) provides a variety of Specialty Mental Health Services (SMHS) for county citizens. 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.

Contra Costa County is located in northern California. It occupies the northern portion of the East Bay region of the San Francisco Bay Area and is primarily suburban. The Plan covers services throughout the Central, East, and West regions in 19 cities: Antioch, Brentwood, Clayton, Concord, Town of Danville, El Cerrito, Hercules, Lafayette, Martinez, Town of Moraga, Oakley, Orinda, Pinole, Pittsburg, Pleasant Hill, Richmond, San Pablo, San Ramon, and Walnut Creek.

As of June 30, 2023, the Plan had 16,530 Medi-Cal beneficiaries receiving specialty mental health services.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS audit of the Plan for the period of July 1, 2022 through June 30, 2023. The audit was conducted from September 12, 2023 through September 22, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on January 29, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On February 7, 2024, the Plan submitted a response after the Exit Conference. The results of our evaluation 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 triennial compliance review (covering fiscal years 2017 through 2020), identified deficiencies incorporated in the Corrective Action Plan (CAP). This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of 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:

Category 1 – Network Adequacy and Availability of Services

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

The Plan is required to provide or arrange TFC services to all children and youth who meet beneficiary access and medical necessity criteria for SMHS. The Plan did not ensure the provision of TFC services through a network of appropriate TFC providers.

Category 2 – Care Coordination and Continuity of Care

No findings were noted 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, toll-free telephone number 24 hours a day, seven days per week, that provides information to beneficiaries about how to access specialty mental health services. The Plan did not ensure its 24/7 toll-free number system provided required information on how to access SMHS and the beneficiary problem resolution and fair hearing processes.

The Plan is required to maintain a written log of the initial requests for specialty mental health services from beneficiaries. The Plan did not log all beneficiary calls requesting access to specialty mental health and urgent condition services.

Category 5 – Coverage and Authorization of Services

No findings were noted during the audit period.

Category 6 – Beneficiary Rights and Protection

No findings were noted during the audit period.

Category 7 – Program Integrity

No findings were noted 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 beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's SMH Contract.

PROCEDURE

DHCS conducted an audit of the Plan from July 1, 2022 through June 30, 2023. The audit included a review of the Plan's Contract with DHCS, its policies and procedures for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), TFC Determination: Ten children and youth assessments were reviewed for criteria and service determination.

ICC/IHBS Provision of Services: 15 children and youth beneficiary files were reviewed for the provision of ICC and/or IHBS services.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Ten beneficiary files were reviewed for evidence of handoff following hospitalization discharge back to the Plan.

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 Test Call Log: Five required test calls were made and review of 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

Notice of Adverse Benefit Determination: Nine beneficiary files were reviewed for evidence of appropriate documentation and completeness.

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

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: 17 grievances were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

There were no reported appeals during the audit period.

Category 7 – Program Integrity

Fraud, Waste, and Abuse Reporting: There were no reportable cases of fraud, waste, and abuse during the audit period.

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

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: Contra Costa County Mental Health Plan
AUDIT PERIOD: July 1, 2022 through June 30, 2023 **DATE OF AUDIT:** September 12, 2023 through September 22, 2023

CATEGORY 1 – NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1.2	Children's Services

1.2.1 Assessment for the Need of TFC Services

The Plan is required to provide or arrange, and pay for, the following medically necessary covered specialty mental health services to beneficiaries. *(Contract, Exhibit A, Attachment 2)*

The Plan has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC. *(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's policy, 722-*MH, Guidelines for Therapeutic Foster Care (Effective 02/01/2023)*, delineates standards and guidelines for providing TFC services to Medi-Cal beneficiaries under the age of 21 who meet State TFC criteria. Beneficiaries residing in out-of-home/family settings or stepping down from a Short-Term Residential Therapeutic Program (STRTP) will be discussed in Child and Family Teams and formally screened/triaged in the Interagency Placement Committee meetings to determine eligibility and appropriateness for TFC mental health services. The Plan is to offer TFC services to all eligible beneficiaries whether or not they are a member of the Katie A. subclass. In addition, the TFC agency is responsible for ensuring that TFC parents are approved by the resource family agency, are trauma-informed, and meet TFC service model training requirements and qualifications as outlined in the most current edition of the Medi-Cal Manual.

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

Although requested, the Plan did not submit completed forms to assess the need for TFC services. Rather, the Plan provided a screening tool *(TFC Criteria Checklist (Draft))* and a blank referral form (*TFC Referral Request)* which identifies beneficiary demographic information and other relevant information, such as medical necessity, to complete a referral for TFC services. However, the Plan was not able to provide any evidence to demonstrate that TFC assessments took place.

In an interview, the Plan stated that it is currently not assessing for the need of TFC services as this service is unavailable. The Plan stated it will refer children and youth in need of intensive services to its STRTP or wraparound services; however, these programs do not meet TFC program criteria.

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

Recommendation: Implement policies and procedures to ensure children and youth who meet beneficiary access criteria for SMHS are assessed to determine if TFC services are needed.

1.2.2 Provision of TFC Services

The Plan is required to provide, arrange, and pay for, medically necessary covered SMHS, such as TFC, to beneficiaries. *(Contract, Exhibit A, Attachment 2)*

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.)*

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

Plan policy, *722-MH, Guidelines for Therapeutic Foster Care (Effective 02/01/2023)*, delineates standards and guidelines for providing TFC services to Medi-Cal beneficiaries under the age of 21 who meet State TFC criteria. The TFC service model shall be provided to all full-scope Medi-Cal beneficiaries who meet medical necessity criteria and have agreed to accept the services. The policy also delineates the requirements for TFC providers. The TFC agency must meet both licensure and accreditation requirements and must have a contract with the Plan to provide SMHS under the TFC service model.

Finding: The Plan did not ensure the provision of TFC services through a network of appropriate TFC providers.

In an interview, the Plan stated that it had a successful Request for Proposal (RFP) process and was able to secure a contract with one subcontractor to provide TFC services. However, the Plan's subcontractor has halted TFC referrals as its seeking guidance regarding the employment status of TFC parents to be able to provide TFC services. In the meantime, the Plan is working with other local agencies to resolve this issue and examining service capacity options, including an additional RFP for TFC service providers; however, these services remain unavailable.

A verification study was not conducted since the Plan did not furnish completed TFC referrals for review. The Plan confirmed that it currently does not have any beneficiaries receiving TFC services.

When the Plan does not contract with TFC providers, it cannot ensure the provision of medically necessary TFC services for children and youth in need of such services.

Recommendation: Implement policies and procedures and referral process to ensure TFC services are rendered by contracted TFC providers.

❖ COMPLIANCE AUDIT FINDINGS ❖
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CATEGORY 4 – ACCESS AND INFORMATION REQUIREMENTS

4.2	Access Line and Written Log

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; provide 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 information on how to use the beneficiary problem resolution and fair hearing processes. *(California Code of Regulations (CCR), Title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1))*

Plan policy, *750-MH Behavioral Health Access Line Service Availability and Telephone Logs for Mental Health Services (Revised 12/02/2019)*, describes the required elements of the Access Line. The Plan shall maintain the Access Line as a toll-free telephone number responsible for providing 24-hr availability with language capability in all languages spoken by beneficiaries of the county. Access Line staff shall offer information, referrals, and crisis/triage support to all callers. Furthermore, the Access Line is to conduct telephone screenings to determine appropriate referrals to behavioral health services, and to ensure that beneficiaries needing specialty mental health services receive care in a timely manner. If the reason for a call is to make a complaint, the Access Line clinician shall provide information to the caller on how to file a grievance.

Finding: The Plan did not ensure its 24/7 Access Line provided required information on how to access SMHS, beneficiary problem resolution and fair hearing processes.

The verification study identified three test calls in which the test caller was not provided information about how to receive SMHS, and one test call in which the caller was not provided information about the beneficiary problem resolution and fair hearing processes.

Furthermore, review of the Plan's 2022 Quality Improvement Plan, outlines the Plan's goals for the 24-hour Access Line. The Plan established internal test call goals of 100 percent compliance for providing information about how to access SMHS as well as information about beneficiary problem resolution and fair hearing processes. The metrics identified that goals pertaining to 24-hour Access Line were not met during the audit period.

In an interview, the Plan stated that administrative staff manage the Access Line during business hours while after-hours are managed by the Plan's contractor. Clinicians are available to screen callers for eligibility of treatment services over the phone. The Plan provides training through a front-end script to Access Line staff and monitors business and after hour test calls (15) on a quarterly basis. However, the Plan lacks an effective monitoring quality improvement process.

Although the Plan provides Access Line training to staff and providers, there is an ongoing CAP for this issue with no definite timeline for CAP resolution due to lack of oversight. The Plan acknowledged it is looking at areas for process improvement and continuous monitoring.

When the Plan does not monitor to ensure the provision of information for access to care, this may limit beneficiaries' ability to access services and/or file appeals or grievances in a timely manner.

This is a repeat finding of the prior year review (Fiscal Year 2019/2020) – D.VI.B1-24/7 Access Line Information

Recommendation: Revise and implement policies and procedures to ensure the Plan's 24/7 Access Line system provides required information for SMHS access, problem resolution, and fair hearing process.

4.2.2 Access Call Log

The Plan shall maintain a written log of the initial requests for specialty mental health services 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, Title 9, section 1810, subdivision 405(f))

Plan policy, 750-*MH Behavioral Health Access Line Service Availability and Telephone Logs for Mental Health Services (Revised 12/02/2019)*, describes the elements of the Access Line. The Access Line is to maintain a written log of all requests for specialty mental health services received by telephone, in person, or in writing, particularly initial requests. All Access Line and backup providers shall log all contacts with callers, including mental health and substance use disorder clients, providers, and caregivers into the electronic health records. The entries in the logged contacts shall include the minimum data elements required to meet compliance standards.

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

The verification study revealed that two of five required DHCS test calls were not properly logged. One call request was made during normal business hours while the second call was made during after-hours.

In an interview, the Plan stated the after-hours contractor will track calls via a secure platform and submit this data to the Plan so it can integrate the data into the Plan's Access call log. The Plan identified challenges that sometimes may occur with contractor's staff not requesting caller's names and phone numbers.
The Plan was provided an opportunity to submit the data for the missing test calls; however, it was unable to provide any further evidence of compliance.

Failure to track beneficiaries' call requests for SMHS can negatively impact the Plan's ability to ensure beneficiaries receive services in a timely manner.

Recommendation: Track and monitor access log procedures to ensure that all SMHS call requests are properly recorded.