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

Fresno County Mental Health Plan

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

Fresno County Mental Health Plan

2024

Contract Number:	22-20101
Audit Period:	July 1, 2022 through June 30, 2023
Dates of Audit:	March 12, 2024 through March 22, 2024
Report Issued:	August 5, 2024

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I. INTRODUCTION

Fresno 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 supporting the mental health needs of the community.

Fresno County is located in central California. The Plan provides services throughout Fresno County, which consists of 55 cities and communities, including the following 15 incorporated cities: Coalinga, Clovis, Firebaugh, Fowler, Fresno, Huron, Kerman, Kingsburg, Mendota, Orange Cove, Parlier, Reedley, San Joaquin, Sanger, and Selma.

In calendar year 2022, the Plan served 21,764 beneficiaries (12,621 adults/9,143 youth) and had a total of 71 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 March 12, 2024, through March 22, 2024. The audit consisted of document reviews, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on July 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 August 1, 2024, the Plan submitted a response after the Exit Conference. The results of the 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). All CAP items were resolved prior to this year's 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 the assessment for the need of TFC services to children and youth who met beneficiary access and medical necessity criteria for SMHS.

The Plan is required to provide necessary 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.

Category 2 – Care Coordination and Continuity of Care

The Plan is required to coordinate the services the Contractor 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. The Plan did not ensure coordination of care between the Plan and other managed care organizations.

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

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

Category 5 – Coverage and Authorization of Services

The Plan is required to provide a beneficiary with a Notice of Adverse Benefit Determination (NOABD) when the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. The Plan did not issue NOABDs for denials for determinations based on type or level of service.

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 beneficiaries comply with federal and state laws, Medi-Cal regulations and guidelines, and the state's SMH(S) Contract.

PROCEDURE

The audit was conducted from March 12, 2024, through March 22, 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 studies were conducted:

Category 1 – Network Adequacy and Availability of Services

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

ICC/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

Coordination of Care Referrals: Ten beneficiary files were reviewed for evidence of referrals from a Managed Care Plan (MCP) to the Mental Health Plan (MHP), initial assessments, and 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: 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

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

Authorizations: Ten beneficiary files were reviewed for evidence of the appropriate services authorization process.

Notices of Adverse Benefit Determination (NOABD) Requirements: 15 beneficiary files were reviewed for evidence of appropriate documentation and completeness of required NOABDs.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: 14 grievances were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Appeal Procedures: One appeal was reviewed for appropriate and timely adjudication.

Category 7 – Program Integrity

No verification study was conducted.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: FRESNO COUNTY MENTAL HEALTH PLAN

AUDIT PERIOD: July 1, 2022, through June 30, 2023
DATES OF AUDIT: March 12, 2024, through March 22, 2024

CATEGORY 1 – NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1.2	Children's Services

1.2.1 Provision of TFC Services

The Plan is required to provide or arrange, and pay for, medically necessary covered SMHS to beneficiaries. *(Contract, Exhibit A, Attachment 2, Section 2(A)(13))*

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, Section 3(B))*

Plan policy *Mental Health Plan Referral and Authorization for Outpatient Specialty Mental Health Services (Revised 12/8/2022)* requires providers to submit authorization requests to provide TFC services.

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.

In an interview, the Plan confirmed that it does not contract with any TFC providers. The Plan stated that TFC services were provided from 2018 through 2021 through a contractor but the contract was not renewed due to challenges with retaining TFC families.

The Plan submitted a written narrative further explaining the challenges it has experienced in recruiting TFC homes, along with limited support from its partnering agencies.

When the Plan does not provide TFC services to children and youth, it may cause delays in accessing needed medically necessary services. This may result in poor health outcomes for children and youth eligible for SMHS.

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

1.2.2 Assessment for the Need of TFC Services

The Plan is required to provide or arrange, and pay for, medically necessary covered SMHS to beneficiaries. *(Contract, Exhibit A, Attachment 2, Section 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 Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, (3rd edition, Jan. 2018), pp. 11 & 34.)*

Plan policy *Mental Health Plan Referral and Authorization for Outpatient Specialty Mental Health Services (Revised 12/8/2022)* states the Plan shall require prior authorization for TFC service determinations. The Utilization Review Specialist (URS) reviews TFC initial and reauthorization requests to determine medical need. Once reviewed, the URS approves or denies the authorization and it is sent to the requesting provider. The Plan's URS will ensure authorization requests are sufficient in amount, duration, and scope to achieve the purpose of the service. A URS may authorize a frequency greater or less than requested at the discretion of the Plan.

Finding: 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.

In an interview, the Plan explained it did not make any TFC determinations during the audit period due to not having contracted providers.

In a written narrative, the Plan stated it is working collaboratively with its local partners to find substitute homes and placements that would meet the level of care utilized with TFC placements, but it has been unable to retain a provider. The Plan also provided a written narrative acknowledging that it did not make TFC determinations during the review period.

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.

CATEGORY 2 – CARE COORDINATION AND CONTINUITY OF CARE

2.1	Coordination of Care Requirements

2.1.1 Referrals and Coordination of Care

The Plan is required to coordinate the services it furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries. *(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(b) and (c))*

Plan policy *PPG 2.1.10 V#: 2, Beneficiary Access/Referral Process (Revised 3/23/2023)*, states that the Plan provides an efficient and culturally sensitive access and referral system for individuals accessing SMHS services. The Plan shall log and track initial requests and referrals for behavioral health services through its Electronic Health Record (EHR), or by any other means deemed acceptable. All persons served seeking SMHS services who meet the criteria for access to the Plan shall be referred and linked to appropriate services. The Client Referrals Form in the EHR documents referrals made for persons currently receiving services.

Finding: The Plan did not ensure beneficiaries received service coordination between the Plan (MHP) and the Managed Care Plan (MCP).

In the verification study, two of ten beneficiary referrals from the MCP to the MHP revealed that the Plan did not document service and referral coordination of care.

- One beneficiary chart included zero documentation. The Plan did not document the exchange of medical information between the MHP and the MCP to appropriately manage the beneficiary's care. (*CCR Title 9, section 1810.415(b))*
- The second chart had a single progress note stating the beneficiary's condition could be appropriately treated by medication services and that the clinician will provide linkage to the beneficiary for treatment by submitting a referral to the MCP; however, there was no evidence of the referral in question. (*CCR Title 9, section 1810.415(c))*

In an interview, the Plan acknowledged missing documentation. The Plan was asked to provide additional documentation (e.g., progress notes, referral forms, team meeting notes) demonstrating coordination of care or relevant communication for the two aforementioned beneficiaries or a narrative explaining why the documentation was

missing. The plan was unable to provide additional evidence for the beneficiaries in questions and provided a narrative stating it could not find additional chart information to demonstrate compliance with the requirement.

When the Plan does not implement coordination of care, this can lead to delays in accessing medically necessary services resulting in poor health outcomes for SMHS-eligible children and youth.

Recommendation: Implement policies and procedures to ensure beneficiaries receive care of coordination.

CATEGORY 5 – COVERAGE AND AUTHORIZATION OF SERVICES

5.4	Notice of Adverse Benefit Determination (NOABD) Requirements

5.4.1 Notice of Adverse Benefit Determination

The Plan is required to provide a beneficiary with a NOABD when the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. *(Contract, Ex. A, Att. 12, Prov. 10(A)(1); 42 C.F.R. section 438.400(b)(1))*

Plan policy *PPG 1.2.12 V#:2, Notice of Adverse Benefit Determination (Effective 03/30/2021)* states that Plan will issue written notification of an adverse benefit determination, in accordance with all applicable federal regulations and contract requirements. An adverse benefit determination is defined as any of the following actions taken by the Plan: the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

Finding: The Plan did not issue NOABD denials or limited authorizations for requested services, including determinations based on the type or level of service.

In a verification study of 14 Plan grievances, DHCS identified a beneficiary grievance that resulted from the beneficiary not receiving a NOABD for denial of authorization for requested services. The Plan had determined that the beneficiary no longer met medical necessity eligibility for treatment and needed to transition to a provider to treat the beneficiary's mild to moderate impairment. The Plan communicated the decision with the beneficiary through phone calls and a contact letter; however, it did not provide the beneficiary the required NOABD for denial of authorization for requested services.

In an interview, the Plan stated that it did not issue a NOABD for denial of authorization for requested services to the beneficiary because the beneficiary eventually agreed to the transition to a lower level of service. The Plan stated that its internal procedure is that when a beneficiary agrees to a transition to a lower level of care it does not send the beneficiary the NOABD for denial of authorization for requested services. The Plan stated that when it sends this NOABDs as a result of level of care determinations, it can lead to increased appeals as beneficiaries may misinterpret the NOABD as denial for mental health treatment.

When a Plan does not provide a NOABD for denial of authorization for requested services it may result in beneficiaries not understanding the reason why a service is being denied or stating a patient's right when a service is denied.

Recommendation: Implement policies and procedures to ensure the Plan provides beneficiaries with NOABDs for denial of authorization for requested services when there is a determination based on the type or level of service.