DHCS REPORT ON THE SUBSTANCE USE DISORDER (SUD) AUDIT OF: Napa County Behavioral Health Services 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 SUBSTANCE USE DISORDER (SUD) AUDIT OF

NAPA COUNTY Behavioral Health Services

2023

Contract Number:	20-10189 Drug Medi-Cal Organized Delivery System
Audit Period:	July 1, 2022 through June 30, 2023
Dates of Audit:	February 13, 2024 through February 23, 2024
Report Issued:	July 10, 2024

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I. INTRODUCTION

Napa 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 Drug Medi-Cal Organized Delivery System (DMC-ODS) treatment services for substance use disorders to county residents.

Napa County is located in northern California. It occupies the northern portion of the North Bay region of the San Francisco Bay Area. The Plan covers services throughout the Central, East, and West regions in five cities: Napa, American Canyon, Yountville, Calistoga, and St. Helena.

As of June 30, 2023, the Plan had 587 Medi-Cal beneficiaries receiving DMC-ODS and had a total of six active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2022, through June 30, 2023. The audit was conducted from February 13, 2024, through February 23, 2024. The audit consisted of document review and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on June 3, 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 June 17, 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 four categories of performance: Availability of DMC-ODS Services, Quality Assurance and Performance Improvement, Coverage and Authorization of Services, and Program Integrity

The prior DHCS compliance report, covering the review period from July 1, 2021, through June 30, 2022, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was not completely closed at the time of onsite; however, this year's audit included a review of documents to determine the 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 – Availability of DMC-ODS Services

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

Category 3 - Quality Assurance and Performance Improvement

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

Category 5 – Coverage and Authorization of Services

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

Category 7 – Program Integrity

The Plan and its subcontractors are required to implement and maintain a provision for a method to verify whether services that have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular

basis. The Plan did not verify if beneficiaries actually received the services documented as having been delivered by network providers.

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 DMC-ODS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from February 13, 2024, through February 23, 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.

There were no verification studies conducted for this audit.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: NAPA COUNTY DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

AUDIT PERIOD: July 1, 2022 through June 30, 2023
DATES OF AUDIT: February 13, 2024 through February 23, 2024

CATEGORY 7 – PROGRAM INTEGRITY

7.3	Service Verification

7.3.1 Service Verification

The Plan and its subcontractors are required to implement and maintain a provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis. *(Contract, Exhibit A, Attachment I, Section II (H)(5)(ii)(e))*

The Plan is required to establish a mechanism to verify whether services were actually furnished to beneficiaries. *(Contract, Exhibit A, Attachment I, Section III (HH)(1))*

Plan policy *02-2002, Alcohol and Drug Services Contract Monitoring (effective July 1, 2022)*, stated that for internal monitoring (of county-operated outpatient program), the Utilization Review Coordinator (URC) and Utilization Review (UR) support staff will perform the following tasks to verify services claimed were actually furnished to beneficiaries:

A. UR staff will review 100 percent of group sign-in sheets and compare to group progress note in the medical record. If a client's signature is missing on the sign-in sheet, then the service shall not be billed for.

B. During annual monitoring, the URC will request a random sample of at least 25 individual service claims from the Fiscal Division. These claims will be compared with progress notes in the medical record to ensure the services claimed align with the service documented.

For provider monitoring, the URC and UR support staff will perform annual monitoring. The URC will request a random sample of at least 25 claims (including both individual and group services) from the Fiscal Division. These claims will be compared with group sign-in sheets and progress notes in the medical record to ensure the services claimed align with the service documented.

Finding: The Plan did not regularly conduct a process to verify if beneficiaries actually received the services documented as having been delivered by network providers.

In an interview, the Plan stated that the UR Team is responsible for conducting the service verification process. The Plan acknowledged the UR Team did not apply the service verification process during fiscal year 2022/2023 but was instead tasked with other priorities.

When the Plan does not apply the service verification process, it cannot ensure that the beneficiaries receive appropriate services delivered by network providers.

This is a repeat of the 2021-2022 audit finding – Program Integrity.

Recommendation: Implement policy and procedures to ensure the provision of services were received by beneficiaries.