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

San Joaquin County Mental Health Plan

2023

Contract Number: 22-20130

Audit Period: July 1, 2022 through June 30, 2023

Dates of Audit: October 31, 2023 through November 9, 2023

Report Issued: April 23, 2024

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I. INTRODUCTION

San Joaquin County Behavioral Health Services (Plan) provides a variety of Specialty Mental Health Services (SMHS) for county residents. 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.

San Joaquin County is located in Northern California's Central Valley. The Plan covers services throughout seven cities: Escalon, Lathrop, Lodi, Manteca, Ripon, Stockton, and Tracy. During fiscal year 2023-24, the Plan provided SMHS to 16,241 beneficiaries.

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 October 31, 2023, through November 9, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on April 4, 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 April 16, 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 year's audit included a review of documents to determine 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 – 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

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 6 – Beneficiary Rights and Protection

The Plan is required to maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. The Plan did not record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt.

Category 7 – Program Integrity

The Plan shall submit disclosures to DHCS regarding any person who is a managing employee or agent of the Plan who has been convicted of a crime related to federal health care programs. The Plan did not ensure the submission of disclosures to DHCS regarding managing employees or agents of the Plan who are convicted of a crime related to federal health care programs.

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 SMHS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from October 31, 2023, through November 9, 2023, for the audit period of July 1, 2022, through June 30, 2023. The audit included a review of the Plan's Contract with DHCS, policies for providing services, the procedures used to implement the policies, and verification studies to determine the effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan representatives.

The following verification studies were conducted:

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 Organization (MCO) to the Plan, initial assessments, and progress notes of treatment planning and follow-up care between the MCO and 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: Ten beneficiary files were reviewed for evidence of appropriate documentation and completeness.

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

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: 16 grievances were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Appeal Procedures: Two appeals were reviewed for appropriate and timely adjudication.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: SAN JOAQUIN COUNTY MENTAL HEALTH PLAN

AUDIT PERIOD: July 1, 2022, through June 30, 2023
DATES OF AUDIT: October 31, 2023, through November 9, 2023

CATEGORY 6 – BENEFICIARY RIGHTS AND PROTECTIONS

6.1	Grievance and Appeal System Requirements

6.1.1 Grievance and Appeal Log

The Plan is required to maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. *(Code of Federal Regulations (CFR), Title 42, section 438.416(a); California Code of Regulations, Title 9, section 1850.205(d)(1); and Contract, Exhibit A(12)(2)(A))*

The Plan's policy, *105.0000.9, Beneficiary Problem Resolution Process (revised April 18, 2023)*, describes the Plan's process on how it resolves beneficiary concerns or problems regarding mental health treatment and/or treatment with programs funded by Drug Medi-Cal Organized Delivery System and contractors. The policy ensures that grievances, appeals, and all expedited appeals will be recorded within one working day of the date of receipt.

Finding: The Plan did not record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

In a verification study, six of sixteen grievances revealed that the Plan did not implement its policy of recording grievances within one working day of the receipt date. The Plan could not verify or provide evidence that the six grievances were logged within the required timeframe.

In a narrative statement, the Plan identified that its logging procedures do not include a verification if grievances and appeals are entered within one working day of the date of receipt.

Failure to log grievances within one working day of the date of receipt may cause a delay in the grievance process and beneficiaries may miss opportunities for improved health care delivery, which may lead to poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that records of grievances, appeals, and expedited appeals are documented in the grievance and appeal log within one working day of the receipt date.

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CATEGORY 7 – PROGRAM INTEGRITY

7.4	Disclosure Requirements

7.4.1 Disclosure of Managing Employees or Plan Agents Convicted of a Crime

The Plan shall submit the following disclosures to DHCS regarding the Plan's management: (1) the identity of any person who is a managing employee of the Plan who has been convicted of a crime related to federal health care programs, and (2) the identity of any person who is an agent of the Plan who has been convicted of a crime related to federal health care programs. *(CFR, Title 42, sections 455.106(a)(1) and (2))*

Finding: The Plan did not ensure submission of disclosures to DHCS regarding managing employees or agents of the Plan who are convicted of a crime related to federal health care programs.

The Plan's policies, *Code of Ethics (issued September 14, 2021)* and *0101.0012.6, Standards of Conduct for Behavioral Health Services Employees (reviewed February 2, 2021)*, describe the Plan's code of ethics and employee standards of conduct. However, the Plan lacked written procedures for submitting to DHCS the required disclosures regarding managing employees or agents of the Plan who are convicted of a crime related to federal health care programs.

The Plan did not provide documentation of disclosure submissions sent to DHCS during the audit period. However, the Plan submitted documents showing that the Plan's staff collected disclosures upon hire and biannually thereafter. There were no documents showing how these disclosures were processed or reported following their receipt.

In an interview, the Plan explained that it lacked a process to report internal findings regarding disclosure requirements of managing employees or agents of the Plan who were convicted of a crime related to federal health care programs to DHCS.

The Plan is vulnerable to criminal activity, fraud, waste, and abuse when it does not ensure and maintain procedures for identifying and submitting disclosures to DHCS regarding employees and Plan agents convicted of a crime related to federal health care programs.

This is a repeat of the fiscal year 2020-2021 audit finding – Program Integrity.

Recommendation: Develop and implement policies and procedures to ensure submission of disclosures to DHCS regarding managing employees or agents of the Plan who are convicted of a crime related to federal health care programs.