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

2023

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

Merced County Behavioral Health Services
Mental Health Services

2023

Contract Number:	17-94595
Audit Period:	July 1, 2022 Through June 30, 2023
Dates of Audit:	August 8, 2023 Through August 17, 2023
Report Issued:	January 10, 2024

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I. INTRODUCTION

Merced 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.

Merced County was established in 1855 and is located in the heart of San Joaquin Valley covering approximately 1,978 square miles. Merced County has six incorporated cities: Atwater, Dos Palos, Gustine, Livingston, Los Banos, and Merced. The County has a population total of approximately 284,836. In the 2023 calendar year, the Plan serviced 6,585 beneficiaries and had a total of 44 active providers.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS audit of the Plan's Medi-Cal SMHS programs for the period of July 1, 2022 through June 30, 2023. The audit was conducted from August 8, 2023 through August 17, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on December 21, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On January 8, 2024, the Plan submitted a response after the Exit Conference. The results of 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. This year's audit included 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

The Plan is required 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 by contracting with TFC providers.

Category 2 - Care Coordination and Continuity of Care

The Plan shall ensure that non-urgent appointments with a non-physician mental health care provider occur within ten business days of the request for appointment. The Plan did not ensure coordination of care for Managed Care Organization (MCO) referred beneficiaries to receive non-urgent appointments within ten business days of the request for the appointment.

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 SMHS. The Plan did not ensure its 24/7 toll-free telephone number system provided required information for SMHS access, urgent condition services, and problem resolution processes.

The Plan is required to maintain a written log of the initial requests for SMHS from beneficiaries. The Plan did not log all calls requesting SMHS from beneficiaries.

Category 5 – Coverage and Authorization of Services

No findings were noted for the audit period.

Category 6 – Beneficiary Rights and Protection

The Plan is required to acknowledge receipt of each grievance, appeal, and request for expedited appeal of Adverse Benefit Determinations to the beneficiary in writing. The Plan did not acknowledge receipt of appeals to beneficiaries in writing.

The Plan is required to have procedures to ensure the prompt and equitable resolution of discrimination-related complaints. The Plan did not maintain procedures to ensure prompt and equitable resolution of discrimination-related grievances.

Category 7 –Program Integrity

The Plan is required to implement and maintain written policies for all employees containing detailed information regarding the False Claims Act and other federal and state laws and employee whistleblower protection. The Plan did not maintain a False Claims Act written policy that includes information about rights of employees and any contractor or agent to be protected as whistleblowers.

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 SMHS Contract.

PROCEDURE

The audit was conducted from August 8, 2023 through August 17, 2023, 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, 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 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 beneficiaries 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 the Plan's call log to ensure logging of each test call and to confirm the log contained all required components.

Category 5 – Coverage and Authorization of Services

Notice of Adverse Benefit Determination Requirements: 11 beneficiary files were reviewed for evidence of appropriate documentation and completeness.

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

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: 15 grievances and three appeals were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

Category 7 – Program Integrity

Fraud and Abuse Reporting: There were no reportable cases of Fraud, Waste, and Abuse (FWA) during the audit period.

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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, medically necessary covered SMHS 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.)*

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.

The Plan lacked policies and procedures to assess the need for TFC services to children and youth eligible for SMHS.

The Plan did not furnish requested evidence of documents or forms used to assess for the need of TFC services.

In a verification study based on requested TFC records, ten of ten records did not have documentation of the Plan's assessment screenings for the need of TFC services.

When the Plan does not make determinations for the need of TFC services, this can lead to missed services and resources necessary to support children and youth who meet SMHS criteria.

Recommendation: Develop and implement policies and procedures to ensure that the Plan screens for TFC needs for SMHS eligible child and youth beneficiaries.

1.2.2 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)*

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))*

Finding: The Plan did not ensure the provision of TFC services by contracting with TFC providers.

The Plan lacked written policies and procedures regarding how it will ensure the provision for TFC services.

The Plan did not furnish requested evidence of subcontracts with TFC providers.

In a verification study based on requested TFC records, ten of ten records did not have documentation of the Plan's provision of TFC services.

In an interview, the Plan confirmed that it has no subcontracts with any TFC providers. The Plan also acknowledged that if there was a need for TFC placement, it does not currently provide TFC services. Furthermore, the Plan did not hold any meetings or discussions on implementing TFC services during the audit period. The Plan stated that subcontracting with providers to provide services as required by the Contract has been difficult due to the intensity and highly coordinated care involving TFC. Additionally, in a written response, the Plan confirmed that it does not currently offer TFC services and has not made TFC a priority in the past.

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: Develop and implement policies and procedures to ensure the provision of TFC services by contracting with TFC providers.

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CATEGORY 2 -- CARE COORDINATION AND CONTINUNITY OF CARE

2.1	Coordination of Care Requirements

2.1.1 Referrals and Coordination of Care

The Plan is required to coordinate services furnished to beneficiaries with services the beneficiary receives from any other MCO, Fee-for-service Medi-Cal, community and social support providers, and other human services agencies used by its beneficiaries. *(Contract, Exhibit A, Attachment 10(1)(A)(2))*

The Plan shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal Managed Care Plan (MCP) serving the Plan's beneficiaries. The Plan shall monitor the effectiveness of its MOU with Medi-Cal MCPs. *(California Code of Regulations (CCR), Title 9, section 1810.370) (Contract, Exhibit A, Attachment 10(1)(B))*

The Plan is required to meet State standards for timely access to care and services, taking into account the urgency of the need for services. The Plan shall ensure that non-urgent appointments with a non-physician mental health care provider occur within ten business days of the request for appointment. (*Behavioral Health Information Notice (BHIN) 20-012*)

Plan *Memorandum of Understanding (MOU), (revised April 5, 2022),* detailed the expectations and delegated activities between the Plan and subcontractor. The MOU addresses Plan and MCO shared responsibilities, requirements for program oversight, assessment and referral procedures, and protocols for the beneficiary's transition, coordination, and continuity of care.

Finding: The Plan did not ensure coordination of care for MCO referred beneficiaries to receive non-urgent appointments within ten business days of the request for the appointment.

The Plan lacks written policies and procedures for how it coordinates care and processes MCO referrals to ensure for timely access to behavioral health care services. However, the Plan submitted the following evidence of its process to monitor for referral timeliness:

- The Plan utilizes a tool named Carelon Medi-Cal Screening and Transition tool that outlines responsibilities of the Plan and the MCP for assessments and referrals including timelines.
- Also, there is a referral tracker between Carelon and the Plan.

Although the Plan has desktop procedures to monitor for referral timeliness, there is no record of the Plan's performance in meeting timeliness requirements.

Joint Plan and MCO meeting minutes showed discussion of appropriate referrals, placements, and follow-ups, but not of timely access of service.

The verification study revealed three of ten referrals from the MCO to the Plan still unresolved were not in compliance with timeliness requirements. The non-urgent appointments scheduled by the Plan were not made within ten business days of the request for appointment. One referral was scheduled 31 days later, a second referral was scheduled 16 days later, and a third referral was scheduled 18 days later.

In an interview, the Plan explained that non-timely access to appointment for MCO referred beneficiaries was due to shortage of staff.

When the Plan does not coordinate care to provide timely appointments for MCO referred beneficiaries, missed or delayed behavioral health care services me result in poor health outcomes.

Recommendation: Develop and implement policies and procedures to ensure coordination of care for MCO referred beneficiaries to receive non-urgent appointments within ten business days of the request for the appointment.

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CATEGORY 4 -- ACCESS AND INFORMATION REQUIREMENTS

4.2	Access Line and Written Log

4.2.1 SMHS Access Information

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. The Plan shall also provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes. *(CCR, Title 9, Chapter 11, sections 1810.405(d) and 1810.410(e)(1))*

Plan policy, *I.D. 01, Access to Specialty Mental Health (revised July 9, 2019),* describes how the Plan maintains a statewide, 24/7 toll-free telephone number, that provides language capabilities in all languages spoken by beneficiaries of the county. The Plan provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

Finding: The Plan did not ensure its 24/7 toll-free telephone number system provided required information for SMHS access, urgent condition services, and problem resolution processes.

In a verification study, seven test calls were made to the Plan's statewide 24/7 toll-free number. Three of seven calls revealed that the Plan did not provide required SMHS-related information as follows:

- One call did not provide information needed to treat a beneficiary's urgent condition.
- A second call did not provide information about how to access SMHS.
- A third call did not provide information about how to use the beneficiary problem resolution and fair hearing process.

In an interview, the Plan explained that all access line calls made to the 24/7 telephone line are answered by Plan staff. These Plan staff are trained to provide beneficiaries with required information in accordance with the Contract. The Plan has a monitoring system using test calls to ensure for Contract compliance; however, the Plan stated that

there is a need for ongoing training to comply with Contract requirements for SMHS information dissemination.

When the Plan does not provide information for SMHS access and problem resolution processes, beneficiaries may not have adequate knowledge to make informed decisions. This can result in poor mental health outcomes due to missed or delayed access to necessary behavioral health services.

This is a repeat finding of the prior review (Fiscal Year 2019/2020) – 24/7 Toll-Free Telephone Information Requirements

Recommendation: Develop and implement policies and procedures to ensure the Plan's 24/7 access line system provides required information for SMHS access, urgent condition services, and problem resolution processes.

4.2.2 Access Call Log

The Plan shall maintain a written log of the initial requests for SMHS 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 *I.D.01, Access to Specialty Mental Health (revised July 9, 2019),* describes how the Plan maintains a written log for all initial requests for SMHS. The Plan will record if requests were 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. Additionally, the Plan logs beneficiary calls requesting information about SMHS access and urgent condition services.

Finding: The Plan did not log all calls requesting SMHS from beneficiaries.

The verification study revealed two of five required test calls were not logged on the Plan's written log.

In an interview, the Plan stated that access line staff answering calls are responsible for logging initial requests for SMHS. The Plan explained that inconsistency in logging initial requests for SMHS is due to being short staffed and inadequate training.

When the Plan does not log initial information requests for SMHS can result in the Plan's inability to monitor and track requests in order to provide timely access to behavioral health services.

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This is a repeat finding of the prior year review– (Fiscal Year 2019/2020) – Written Log for Initial Requests for SMHS

Recommendation: Revise and implement procedures to ensure the Plan logs all inquiry calls requesting SMHS access information and urgent condition services.

CATEGORY 6 -- BENEFICIARY RIGHTS AND PROTECTION

6.1	Grievance and Appeal System Requirements

6.1.1 Acknowledgement Letters for Appeals

The Plan shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of Adverse Benefit Determinations to the beneficiary in writing. *(Contract, Exhibit A, Attachment 12 (1)(B)(5))*

The Plan's appeal process shall, at a minimum, require a beneficiary who makes an oral appeal that is not an expedited appeal, to subsequently submit a written, signed appeal. The Plan shall ensure that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as appeals and confirmed in writing unless the beneficiary or the provider requests an expedited resolution. The date the Plan receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes. (*CFR, Title 42, section, 438.402(c)(3)(ii)); CFR, Title 42, section 438.406(b)(3)) (Contract, Exhibit A, Attachment 12 (5)(2))*

Plan policy, *I.C.05 Problem Resolution Process (revised August 12, 2020),* states the Plan's grievance and appeal problem resolution process. The policy assures grievances, appeals, and request for expedited appeals of Adverse Benefit Determinations are acknowledged to the beneficiary in writing.

Finding: The Plan did not acknowledge receipt of appeals to beneficiaries in writing.

The verification study revealed that three of three appeals submitted did not include acknowledgments letters sent to beneficiaries.

In an interview, the Plan explained it was unaware of the requirement to send beneficiaries acknowledgment letters to confirm receipt of appeals. Additionally, the Plan stated that despite having this requirement outlined in their policy, it does not currently send appeal acknowledgement letters to its beneficiaries.

In a written response, the Plan stated that it was unaware of the requirement to send beneficiaries appeal acknowledgment letters.

When the Plan does not acknowledge receipt of appeals in writing, beneficiaries may not receive critical information necessary to exercise their rights to appeal disputes within required timeframes. This can result in delayed or missed access to necessary services.

Recommendation: Revise and implement policies and procedures to ensure the Plan sends beneficiaries appeal acknowledgment letters.

6.1.2 Discrimination Grievances

The Plan shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. The Plan shall not require a beneficiary to file a discrimination grievance with the Plan before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Department of Health and Human Services, Office for Civil Rights. *(Contract, Exhibit, A, Attachment 12(4)(A)(2))*

Finding: The Plan did not maintain procedures to ensure prompt and equitable resolution of discrimination-related grievances.

The Plan does not have policies and procedures to ensure prompt and equitable resolution of discrimination-related grievances.

In an interview, the Plan acknowledged it does not have an active policy for discrimination-related grievances. The Plan also stated they were unaware it needed to develop a process for discrimination grievances.

When the Plan does not have a process to address discrimination grievances, this can lead to a loss of trust and beneficiaries may be more reluctant to seek health care. This may result in poor health outcomes due to delays in accessing necessary behavioral health care services.

Recommendation: Develop and implement policies and procedures to ensure prompt and equitable resolution of discrimination grievances.

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CATEGORY 7 -- PROGRAM INTEGRITY

7.2	Fraud Reporting Requirements

7.2.1 False Claims Act

The Plan is required to implement and maintain written policies for all employees and any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws, including information about rights of employees to be protected as whistleblowers. The Plan shall implement and maintain arrangements or procedures that include provision for the Plan's suspension of payments to a network provider for which there is a credible allegation of fraud. (*Contract, Exhibit A, Attachment 13 (4)(C))*

The Plan is required to implement and maintain arrangements or procedures designed to detect and prevent FWA that include prompt reporting to DHCS. *(CFR, 42, section 438.608(a)(7)) (Contract, Exhibit A, Attachment 13(4)(D))*

Finding: The Plan did not maintain a False Claims Act written policy that includes information about rights of employees and any contractor or agent to be protected as whistleblowers.

The Plan did not maintain policies outlining information about the False Claims Act and other federal and state laws, including the rights about employees to be protected as a whistleblower. The Plan provided multiple policies throughout its system of care specific to program integrity and FWA; however, the polices did not delineate the False Claims Act and protection of whistleblowers.

In an interview, the Plan acknowledged it does not have an active policy that outlines the requirement about the False Claims Act and protection of whistleblowers. The Plan stated it is in the process of developing and implementing this policy, but it has not been fully executed due to staffing shortages and they could not provide a timeframe of when an active policy will be implemented.

In a written response, the Plan stated it does not have an official policy or procedure regarding the False Claims Act.

When the Plan lacks policies and procedures to implement the False Claims Act and employee whistleblower protections, this may result in FWA going unreported or it may limit employee whistleblowing due to fear of retaliation.

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This is a repeat finding of the prior review (Fiscal Year 2019/2020) – False Claims Act and Whistleblower Rights and Protections

Recommendation: Develop and implement policies and procedures regarding the False Claims Act, including information about rights of employees to be protected as whistleblowers.