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

2023

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

Ventura County Mental Health Plan

2023

Contract Number:	22-20146
Audit Period:	July 1, 2022 through June 30, 2023
Dates of Audit:	October 16, 2023 through October 27, 2023
Report Issued:	March 13, 2024

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I. INTRODUCTION

Ventura County Behavioral Health (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.

Ventura County was formed on January 1, 1873, and it is the eleventh most populous county in the State of California. The County has a population total of approximately 832,605. In the 2022 – 2023 fiscal year, the Plan serviced 17,764 beneficiaries.

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 October 16, 2023, through October 27, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on February 28, 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 March 7, 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 seven categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Quality Assurance and Performance Improvement, 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 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 of children and youth for TFC services.

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 for this audit period.

Category 3 – Quality Assurance and Performance Improvement

No findings were noted for this audit period.

Category 4 – Access and Information Requirements

No findings were noted for this audit period.

Category 5 – Coverage and Authorization of Services

The Plan is required to comply with authorization timeframes. The Plan did not review and make a decision regarding a provider's request for prior authorization within five business days.

Category 6 – Beneficiary Rights and Protection

No findings were noted for this audit period.

Category 7 – Program Integrity

No findings were noted for this 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 Contract.

PROCEDURE

The audit was conducted from October 16, 2023, through October 27, 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, its 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 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: 15 beneficiary referrals from a Managed Care Organization (MCO) to the Plan were reviewed to ensure compliance scheduling beneficiary appointments.

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 confirm the log contained all required components.

Category 5 – Coverage and Authorization of Services

Notice of Adverse Benefit Determination Requirements: Five 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: Ten grievances and five appeals were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: VENTURA COUNTY MENTAL HEALTH PLAN
AUDIT PERIOD*:* July 1, 2022, through June 30, 2023 **DATES OF AUDIT: October 16, 2023, through October 27, 2023**

CATEGORY 1 – NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1.2	Children's Services

1.2.1 Assessment of TFC Services

The Plan is required to provide or arrange, and pay for, TFC services for beneficiaries under the age of 21. *(Contract, Exhibit A, Attachment 2, Provision 2(A)(13))*

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. 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 did not submit documentation of evidence supporting compliance with ensuring assessments for the need of TFC services for children and youth eligible for SMHS.

In an interview, the Plan stated that it does not conduct assessments for the need of TFC services since these are done by Child and Family Services and juvenile probation partners during its Interagency Placement Committee (IPC) meetings. However, the Plan's policy CA-53, *Accessing Specialty Mental Health Services (effective January 2023*), did not describe how the Plan receives and considers assessments from IPC meetings to determine a beneficiary's need for TFC services.

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

This is a repeat finding of the prior review (Fiscal Year 2019/2020) – TFC Service Requirements.

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

1.2.2 Provision of TFC Services

The Plan is required to provide or arrange, and pay for, TFC services for beneficiaries under the age of 21. *(Contract, Exhibit A, Attachment 2, Provision 2(A)(13))*

The Plan must provide TFC services to all children and youth who meet beneficiary access criteria for SMHS as medically necessary. (*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. 34.)*

Finding: The Plan did not ensure the provision of TFC services to children and youth.

The Plan's policies YF-93, *Residential Placement and Authorization Procedures (effective April 2016),* and CA-53, *Accessing Specialty Mental Health Services (effective January 2023),* did not describe how the Plan ensures provision of TFC services to children and youth who meet criteria for SMHS.

In an interview, the Plan confirmed that it does not contract with any TFC providers. In addition, the Plan stated that there is a lack of TFC providers due to the documentation requirements resource families must meet along with inadequate financial compensation for training and providing services. Furthermore, contracted providers are not interested in overseeing resource families providing TFC services due to the lack of resources available.

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

This is a repeat finding of the prior review (Fiscal Year 2019/2020) – TFC Service Requirements.

Recommendation: Develop and implement policies and procedures to ensure that the Plan provides TFC services for children and youth.

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CATEGORY 5 – COVERAGE AND AUTHORIZATION OF SERVICES

5.1	Authorization – General Requirements

5.1.1 Service Authorizations

The Plan shall comply with authorization timeframes in accordance with BHINs 22-016 and 22-017, or any subsequent Departmental notices issued to address parity in mental health and substance use disorder benefits. *(CFR, Title 42, section 438.910(d); Contract, Exhibit A, Attachment 6, 2(B))*

The Plan must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five business days from the Plan's receipt of information reasonably necessary and requested by the Plan to make the determination. *(BHIN 22-016, Authorization of Outpatient SMHS)*

Plan policy UR-05, *Authorization of Outpatient Specialty Mental Health Services (effective September 2022)*, states that the Plan must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five business days from the receipt of the information.

Finding: The Plan did not review prior authorizations within five business days of the Plan's receipt of information necessary to make a determination.

A verification study revealed seven of ten prior authorizations for IHBS and Therapeutic Behavioral Services occurred after the requisite five business days. Delays ranged from six to 20 days of the Plan's receipt of information necessary to make a determination.

In an interview, the Plan stated that the delays in reviewing prior authorizations and referrals are attributed to staff turnover. Additionally, acquainting new staff with the authorization and referral process have further contributed to delays in meeting timeframe requirements.

When the Plan does not review and make a decision for prior authorization requests within required timeframes, the Plan delays necessary services to beneficiaries.

Recommendation: Implement policies to ensure authorizations and referrals meet timeframe requirements.