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

Napa County Mental Health Plan

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 SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF

Napa County Mental Health Plan

2023

Contract Number:	22-20119
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) 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.

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, Napa County Behavioral Health Plan had 1,645 Medi-Cal beneficiaries receiving specialty mental health services and had a total of 18 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 February 13, 2024, through February 23, 2024. The audit consisted of document review, verification studies, 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 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 covered fiscal years 2018 through 2021. The prior year Corrective Action Plan 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. 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 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 to provide beneficiaries information regarding how to access SMHS, services to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes. The Plan did not ensure its 24/7 Access Line provided the required information on how to access SMHS, how to treat a

beneficiary's urgent condition, or information about beneficiary problem resolution and fair hearing processes.

The Plan is required to maintain a written log of the initial requests for SMHS, and services needed to treat a beneficiary's urgent condition. The Plan did not log all calls requesting SMHS or requests for urgent condition services from beneficiaries.

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

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 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, 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

ICC/IHBS Provision of Services: Eight 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: Ten beneficiary files were reviewed for evidence of the compliant bidirectional referrals between Managed Care Plan and MHP.

Category 4 – Access and Information Requirements

Access Line Test Calls: Four test calls requesting information about SMHS services 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: Four 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: 17 beneficiary files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Authorizations: 22 beneficiary files were reviewed for evidence of the appropriate services authorization process.

Category 6 – Beneficiary Rights and Protection

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

Appeals Procedure: One appeal was reviewed for appropriate and timely adjudication.

Category 7 – Program Integrity

No verification study conducted.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: NAPA COUNTY MENTAL HEALTH PLAN

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

CATEGORY 4 – ACCESS AND INFORMATION REQUIREMENTS

4.2	24/7 Access Line and Written Log of Requests for SMHS

4.2.1 Access Line

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 specialty mental health services, including specialty mental health services 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. *(California Code of Regulations (CCR), Title 9, sections 1810.405(d) and 1810.410(e)(1))*

Plan policy *06-6020, Availability and Accessibility of Mental health Plan Specialty Mental Health Services (revised June 28, 2022),* describes how the Plan maintains a statewide, 24/7 toll-free Access Line that provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services 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.

The verification study identified three calls in which the Plan did not provide information about services needed to treat a beneficiary's condition. The first test call was not provided information on how to access SMHS. The second test call was not provided information about how to access SMHS and how to treat a beneficiary's urgent condition. The third test call was not provided information regarding the beneficiary problem resolution and fair hearing processes.

In an interview, the Plan stated that clerical staff movement and instability within the Access unit attributed to the lack of oversight and monitoring to ensure adherence to the Plan's Access Line process. The Plan explained that there were only two clerical staff that assisted in covering the phones, while three other clerical staff were rotated during the audit period to train on Access procedures. The Plan also explained that although staff are trained to provide beneficiaries with required information in accordance with the

Contract, the Plan stated that there is a need for ongoing training to comply with Contract requirements for SMHS information dissemination.

The Plan contracts with a crisis services facility to answer the Access Line after hours. The staff at this facility assist callers experiencing crises and are not trained to provide callers with information outlined in the contract. Additionally, the phone tree directs calls to information for crisis services and did not include an option for access to SMHS.

When the Plan does not provide information to beneficiaries about how to access SMHS, and problem resolution processes, beneficiary 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 of the 2021-2022 audit finding – Access and Information Requirement.

Recommendation: 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 is required to maintain a written log of the initial requests for specialty mental health services 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 *06-6020, Availability and Accessibility of Mental Health Plan Specialty Mental Health Services (revised June 28, 2022),* describes the Plan's process to enter the caller information into their Central Authorization and Access Tool (CAAT) log. The policy ensures:

i. Caller information is gathered on the paper log sheets or logged directly into the CAAT log.
ii. When answering the phone, staff are to obtain all information required for the CAAT log. At a minimum, information required for the CAAT log includes date of the request, first and last name of the caller, age group, preferred language, nature of the request, and initial disposition of the request.

iii. Each day, designated Access staff will log the information from the paper log from the qualified provider log, into the CAAT log."

Finding: The Plan did not log all beneficiary calls requesting specialty mental health services.

The verification study revealed that four of four DHCS-required test calls were not logged.

In an interview, the Plan stated that clerical staff movement and instability within the Access unit attributed to the lack of oversight and monitoring to ensure adherence to written log requirements for SMHS request. The Plan explained that there were only two clerical staff that assisted in covering the phones, while three other clerical staff were rotated during the audit period to train on Access procedures. The Plan also explained that staff are trained to provide beneficiaries with required information in accordance with the Contract. However, the Plan stated that there is a need for ongoing training to comply with Contract requirements for SMHS information dissemination. Plan staff also stated that 42.86 percent of afterhours calls were logged onto the master log sheet resulting in below average Behavioral Health Access percentages. The missing calls not logged was failing to provide the Plan faxes of all calls received afterhours correlated to test calls number one, three and seven.

Failure to track beneficiaries' call requests for SMHS can negatively impact the Plan's ability to ensure beneficiaries receive services in a timely manner.

This is a repeat of the 2021-2022 audit finding – Access and Information Requirement.

Recommendation: Revise and implement policies and procedures to ensure that the Plan logs all beneficiary calls requesting specialty mental health services.