DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

RANCHO CUCAMONGA SECTION

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF SAN LUIS OBISPO COUNTY MENTAL HEALTH PLAN FISCAL YEAR 2024-25

Contract Number: 22-20131

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: October 22, 2024 — November 1, 2024

Report Issued: February 10, 2025

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I. INTRODUCTION

San Luis Obispo County Mental Health Plan (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing mental health services to county residents.

San Luis Obispo County Mental Health Plan is located along the central coast of California. The Plan provides services within the unincorporated county and in seven cities: Arroyo Grande, Atascadero, Grover Beach, Morro Bay, Paso Robles, Pismo Beach, and San Luis Obispo.

As of June 2024, the Plan had a total of 4,765 members receiving services and a total of 358 active providers.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2023, through June 30, 2024. The audit was conducted from October 22, 2024, through November 1, 2024. The audit consisted of documentation reviews, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on January 23, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On February 3, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated five categories of performance: 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 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 closed at the time of onsite.

The summary of the findings by category follows:

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

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

Category 5 – Coverage and Authorization of Services

The Plan is required to monitor subcontractor's compliance with the provisions of the subcontract. A decision to modify an authorization request must first be communicated to the treating providers by telephone or facsimile, followed by written notification. The decision must include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with them. The Plan did not have an effective monitoring process to ensure that subcontractors included the name of the decision-maker in written notification letters.

Category 6 – Beneficiary Rights and Protection

The Plan is required to provide written notification to the beneficiary or the appropriate representatives regarding the resolution of a grievance. The Plan did not provide written notification to the beneficiaries of the resolution of their grievance.

The Plan is required to maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal, or expedited appeal. The Plan is required to provide the beneficiary with a written acknowledgement of receipt of submitted grievances. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance. The Plan did not meet timeframes for written log entries and acknowledgment letters.

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 the audit to ascertain that medically necessary services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Specialty Mental Health Services Contract.

PROCEDURE

DHCS conducted an audit of the Plan from October 22, 2024, through November 1, 2024, for the audit period of July 1, 2023, through June 30, 2024. 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.

The following verification studies were conducted:

Category 2 – Care Coordination and Continuity of Care:

Coordination of Care Referrals: 20 beneficiary files were reviewed for evidence of a coordination of care bidirectionally between the Mental Health Plan (MHP) and Managed Care Plan (MCP).

Category 4 – Access and Information Requirements:

Access Line Test Calls: seven DHCS 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 DHCS 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 DHCS test calls were made, and a review of Plan's call log was conducted to confirm compliance with regulatory requirements.

50 Plan internal test calls were reviewed to ensure logging of each test call. 10 test calls scripts from the Plan's internal test calls were sampled to confirm the log contained all required components.

Category 5 – Coverage and Authorization of Services:

Authorizations: 20 beneficiary files were reviewed for evidence of appropriate treatment authorization process, including the concurrent review process.

Category 6 – Beneficiary Rights and Protection:

Grievance Procedures: 17 grievances were reviewed for a timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

There were no reported appeals during the audit period.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.1 COVERAGE AND AUTHORIZATION OF SERVICES

5.1.1 DECISION-MAKER IN WRITTEN NOTIFICATION LETTERS

The Plan must implement mechanisms to assure authorization decision standards comply with BHINs 22-016 and 22-017. *[Contract, Exhibit A Attachment 6 (2)(A)]*

The Plan is required to monitor subcontractor's compliance with the provisions of the subcontract and this contract and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified. *[Contract, Exhibit A – Attachment 1 (4)(E)(6)(12)]*

A decision to modify an authorization request must first be communicated to the treating provider(s) by telephone or facsimile, followed by written notification. The decision must include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with them. *[Behavioral Health Information Notice 22-016; Welfare and Institutions Code 14197.1; Health and Safety Code 1367.01 (h)(4)]*

Plan's policy, *3.30 Notices of Adverse Benefit Determination*, states the Plan must make timely communication of any adverse determination, including denial or limited authorization of a requested service, first by telephone or fax, then in a written Notice of Adverse Benefits Determination (NOABD) to the provider that includes the name and telephone number of the decision-maker on the NOABD.

Finding: The Plan did not have an effective monitoring process to ensure that subcontractors included the name of the decision-maker in written notification letters.

Although the Plan's policy, *3.30 Notices of Adverse Benefit Determination*, states the Plan will include the name of the decision-maker in written appeal notification letters, the Plan did not monitor subcontractors to ensure NOABDs include the decision-maker's name and phone number.

The verification samples revealed that all three NOABD letters issued by the Plan's

subcontractor did not include the name of the authorization decision-maker.

In the interview, the Plan stated they review monthly quality reports on subcontractors' concurrent authorizations and conduct annual chart reviews. However, the Plan's current monitoring process does not comply with BHIN 22-016, as the Plan's monitoring tools lack criteria to identify decision-makers for each authorization.

Without the decision maker's name and direct telephone number in written notification letters, the member's treating provider may miss opportunities or experience delays in coordinating effective mental health care.

Recommendation: Implement policies and procedures to ensure effective oversight and monitoring of contracted providers to include the name of the health care professional responsible for making the appeal decision within the written notification letters.

COMPLIANCE AUDIT FINDINGS

Category 6 – Beneficiary Rights and Protection

6.1 BENEFICARY RIGHTS AND PROTECTION

6.1.1 NOTICE OF GRIEVANCE RESOLUTION (NGR)

The Plan is required to provide written notification to the beneficiary or the appropriate representatives regarding the resolution of a grievance. It should also document the notification or attempts to contact the beneficiary if unreachable. The Plan must ensure that notifications meet the applicable standards in format and language. *[Contract, Exhibit A, Attachment 12 (3)(E & F)]*

The Plan shall adhere to the following: record keeping, monitoring, and review requirements: Provide notice in writing to any provider identified by the beneficiary or involved in the grievance of the final disposition of the beneficiary's grievance. *[Contract, Exhibit A, Attachment 12 (2)(E)]*

The Plan shall establish, implement, and maintain a Grievance and Appeal System with appropriate oversight to ensure the receipt, review, and resolution of grievances and appeals. *[MHSUDS Information Notice No.: IN 18-010E]*

Plan Policy, *4.07 Beneficiary Grievances, Appeals & Expedited Appeals (effective date 11/18/2015),* states the Plan will provide written notification of resolution to beneficiaries, representatives, and any provider involved in or identified by the beneficiary of the final disposition of the process, and the Plan will use a Notice of Grievance Resolution (NGR) to provide this notification. The NGR will contain a clear and concise explanation of the Plan's decision.

Finding: The Plan did not provide written notification to the beneficiaries of the resolution of their grievance.

Although Plan policy, *4.07*, *Beneficiary Grievances, Appeals & Expedited Appeals,* states that the Plan will provide NGR letters to the beneficiaries, representatives, and any involved providers, the Plan did not follow and implement its policy as required. The verification study revealed the Plan did not send DHCS standard NGR letters to inform beneficiaries of their grievance resolution for ten of 17 samples.

During the interview, the Plan stated that staffing coverage impacted their operation and hindered the processing of NGR letters to beneficiaries. The Plan acknowledged staffing shortages, which contributed to the Plan not providing written notification to the beneficiaries of the resolution of their grievance.

When the Plan does not send written notification of grievance resolution, beneficiaries may miss critical information that can lead to delays or missed access to necessary services.

Recommendation: Implement policies and procedures to ensure the Plan sends NGR letters to its beneficiaries.

6.1.2 GRIEVANCE TRACKING

The Plan shall have a grievance and appeal system that shall be implemented to handle appeals of adverse benefit determinations and grievances and shall include processes to collect and track information. *[Contract, Exhibit A, Attachment 12(1)(A)]*

The Plan is required to maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal, or expedited appeal. *[Contract, Exhibit A, Attachment 12(2)(A)]*

The Plan is required to provide the beneficiary written acknowledgement of receipt of submitted grievances. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance. *[Contract, Exhibit A, Attachment 12(3)(B)]*

Plan Policy, *4.07 Beneficiary Grievances, Appeals & Expedited Appeals (effective date 11/18/2015),* describes the Plan's beneficiary problem resolution process that includes timeframes for grievance log entries and grievance acknowledgment letters. The Plan maintains a grievance and appeal log to record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal, or expedited appeal. Additionally, the Plan will send the beneficiary a written acknowledgement letter of receipt of submitted grievances that must be postmarked within five calendar days of receipt of the grievance.

Finding: The Plan did not meet timeframes for written log entries and acknowledgment letters.

Although Plan policy, 4.07, Beneficiary Grievances, Appeals & Expedited Appeals, stated the Plan will maintain a grievance and appeal log to record grievances in the log within one business day of the date of receipt of the grievance and send the beneficiary an acknowledgment letter from the date of receipt of the grievance, the Plan did not meet timeframes for written log entries and acknowledgment letters.

The timeframe for logging grievance entries and sending out grievance acknowledgement letters is based on the grievance receipt date. The Plan did not ensure timely grievance log entries and acknowledgement letters due to inaccurate recording of the grievance receipt date.

The verification study revealed five of 17 grievances had an inaccurate receipt date on the Plan log. The Plan's log contained one-to-three-month timeframe gaps between when the beneficiary logged the grievance and when the grievance was received. Therefore, the Plan did not record grievances within one business day of receipt of the grievance.

In an interview, the Plan stated clinic staff were not trained on the procedure to check the locked mailbox for grievances daily. The Plan acknowledged a lack of oversight and training was the cause of not ensuring the lock boxes were being checked daily.

When the Plan does not accurately track grievances and send out timely acknowledgment letters, a delay in beneficiary access to necessary SMH services may occur.

Recommendation: Implement policies and procedures to collect and accurately track grievances to meet timeframes for written log entries and acknowledgment letters.