State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: December 19, 2022

Behavioral Health Information Notice No: 22-063
Supersedes BHIN No.: 21-053

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Annual Review Protocol for Specialty Mental Health Services (SMHS) and Other Funded Services for Fiscal Year 2022-2023.

PURPOSE: To inform county Mental Health Plans (MHPs) about the Department of Health Care Services' (DHCS) triennial review process for Fiscal Year (FY) 2022-2023.

REFERENCE: Behavioral Health Information Notice (BHIN) Nos.: 20-049, 21-073, 22-016, 22-017, 22-019; California Medicaid State Plan; California Advancing and Innovating Medical (CalAIM) 1915(b) Waiver; Title 42 of the Code of Federal Regulations (CFR), part 43; Welfare and Institutions Code (W&I), section 14700 et seq.; California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.380(a); MHP Contract.

The following enclosures are included with this BHIN:

- Enclosure 1 – FY 2022-2023 Annual Review Protocol for Specialty Mental Health Services and Other Funded Services
- Enclosure 2 – FY 2022-2023 Triennial Review Schedule (including Short-Doyle/Medi-Cal Hospital Review Schedule)

- Enclosure 3 – FY 2022-2023 SMHS Reasons for Recoupment
- Enclosure 4 – FY 2022-2023 Technical Assistance Chart Review Schedule

BACKGROUND:
In accordance with the CCR, Title 9, Chapter 11, Section 1810.380(a), DHCS conducts monitoring and oversight activities to review the MHPs' SMHS programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to Medi-Cal beneficiaries, who meet medical necessity and criteria for beneficiary access to SMHS as established in BHIN 21-073, in compliance with the applicable State and Federal laws and regulations, and/or the terms of the contract between DHCS and the MHP, and DHCS BHINs which spell out other specific requirements:

DHCS has the responsibility to conduct monitoring and oversight of the MHPs under the following authorities:

- California Medicaid State Plan
- California Advancing and Innovating Medical (CalAIM) 1915(b) Waiver
- Title 42 of the Code of Federal Regulations, part 438, "Managed Care"
- Welfare and Institutions Code, section 14700 et seq.
- California Code of Regulations, Title 9, Chapter 11
- MHP Contract
- Department of Health Care Services Behavioral Health Information Notices

POLICY:
<u>Annual Review Protocol for SMHS and Other Funded Services for FY 2022-2023</u>

DHCS revised the FY 2022-2023 Annual Review Protocol for SMHS and Other Funded Services (Protocol) in collaboration with DHCS' Compliance Advisory Committee. This BHIN covers the system review categories (1 – 7), and the chart review categories (8 – 10):

Category 1	Network Adequacy and Availability of Services
Category 2	Care Coordination and Continuity of Care
Category 3	Quality Assurance and Performance Improvement
Category 4	Access and Information Requirements
Category 5	Coverage and Authorization of Services
Category 6	Beneficiary Rights and Protections
Category 7	Program Integrity

Category 8	Chart Review – Non-Hospital Services
Category 9	Chart Review – Short-Doyle/Medi-Cal Hospital Services
Category 10	Utilization Review – Short-Doyle/Medi-Cal Hospital Services

Triennial Reviews

Pursuant to the CalAIM 1915(b) Waiver, the County Triennial reviews may be conducted either virtually or onsite.

Prior to performing the virtual or onsite visit, DHCS will perform review activities, sampling methods, and reporting that is consistent with prior triennial reviews. MHPs are required to submit all review documentation(s) to DHCS before the initiation of the review. To assist with preparation, DHCS will send each MHP a comprehensive document submission checklist that will include all of the requested documentation(s) for the system and outpatient chart reviews. MHPs must provide documented evidence of compliance for each requirement included in the Protocol, as well as any additional information requested by DHCS pertaining to the provision of SMHS to Medi-Cal beneficiaries.[1] DHCS will provide each MHP with instructions for accessing DHCS' secure e-transfer portal, which allows for the secure transmission of documents containing protected health information.

During the visit, DHCS will interview key personnel from the MHP. The topics for discussion during the interview are derived from the enclosed SMHS Protocol and will consist of the following:

- 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 Protections
- Program Integrity
- Chart Review – Non-Hospital Services (i.e., discussion of specific chart documentation issues/questions)

The enclosed review schedule identifies the dates of the FY 2022-2023 MHP system and non-hospital chart reviews, which occur simultaneously, as well as the Short-Doyle/Medi-Cal (SD/MC) hospital reviews. See Enclosure 2 for details.

[1] See 42 C.F.R. § 438.3(h).

Chart Reviews

DHCS is conducting the Chart Reviews for FY 2022-2023, pursuant to the authority in the CalAIM 1915(b) Waiver. In addition, as a result of Assembly Bill (AB) 133 (Committee on Budget, Chapter 143, Statutes of 2021) and the CalAIM initiative, effective July 1, 2022, DHCS has implemented updates to documentation requirements as reflected in BHIN 22-019. The protocol is reflective of these requirements. Findings warranting recoupment during this review period are limited to the issues identified in the Reasons for Recoupment document that is attached to this BHIN with a focus on fraud, waste, and abuse.[2] For the recoupment list, see Enclosure 3, FY 2022-2023 SMHS Reasons for Recoupment".

The purpose of the review is to verify that the MHP provided medically necessary services; to assess the MHPs and their network providers' compliance with DHCS' established documentation requirements; and to assess the appropriateness of reimbursement of Federal Financial Participation. The review includes all medical records associated with the beneficiary's care during the review sample period.

As the documentation requirements specified in BHIN 22-019 became effective July 1, 2022, these requirements will be reviewed during the FY 2022-2023 as "Survey Only" questions. The "Survey Only" questions allow DHCS to review and determine the MHPs status and effectiveness in implementing and complying with the new documentation requirements, as well as providing feedback and technical assistance to MHPs.

Chart Review – Non-Hospital Services

As stated above, some elements of the triennial chart reviews will be based on the new documentation requirements found in BHIN 22-019 which are effective July 1, 2022.

For all counties, those scheduled for triennial review (Enclosure 2) and all others (Enclosure 4), the *new* documentation requirements will be reviewed as "Survey Only" questions to determine the MHPs effectiveness in implementation and compliance. MHP counties listed in Enclosure 4 will submit a small sample size of medical records for individuals who became beneficiaries of the MHP on or after July 1, 2022. Instruction for the submission of medical records will be forthcoming.

For "Survey Only" questions, DHCS will not issue a Findings Report, but instead, DHCS will issue a written feedback summary on the charting items that are not in alignment with the new CalAIM documentation reform requirements, including recommendations

[2] Fraud and abuse are defined in CFR, Title 42, § 455.2 and W&I, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

on how the MHP can make improvements and/or come into compliance with the new requirements. For “Survey Only” questions, there will be no recoupments or Corrective Action Plan.

DHCS may request additional beneficiary medical records, as appropriate.

Chart Review – SD/MC Hospital Services
If the MHP conducted concurrent review:
DHCS will review MHPs’ records to ensure the MHP performed and documented concurrent review is consistent with the MHPs' own policies and BHIN 22-017. DHCS will determine whether the MHP is compliant with using applicable medical necessity criteria review in authorizing inpatient stays by reviewing beneficiary medical charts in addition to other evidence that the MHP provides to DHCS.

If the MHP conducted a retrospective review:
DHCS will review medical records of 60 adult and/or child/youth beneficiaries. A random sample will be drawn for the most recent 90-day period for which claims appear to be completed.

DHCS may request additional beneficiary medical records, as appropriate.

Post Review Evidence
The MHP is allowed to submit any additional evidence within five (5) business days of their review for consideration by DHCS. This evidence will be considered by DHCS in making final compliance determinations and writing the final report.

Findings Reports
If during the review, DHCS determines that an MHP is out of compliance, DHCS will provide a written Notice of Noncompliance referred to as a “Findings Report”, which will include a description of the finding(s) and any required corrective action(s).[3]

In addition, if DHCS determines the medical record documentation meets the criteria listed in the Reasons for Recoupment for FY 2022-2023, those claims will be disallowed and the MHP will be required to void those claims pursuant to BHIN 20-049 as described later in this letter. See Enclosure 3, “FY 2022-2023 SMHS Reasons for Recoupment” for additional details.

[3] W&I, § 14197.7, subds. (d) and (r)(1).

Corrective Action Plan (CAP)

A CAP is required for items determined to be out of compliance.[4] The MHP is required to submit a CAP to DHCS within 60 days of receipt of the Findings Report for all reviewed items deemed out of compliance. The CAP must include the following information:

- Description of corrective actions, including milestones;
- Timeline for implementation and/or completion of corrective actions;
- Proposed (or actual) evidence of correction that will be submitted to DHCS;
- A mechanism for monitoring the effectiveness of corrective actions over time;
- If DHCS determines the CAP to be ineffective, the MHP will be required to propose an alternative CAP to DHCS; and
- Descriptions of corrective actions required of the MHPs contracted providers to address the findings.

The MHPs' CAP must be submitted electronically via **secure** email (i.e., using encryption and typing "[secure]" in the subject line of the email) to MCBHDMonitoring@dhcs.ca.gov.

Appeals

If an MHP elects to appeal any item within their Findings Report, the MHP may do so by submitting an appeal, in writing, within 15 business days after receipt of the Findings Report. The appeal may be submitted via **secure** email (i.e., using encryption and typing "[secure]" in the subject line of the email). Depending on the type of appeal (i.e., system, chart), please send the appeal electronically to the relevant email addresses below:

- Chart Review Appeals: DHCSMentalHealthAppeals@dhcs.ca.gov
  CC: MCBHDMonitoring@dhcs.ca.gov, and Martine.Carlton@dhcs.ca.gov
- System Review Appeals: MCBHDMonitoring@dhcs.ca.gov
  CC: Ayesha.Smith@dhcs.ca.gov

DHCS will adjudicate any appeals and/or technical corrections (e.g., calculation errors, etc.) submitted by the MHP and, if appropriate, send an amended report. If an appeal is submitted, and/or the original findings are upheld, the MHP should send the CAP within 60 calendar days of receipt as described above. DHCS will no longer issue a "Final" report.

[4] See W&I §§ 14713, subd. (b), 14197.7, subds. (d); Section 1915(b) SMHS Waiver, p. 90.

Voiding of Disallowed Claims

Please note that pursuant to BHIN 20-049 and beginning with FY 2019-20, DHCS will no longer issue an invoice to the MHP for disallowed claims, instead, counties will be required to void all claims that are disallowed based on findings from the triennial chart review. Along with the MHPs report, DHCS will include a summary report of claims that have been disallowed, reasons for the disallowance, and the Payor Claim Control Number (PCCN) for each disallowed claim.

The MHP will have 15 business days to appeal the disallowances, and the department will issue a final decision within 30 calendar days after receipt of the appeal. Once the appeal process is complete, MHPs will be required to void any remaining disallowed claims within 90 calendar days of the final Findings Report using the PCCNs provided with this report. Please refer to page 30 of the Mental Health Services Short-Doyle Medi-Cal HIPAA Transaction Standard Companion Guide to learn more about the SMHS claim void process. If you have any questions regarding how to void a claim, please e-mail MedCCC@dhcs.ca.gov.

DHCS will monitor the Short-Doyle Medi-Cal claiming system to ensure each disallowed claim is voided within 60 calendar days. MHPs that do not void disallowed claims within 60 calendar days may be subject to sanctions, fines, and penalties pursuant to W&I section 14197.7.

Report Posting

Pursuant to the CalAIM section 1915(b) Waiver Special Terms and Conditions, the findings report and the MHPs CAP will be posted on DHCS' website.

If you have any questions regarding this BHIN, please contact DHCS at CountySupport@dhcs.ca.gov.

Sincerely,

Original signed by

Ivan Bhardwaj, Acting Chief
Medi-Cal Behavioral Health Division