CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2018/2019

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE BUTTE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT-AMENDED

Review Dates: May 22, 2019 and May 23, 2019

Butte County Mental Health Plan
FY 2018/2019 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

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EXECUTIVE SUMMARY

The California Department of Health Care Services' (DHCS) mission is to provide Californians with access to affordable, integrated, high-quality health care including medical, dental, mental health, substance use treatment services, and long-term care. Our vision is to preserve and improve the overall health and well-being of all Californians.

DHCS helps provide Californians access to quality health care services that are delivered effectively and efficiently. As the single state Medicaid agency, DHCS administers California's Medicaid program (Medi-Cal). DHCS is responsible for administering the Medi-Cal Specialty Mental Health Services (SMHS) Waiver Program. SMHS are "carved-out" of the broader Medi-Cal program. The SMHS program operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act.

Medi-Cal is a federal/state partnership providing comprehensive health care to individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of important services to approximately 13.2 million Californians.

The SMHS program which provides SMHS to Medi-Cal beneficiaries through county Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries' in their counties that meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiaries client plan.

In accordance with the California Code of Regulations, title 9, chapter 11, § 1810.380, DHCS conducts monitoring and oversight activities such as the Medi-Cal SMHS Triennial System and Chart Reviews to determine if the county MHPs are in compliance with state and federal laws and regulations and/or the contract between DHCS and the MHP.

DHCS conducted an onsite review of the Butte County MHP's Medi-Cal SMHS programs on May 22, 2019 and May 23, 2019. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2018/2019 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

The Medi-Cal SMHS Triennial System Review evaluated the MHP's performance in the following categories:

- Section A: Network Adequacy and Availability of Services
- Section B: Care Coordination and Continuity of Care
- Section C: Quality Assurance and Performance Improvement

- Section D: Access and Information Requirements
- Section E: Coverage and Authorization of Services
- Section F: Beneficiary Rights and Protections
- Section G: Program Integrity
- Section H: Other Regulatory and Contractual Requirement

This report details the findings from the Medi-Cal SMHS Triennial System Review of the Butte County MHP. The report is organized according to the findings from each section of the FY 2018/2019 Protocol and the Attestation deemed out-of-compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS.

For informational purposes, this findings report also includes additional information that may be useful for the MHP (e.g., a description of calls testing compliance of the MHP's 24/7 toll-free telephone line).

The MHP will have an opportunity to review the report for accuracy and appeal any of the findings of non-compliance (for both system review and chart review). The appeal must be submitted to DHCS in writing within 15-business days of receipt of the findings report. 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.

A Plan of Correction (POC) is required for all items determined to be out-of-compliance. The MHP is required to submit a POC to DHCS within 60-days of receipt of the original findings report for all system and chart review items deemed out-of-compliance. The POC should include the following information:

(1) Description of corrective actions, including milestones;
(2) Timeline for implementation and/or completion of corrective actions;
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS;
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS; and
(5) Description of corrective actions required of the MHP's contracted providers to address findings.

Review Findings Overview

- In DHCS review, the Butte County MHP demonstrated numerous strengths, including, but not limited to the following examples:
    - Responsiveness and resiliency in disaster response during recent fires and flood;
    - Recent reorganization of Quality Assurance and Research Division providing data-driven decision making effort using data to drive policy and program decisions (e.g. timeliness data, over/under utilization data etc.);

- Strong collaboration with community cultural leaders to input on the Cultural Competence Plan and provide locally based cultural competence training; and
- Long-term effort in implementing trauma informed case initiative.

- DHCS identified opportunities for improvement in various areas, including:
  - Monitoring processes for review and update of policies and procedure update and monitoring process;
  - Monitoring timely access for psychiatry services;
  - Establishing collaborative working relationship with Managed Care Providers;
  - Grievance/Appeals monitoring;
  - Absence of Medical Director affecting monitoring of psychiatry services and medication monitoring processes; and,
  - Unlicensed staff training and licensed staff retention.

Questions about this report may be directed to DHCS via email to MCBHDMonitoring@dhcs.ca.gov.

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (42 C.F.R. § 438.206(c)(1)(i).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.206(c)(1)(i). The MHP must meet, and require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of SMHS.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Service request log;
- Performance metrics dashboards – timely access;
- Provider Subcontracts for Telehealth and Locum Tenens; and
- Policy and Procedure 336 Time/Distance and Timely Access Standards.

While the policy indicates the adoption of the statewide standards for timely access to care pursuant to Welf. & Inst. Code, § 141197(d)(1) and California Code Regulations, title 28, § 1300.67.2.2(c)(5)(D), performance metrics data indicated ongoing non-compliance with timely access for psychiatry services.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.206(c)(1)(i). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).)
The MHP shall take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.206(c)(1)(iv) and (vi). The MHP must establish mechanisms to ensure that network providers comply with the timely access requirements and take corrective action if there is a failure to comply with timely access requirements.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Service request log;
- Performance metrics dashboards – timely access;
- Provider Subcontracts for Telehealth and Locum Tenens; and
- Policy and Procedure 336 Time/Distance and Timely Access Standards.

While the policy indicates adoption of the statewide standards for timely access to care pursuant to Welf. & Inst. Code, § 141197(d)(1) and California Code Regulations, title 28, § 1300.67.2.2(c)(5)(D), performance metrics data indicated ongoing non-compliance with timely access for psychiatry services.

During the on-site review, the MHP reported improvement in data collection and submitted additional timely access data showing improvement. However, the data still indicated ongoing non-compliance with timely access for psychiatry services.

The MHP did not submit evidence of tracking mechanisms for ongoing corrective action(s) to address timely access for psychiatry services.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.206(c)(1)(iv) and (vi). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
If the MHP identifies deficiencies or areas of improvement, the MHP and the subcontractor shall take corrective action. (MHP Contract, Ex. A, Att. 8)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 8. The MHP and the subcontractor must take corrective action if the MHP identifies deficiencies or areas of improvement.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Contract monitoring meeting minutes;
- Chart Auditing Tools;
- Chart Auditing Reports; and
- Policy and Procedure 214: Quality Management Specialty Mental Health Services Chart Audits.

The MHP submitted a policy and procedure outlining the chart audit process and corrective action process. Per the policy, the corrective action form is to be utilized to follow up on the deficiencies. While the chart audit reports indicate areas of deficiencies and disallowance, the MHP did not submit evidence of corrective action taken with identified subcontractors or corrective action form tracking mechanisms to ensure completion of the corrective actions implemented. During the on-site review, the MHP

reported that the corrective action form is tracked by the Quality Assurance team as outlined in the policy.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 8. The MHP must complete a POC addressing this finding of non-compliance.

CARE COORDINATION AND CONTINUITY OF CARE

REQUIREMENT
The MHP shall coordinate the services the MHP furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(2)(i)-(iv), CCR, tit. 9 § 1810.415.)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(2)(i)-(iv) and CCR, tit. 9 § 1810.415. The MHP must coordinate the services the MHP furnishes to the beneficiary between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy and Procedure 131: Discharge Summary and Aftercare Plan (PHF);
- Policy and Procedure 91: Consumer Discharge (PHF);
- Policy and Procedure 58: IMD Client Out of County Acute Hospitalization (PHF);
- Policy and Procedure 56: IMD Client Step-Down to Community Placement;
- Policy and Procedure 248: Interdisciplinary Treatment Plan (ITP);
- Policy and Procedure (Draft): Triage Connect Team (TCT) Discharge Planning and Care Coordination;
- Policy and Procedure 211: Coordination of Care;
- Policy and Procedure 212 (Draft): Targeted Case Management; and
- Policy and Procedure (Draft): Medi-Cal Managed Care Plans.

The MHP submitted multiple policies regarding its efforts related to coordination of care. Specifically, policy and procedure 211: Coordination of Care addresses that, as appropriate, the Care Coordinator will coordinate services between settings of care, other managed care organizations, and other human service agencies including community and social support providers, as needed.

However, in the chart review, there were two cases where documentation did not reflect that services were coordinated between the crisis service providers and the outpatient

service providers. Specifically, line [1] indicated the client was admitted to the CSU on [2] and San Jose Behavioral Health on [3]. On [4], progress note documents a call to the client to determine why he missed his scheduled appointment. The client indicated that he had just been released from the hospital. Also, line [5] indicated that client was receiving ongoing outpatient treatment prior to crisis intervention on [6]. Information from the crisis assessment and intervention was not utilized during outpatient treatment sessions following the crisis incident.

DHCS deems the MHP out-of-compliance with Ex. A, Att.10; 42 C.F.R. § 438.208(b)(2)(i)-(iv); and, CCR, tit. 9 § 1810.415. The MHP must complete a POC addressing this finding of non-compliance.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

REQUIREMENT
The MHP has mechanisms to assess beneficiary/family satisfaction by evaluating beneficiary grievance, appeals and fair hearings at least annually. (MHP Contract, Ex. A, Att. 5)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 5. The MHP must have mechanisms to assess beneficiary/family satisfaction by evaluating beneficiary grievance, appeals, and fair hearings at least annually.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy and Procedure 325: Quality Assessment and Performance Improvement (QAPI) Program;
- QAPI Work plans; and
- QIC minutes.

While the policy and procedure addresses this requirement, the QAPI work plan matrix and QIC minutes did not demonstrate evidence of actual practice to evaluate beneficiary grievance, appeals, and fair hearings at least annually. Specifically, QIC minutes on May 2, 2018 and October 3, 2018 indicated some discussion of the grievance and appeals evaluation. However, the minutes from May 2, 2018 indicated "no apparent trend, most grievances dealt with a Quality of Care concern" with no specific information or action plan. The same QIC minutes indicated, "all of the grievances were resolved within the timeline", but the grievance verification study could

[1] Line number(s) removed for confidentiality
[2] Date(s) removed for confidentiality
[3] Date(s) removed for confidentiality
[4] Date(s) removed for confidentiality
[5] Line number(s) removed for confidentiality
[6] Date(s) removed for confidentiality

not verify this claim as the grievance files often lacked dates of the acknowledgement letter and/or resolution letters being sent. As such, DHCS was unable to verify the accuracy of the grievance timeline indicated in the grievance log. The minutes from October 3, 2018 indicated some discussion of "trends" with no specific information or follow up action plan.

Due to lack of details in QIC minutes, and no additional data analysis or corrective action tracking mechanisms being provided to DHCS for the grievance/appeals/fair hearing evaluations, DHCS was unable to verify if the MHP maintains an adequate mechanism to assess beneficiary/family satisfaction by evaluating beneficiary grievance, appeals, and fair hearings at least annually.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 5. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The Contractor has mechanisms to:
Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
Take appropriate follow-up action when such an occurrence is identified.
Evaluate the results of the intervention at least annually. (MHP Contract, Ex. A, Att. 5)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 5. The MHP must have mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns; take appropriate follow-up action when such an occurrence is identified; and, evaluate the results of the intervention at least annually.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Chart Auditing Tools;
- Chart Auditing Reports;
- Policy and Procedure 214: Quality Management Specialty Mental Health Services Chart Audits;
- Policy and Procedure 325: Quality Assessment and Performance Improvement (QAPI) Program;
- FY2017-2018 Grievances and Appeals;
- FY2017-2018 Grievances and Appeals Log;
- Quality Improvement Committee Minutes; and
- QAPI work plans.

The MHP submitted a policy and procedure outlining the chart audit process and corrective action process. Per the policy, the corrective action form is to be utilized to

follow up on the deficiencies. While the chart audit reports indicate areas of deficiencies and disallowance, the MHP did not submit evidence of corrective action taken with identified subcontractors or corrective action form tracking mechanisms to ensure implementation and completion of the corrective actions required. During the on-site review, MHP reported that the corrective action form is tracked by the Quality Assurance team as outlined in the policy.

The MHP also submitted samples of Grievances and Appeals as well as the Grievances and Appeals log for FY 2017-2018. Many samples indicated quality of care concerns. However, while the policy and procedure addresses this requirement, the QAPI work plan matrix and QIC minutes did not demonstrate evidence of actual practice to monitor appropriate and timely intervention of occurrences that raise quality of care concerns, follow-up actions and annual evaluation of the results of the intervention. Specifically, the QIC minutes from May 2, 2018 indicated "no apparent trend, most grievances dealt with a Quality of Care concern" with no specific information regarding what the quality of care concerns were or what actions were taken to resolve them.

Due to lack of details in QIC minutes, lack of corrective action plan tracking/monitoring mechanisms for identified quality of care concerns, and no additional data analysis or corrective action tracking mechanisms being provided to DHCS regarding quality of care concern data and the MHP's follow-up processes, DHCS was unable to verify MHP's compliance with this requirement.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 5. The MHP must complete a POC addressing this finding of non-compliance.

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
The MHP provides training for staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities. (CCR, title 9, chapter 11, sections 1810.410 (c) (4)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with CCR, title 9, chapter 11, sections 1810.410 (c) (4). The MHP must provide training for staff responsible for the statewide, toll-free, 24-hour telephone line to ensure linguistic capabilities.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Patient rights information call script;
- Policy and Procedure 264: Access to 24hour crisis & Urgent Care Services;
- Training Plan: Access Team Procedures;
- Staff Training Schedule;

- New Hire Training Checklist; and
- Language Interpretation Service Vendor Contract.

The MHP submitted a policy and procedure addressing crisis and urgent care service staff training procedure. The MHP also submitted a training plan and call script including many scenarios and resource information to answer the access line. While those items addressed how to answer patient rights/problem resolution information and urgent care information extensively, they did not provide detailed information on how to answer the request for SMHS.

DHCS deems the MHP out-of-compliance with CCR, title 9, chapter 11, sections 1810.410 (c) (4). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number (Cal. Code Regs., tit. 9, chapter 11, §§ 1810.405(d) and 1810.410(e)(1)).
The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

DHCS' review team made seven (7) calls to test the MHP's statewide, 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, §§ 1810.405(d) and 1810.410(e)(1). Each MHP must provide a statewide, toll-free telephone number 24-hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes. The seven (7) test calls are summarized below.

TEST CALL #1

Test call was placed on Wednesday, October 3, 2018, at 7:38 a.m. The call was initially answered after one (1) ring via a live operator. Caller requested information on how to file a complaint and the problem resolution process. The operator responded that after 8:00 a.m. the caller can call the outpatient clinic and can request another provider. The caller asked if s/he could remain anonymous. The operator mentioned that the caller has to give the name and therapist's name so that the MHP will know who they are dealing with. The operator further stated that it is a right under HIPPA where the patient can request a different provider. Caller asked if s/he should call back at 8:00 a.m. The operator replied "yes, this is the crisis line". Call ended. The caller did not receive information on how to file a complaint and receive information on the problem resolution and the fair hearing process.

FINDINGS
DHCS deems the MHP out-of-compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1).

TEST CALL #2
Test call was placed on Wednesday, October 3, 2018, at 12:59 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller for his/her name. The caller provided the name Rex. The operator asked the caller for his/her telephone number. The caller replied to the operator that he is borrowing a phone and did not want to provide the telephone number. The operator asked the caller what city he/she lives in. The caller replied, Durham. The operator asked the caller what city is he/she near. The caller said Chico. The operator informed the caller to call Chico Outpatient to ask more about services. The operator provided the address of the clinic and explained available services. The operator asked the caller if he/she will harm self or other people. The caller replied in the negative. The caller thanked the operator and ceased the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

FINDINGS
DHCS deems the MHP in compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1).

TEST CALL #3
Test call was placed on Wednesday, October 10, 2018, at 7:41 a.m. The call was immediately answered by a live operator. The caller provided information on their symptoms and requested information about accessing mental health services in the county. The operator requested a phone number and put the caller on hold for two minutes. The operator suggested the caller establish a doctor as soon as possible. The operator provided two methods to obtain the required medication quickly, by going to the hospital emergency room or a prompt care clinic, and provided the location for the urgent care clinic. The operator said to call back if the caller required further assistance. The caller was provided information about services needed to treat a beneficiary's urgent condition. Initial SMHS information requirement was deemed not applicable because the operator provided information to solve the beneficiaries' problem through medication management without the need for initial SMHS from the MHP.

FINDINGS
DHCS deems the MHP in compliance with specific requirements in California Code of Regulations, title 9, chapter 11, §§ 1810.405(d) and 1810.410(e)(1).

TEST CALL #4

Test call was placed on Friday, November 2nd, 2018, at 3:17 p.m. The call was initially answered after three (3) rings via a live operator. The caller requested information about accessing mental health services for her son in the county. The operator asked the caller to provide his/her name and some contact information and asked how old the caller's son is and how he was behaving today. The operator advised the caller that the county has a number of agencies that can help with her son, including youth services. The operator provided an abundance of additional information about SMHS to the caller. The caller was provided information about how to access SMHS for her son, including information about services needed to treat a beneficiary's urgent condition, crisis services.

FINDINGS

DHCS deems the MHP in compliance with specific requirements in California Code of Regulations, title 9, chapter 11, §§ 1810.405(d) and 1810.410(e)(1).

TEST CALL #5

Test call was placed on Tuesday, March 12, 2019, at 7:42 a.m. The call was answered after one (1) ring via a live operator. The operator informed the caller that she had reached the Butte County Crisis line and that her name was Kim. The caller described her current condition of feeling down, crying all the time, not having an appetite, and struggling to get out the bed. The operator asked the caller her name. The caller replied Grace. The operator asked the caller how long the caller had been having the symptoms that she described and the caller replied 6-7 weeks. The operator asked the caller if she had experienced symptoms of depression in the past and the caller replied no. The operator stated that she was not a counselor, but would recommend the caller walk into the clinic for assessment. The operator provided the clinic walk-in hours from 8 a.m. to 11 p.m. and the clinic address as 560 Cohasset Suite 180. The caller was informed that they could walk in and speak to the receptionist and they would make sure that the caller would be seen. The caller thanked the operator and ended the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

FINDINGS

DHCS deems the MHP out-of-compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1).

TEST CALL #6

Test call was placed on Monday, November 5, 2018, at 8:31 a.m. The call was initially answered after two (2) rings via a live operator who identified themselves as Ryan. The caller requested information about filing a complaint against a therapist the caller was seeing because the caller thought they were not doing a good job. The operator responded sure and assured the caller that there would not be any discrimination against the caller by filing a grievance. The operator let the caller know there were a couple of ways to file a grievance. The operator gave the first way by calling the patients

advocate line and leaving a message. The operator gave the caller the contact number: 1-800-497-1445. The operator explained that the caller could leave a voicemail and would be contacted back. The operator also stated the caller could also visit a clinic lobby and ask the front receptionist for a problem resolution form. The operator said once this is filled out it could be mailed back in or dropped off. The operator explained once the form is turned in someone would contact the caller in 24 to 48 hours unless it is a weekend or a holiday. The operator asked if he could assist the caller with the process now. The caller declined. The operator asked for the caller's name, the caller responded Sarah. The operator asked for the caller's last name and the caller stated they didn't want to say. The operator offered to mail the form and the caller declined. The operator asked if there was anything else he could help me with. The caller stated no, but thanked the operator for his help. The operator thanked the caller for calling and the call was disconnected. The caller received information on how to file a complaint and receive information on the problem resolution and the fair hearing process.

FINDINGS

DHCS deems the MHP in compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1).

TEST CALL #7

Test call was placed on Thursday, April 4, 2019, at 11:13 a.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide the name and contact information in case of disconnect. The caller provided the name John Morison and stated he was using a friend's phone and declined to provide the phone number. The operator asked caller if he was from this county or had been receiving services in a different county.. The caller stated he just moved there from a previous county and was out of medication. The operator informed the caller he should make contact with his previous county to see about getting a refill since they are familiar with him. The operator provided the address for the Butte County facility located as: 18 County Center Drive. The operator informed the caller to come in to establish themselves. The operator then asked the caller if the caller is in crisis, suicidal, or wanted to hurt oneself or others. The caller stated, no. No additional information about SMHS was provided to the caller. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDINGS

DHCS deems the MHP in compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1).

SUMMARY OF TEST CALL FINDINGS

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	IN			IN		IN		100%
2		IN			IN		IN	100%
3		IN	IN	IN	OOC		IN	80%
4	OOC					IN		50%

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, § 1810.405(d). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The written log(s) contain the following required elements (Cal. Code Regs., tit. 9, chapter 11, § 1810.405(f).): a) Name of the beneficiary. b) Date of the request. c) Initial disposition of the request.

FINDING

The MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, chapter 11, § 1810.405(f). The MHP must maintain a written log of the initial requests for SMHS from beneficiaries of the MHP. The requests must be recorded whether they are made via telephone, in writing, or in person. The log must contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- BCDBD Crisis Calls reports;
- Policy and Procedure 264: Access to 24hour crisis & Urgent Care Services; and
- Training Plan: Access Team Procedures.

One of five required DHCS test calls were not logged on the MHP's access log. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	10/3/2018	12:59 PM	IN	IN	IN
2	10/10/2018	7:41 AM	OOC	OOC	OOC
3	11/2/2018	3:17 PM	IN	IN	IN
4	3/12/2019	7:42 AM	IN	IN	IN
5	4/4/2019	11;13 AM	IN	IN	IN
Compliance Percentage			**80%**	**80%**	**80%**

Note: Only calls requesting information about SMHS, including services needed to treat a beneficiary's urgent condition, are required to be logged.

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, § 1810.405(f). The MHP must complete a POC addressing this finding of non-compliance.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
The MHP shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c). The MHP must notify the requesting provider and give beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Report of all issues NOABDs between 7/1/2017 and 6/30/2018;
- NOA-A status report;
- NOA-A and NOA-E data reports;
- NOABD templates;
- Policy and Procedure 171D.1 (Draft): Notice of Adverse Benefit Determination – Medical Necessity;
- Policy and Procedure 171D.2 (Draft): Notice of Adverse Benefit Determination – Authorization Denial;

- Policy and Procedure 171D.2 (Draft): Notice of Adverse Benefit Determination – Payment Denial;
- Policy and Procedure 171D.4 (Draft): Notice of Adverse Benefit Determination – Termination of Services;
- Policy and Procedure 171D.5 (Draft): Notice of Adverse Benefit Determination – Timeliness;
- Policy and Procedure 171D.6: Notice of Adverse Benefit Determination – Financial Liability Dispute;
- Policy and Procedure 171D.7 (Draft): Notice of Adverse Benefit Determination – Authorization Modification;
- Policy and Procedure 171D.8 (Draft): Notice of Adverse Benefit Determination – Authorization Delay; and
- Policy and Procedure 171D.9 (Draft): Notice of Adverse Benefit Determination – Termination of Services.

The MHP submitted policies and procedures for Notice of Adverse Benefit Determinations (NOABD). Verification of the actual NOABDs revealed that one (1) NOABD was missing for one of the TARs that was reviewed. The MHP was provided opportunity to find the NOABD but unable to submit the evidence.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c). The MHP must complete a POC addressing this finding of non-compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1). The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP's policy addressed this requirements, grievance samples lacked evidence of actual practice as evidenced by missing acknowledgement letters in some of the samples reviewed.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The acknowledgment letter shall include the following: (MHSUDS IN No. 18-010E)
Date of receipt

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN No. 18-010E. The MHP must include date of receipt in the acknowledgement letter.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP's policy addressed this requirement, grievance samples lacked evidence of actual practice as evidenced by a majority of the samples were missing the date of receipt. Though the grievance log indicated the date of receipt of the grievance, DHCS was unable to verify the date of receipt in the majority of the acknowledgement letters as only two (2) acknowledgement letters included the date of receipt. In addition, there were some grievances reviewed that were missing the acknowledgement letter itself.

DHCS deems the MHP out-of-compliance with MHSUDS IN No. 18-010E. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN 18-010E. The MHP must postmark the written acknowledgement to the beneficiary within five (5) calendar days of receipt of the grievance.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;

- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP's policy addressed this requirement, grievance log and samples showed inconsistency in this practice. While the log indicated acknowledgement letter mailing dates, some of the acknowledgement letters did not have any dates on it. DHCS was unable to verify the accuracy of the grievance log.

DHCS deems the MHP out-of-compliance with MHSUDS IN 18-010E. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP shall not subject a beneficiary to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(5).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(5). The MHP must not subject a beneficiary to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted the policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence was submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(5). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP's procedures for the beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(6).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12 and Cal. Code Regs., tit. 9, § 1850.205(c)(6). The MHP must have procedures

for the beneficiary problem resolution process to maintain the confidentiality of each beneficiary's information.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted the policies and procedures addressing beneficiary program resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12 and Cal. Code Regs., tit. 9, § 1850.205(c)(6). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP shall include a procedure to transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the Contractor's operations. The MHP shall consider these issues in the MHP's Quality Improvement Program, as required by Cal. Code Regs., tit. 9, §1810.440(a)(5). (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(7).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12 and Cal. Code Regs., tit. 9, § 1850.205(c)(7). The MHP must include a procedure to transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the MHP's Quality Improvement Committee (QIC), the MHP's administration or another appropriate body within the MHP's operations. The MHP shall consider these issues in the MHP's Quality Improvement Program, as required by Cal. Code Regs., tit. 9, §1810.440(a)(5).

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018;
- Grievance/Appeals logs for FY 2017-2018;
- Policy and Procedure 325: Quality Assessment and Performance Improvement (QAPI) Program;
- QAPI Work plans; and
- QIC minutes.

The MHP's policy and procedure addresses this requirement and QAPI work plan matrix and QIC minutes on May 2, 2018 and October 3, 2018 indicated limited discussion regarding issues identified as a result of the grievance, appeals or expedited appeal process. However, the minutes from May 2, 2018 indicated "no apparent trend, most grievances dealt with a Quality of Care concern" with no specific information regarding what the quality of care concerns were or what action was taken to resolve them. The same QIC minutes indicated "all of the grievances were resolved within the timeline", but the grievance verification study revealed multiple acknowledgement and resolution letters were missing. In addition, some acknowledgement and resolution letters did not have dates on them, therefore DHCS was unable to verify accuracy of the grievance timeline indicated in the grievance log. The minutes from October 3, 2018 indicated some discussion of "trends" with no specific information or follow up plans.

Due to lack of details in QIC minutes, and no additional data analysis or corrective action tracking mechanisms being provided to DHCS regarding issues identified as a result of the grievance/appeals/fair hearing process, DHCS was unable to verify if the MHP maintains mechanisms to transmit issues identified as a result of the grievance, appeals and expedited appeal process to the MHP's QIC.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12 and Cal. Code Regs., tit. 9, § 1850.205(c)(7). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP shall provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MHP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in §438.408(b) and (c) in the case of expedited resolution. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(4).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12, and 42 C.F.R. § 438.406(b)(4). The MHP must provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MHP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in §438.408(b) and (c) in the case of expedited resolution.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted the policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12, and 42 C.F.R. § 438.406(b)(4). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); and, 42 C.F.R. § 438.228(a). The MHP must ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted the policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); and, 42 C.F.R. § 438.228(a). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT

The MHP shall treat oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal) and must confirm these oral inquiries in writing, unless the beneficiary or the provider requests expedited resolution. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(3).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12 and 42 C.F.R. § 438.406(b)(3). The MHP must treat oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal) and must confirm these oral inquiries in writing, unless the beneficiary or the provider requests expedited resolution.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP's policy addresses this requirement, the Grievance/Appeals sample and log revealed there was one orally reported grievance logged on May 16, 2018 regarding adverse beneficiary determination that was treated as a grievance instead of an appeal. In addition, two appeals were logged as appeals, but the resolution letters addressed these issues as grievance resolution creating confusion in differentiating grievance and appeals.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 12 and 42 C.F.R. § 438.406(b)(3). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP shall adhere to the following record keeping, monitoring, and review requirements:
Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person whom the appeal or grievance was filed.
Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. (Cal. Code Regs., tit. 9, § 1850.205(d)(2).)

Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(3).)
Provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(6).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.416(b)(2), (3) and (6). The MHP must:

- Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log;
- Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal; and
- Provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted policies and procedures addressing the beneficiary problem resolution process, the policy did not address these requirements. Also, the verification study of the grievance/appeals samples and log revealed that many of the dates in the log cannot be verified due to a lack of original grievance/appeals information, the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, and/or the date of resolution at each level in the grievance/appeals files. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.416(b)(2), (3) and (6). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT

Provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted. (Cal. Code Regs.,tit. 9, § 1850.206(c).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with Cal. Code Regs.,tit. 9, § 1850.206(c). The MHP must provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with Cal. Code Regs.,tit. 9, § 1850.206(c). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP's appeal process shall, at a minimum:
Allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing (42 C.F.R. § 438.406(b)(4).);
Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the beneficiary (42 C.F.R. § 438.406(b)(5).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.406(b)(4) and (5).The MHP's appeal process must:

- Allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing; and,

- Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the beneficiary.

The MHP submitted the following documentation as evidence of compliance with this requirement:
- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.406(b)(4) and (5). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP includes in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. (42 C.F.R. § 438.408(e)(1)).
The MHP includes in the NAR the beneficiary’s right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. (42 C.F.R. § 438.408(e)(2)(i)).
The MHP includes in the written notice of the appeal resolution the beneficiary’s right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request. (42 C.F.R. § 438.408(e)(2)(ii)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.408(e)(1), and 42 C.F.R. § 438.408(e)(2)(i) and (ii). The MHP must include in the written Notice of Appeal Resolution (NAR):
- Results of the resolution process and the date the process was completed;
- The beneficiary’s right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary; and
- Resolution the beneficiary’s right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

Though the MHP's policy addresses this requirement, samples of two (2) appeal resolution letters did not include the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.408(e)(1), and 42 C.F.R. § 438.408(e)(2)(i) and (ii). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
The MHP provides notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. (CCR, title 9, § 1850.205(d)(6)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with CCR, title 9, § 1850.205(d)(6).The MHP must provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP's policy addressed this requirement, the grievance and appeals sample did not include evidence of written notice to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. No other evidence was provided to show how any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal is notified of the disposition.

DHCS deems the MHP out-of-compliance with CCR, title 9, § 1850.205(d)(6). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT

Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (42 C.F.R. § 438.410(b).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.410(b). The MHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.410(b). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
If, at the beneficiary's request, the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs: a) The beneficiary withdraws the appeal or request for a State Hearing;
b) The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal; and
c) A State Hearing office issues a hearing decision adverse to the beneficiary. (42 C.F.R. § 438.420(c).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.420(c). At the beneficiary's request, the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs:

- The beneficiary withdraws the appeal or request for a State Hearing;

- The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal; and
- A State Hearing office issues a hearing decision adverse to the beneficiary.

The MHP submitted the following documentation as evidence of compliance with this requirement:
- Policies and Procedures 164E: Beneficiary Problem Resolution Process;
- Grievance/Appeals samples from FY 2017-2018; and
- Grievance/Appeals logs for FY 2017-2018.

While the MHP submitted policies and procedures addressing the beneficiary problem resolution process, the policy did not address this requirement. No additional evidence submitted to demonstrate compliance with this requirement.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.420(c). The MHP must complete a POC addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018).

FINDING
The MHP did not furnish evidence to demonstrate compliance with this survey item requirement.

SUGGESTED ACTION
DHCS recommends, at a minimum, the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews:
- Maintain policies and procedures to address the requirements;
- Continue discussion with interested contractors in providing TFC; and
- Update the Provider Contract Boilerplate to reflect the requirements as needed.

CARE COORDINATION AND CONTINUITY OF CARE

REQUIREMENT

The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the DHCS's transition of care policy (MHP Contract, Ex. A, Att.10; 42 CFR §§ 438.62(b)(1) and (2)).

SURVEY FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP Contract and 42 CFR § 438.62(b)(1) and (2). The MHP submitted various policies, correspondences, and referral-tracking log as evidence of compliance with this requirement; however, the evidence provided did not include policies and procedures on the MHP's transition of care policy.

SUGGESTED ACTION
DHCS recommends, at a minimum, the MHP develop policies and procedures on DHCS's transition of care policy in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
MHPs must review and make a decision regarding a provider's request for prior authorization within 5-business days after receiving the request.

SURVEY FINDING
The MHP did not furnish evidence to demonstrate it complies with this survey item requirement.

SUGGESTED ACTION
DHCS is not requiring any action at this time; pending release of the relevant DHCS guidance.