CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2020/2021

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW OF THE FRESNO COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: August 10, 2021 to August 12, 2021

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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 a webinar review of the Fresno County MHP's Medi-Cal SMHS programs on August 10, 2021, to August 12, 2021. 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) 2020/2021 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:

- 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

This report details the findings from the Medi-Cal SMHS Triennial System Review of the Fresno County MHP. The report is organized according to the findings from each section of the FY 2020/2021 Protocol 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 Corrective Action Plan (CAP) is required for all items determined to be OOC or in partial compliance. The MHP is required to submit a CAP to DHCS within 60-days of receipt of the findings report for all system and chart review items deemed OOC. The CAP 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 the CAP is determined to be ineffective, the MHP should inform their county liaison of any additional corrective actions taken to ensure compliance; and
(5) A description of corrective actions required of the MHP's contracted providers to address findings.

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Question 1.1.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must 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.

Triennial review will focus on timeliness of all urgent appointments and physician appointments.

1. Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
2. Emergent care appointments for services that require prior authorization: within 96 hours of the request for appointment

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

- Service Request Data
- 009 Jan-Mar 2020 Service Requests
- 2018 Implementation Plan
- 2019 Implementation Plan
- Timeliness Policy Individual & Group Providers
- Timeliness Policy Org
- Network Adequacy Timeliness and Access to Care Letter
- 19-277 Master Agreement Child Welfare Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has implemented monitoring and tracking of emergent care appointments for services that require prior authorization within the 96-hour period. Per discussions prior to and during the review, the MHP stated it had focused on complying with the ongoing requirements for the Network Adequacy timeliness standards including routine service requests, urgent care requests that do not require prior authorization within the 48-hour period, and psychiatric appointment requests. The MHP stated that moving forward, it will have a mechanism in place to track and monitor all required timeliness standards.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

The MHP must comply with CAP requirement addressing this finding of non-compliance.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.3.2

FINDING

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, section 1810, subdivision 405(d) and 410(e)(1). The toll-free telephone number provides information to beneficiaries to the below listed requirements:

1. The MHP provides 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.
2. The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3. The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4. The toll-free telephone number provides information to the beneficiaries about 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 Thursday, April 15, 2021, at 3:42 p.m. The call was answered after two (2) rings via phone tree directing the caller to select a language option, which included the MHP's threshold languages. The phone tree included a recorded greeting with instructions to hang up and dial 911 if experiencing a life-threatening emergency. A live operator who identified him/herself by name responded to the call after a brief hold, the operator requested that the caller provide personally identifying information. The caller provided his/her name, his/her son's name, and described the concerning and disruptive behavior issues the child was exhibiting. The operator asked for additional information, including a call back phone number, the child's date of birth, and type of medical insurance. The caller declined to provide the telephone number and date of birth but stated the child was covered by Medi-Cal. The operator confirmed that the child was a Fresno county resident and assessed the need for crisis or urgent services. The operator provided the caller with the phone number for Children's Services as well as the address and hours of operations.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

FINDING
The call is deemed *in compliance* with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #2
Test call was placed on Monday, November 2, 2020, at 3:39 p.m. The call was answered after one (1) ring via phone tree directing the caller to select a language option, which included the MHP's threshold languages. A recorded greeting provided instructions to hang up and dial 911 if experiencing a life-threatening emergency. The phone tree offered the caller multiple service options that included substance use disorder and other county-provided services. The caller selected mental health services, however, the call immediately disconnected.

The caller was not 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.

FINDING
The call is deemed *in partial compliance* with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #3
Test call was placed on Friday, March 5, 2021, at 8:08 a.m. The call was immediately answered via phone tree. A recorded greeting provided instructions to hang up and dial 911 if experiencing a life-threatening emergency. The phone tree provided language options for English and the county's threshold languages. After selecting the appropriate language option, the phone tree menu provided service type options from which the caller selected mental health services. Upon this selection, the call disconnected. The caller attempted to reach the MHP two (2) additional times at 8:09 a.m. and 8:11 a.m., but these attempts were also disconnected.

The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information on how to treat an urgent condition.

FINDING
The call is deemed *in partial compliance* with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #4
Test call was placed on Monday, May 17, 2021, at 3:07 p.m. The call was immediately answered via phone tree. A recorded greeting provided instructions to hang up and dial

911 if experiencing a life-threatening emergency. The phone tree offered the information in English and the county's threshold languages. When prompted, the caller selected English and then chose the mental health services option from the phone tree menu. After making the service selection, there was a brief pause and then the call disconnected. The caller attempted to call back two (2) additional times at 3:09 p.m. and 3:15 p.m., but these attempts were also disconnected.

The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information on how to treat an urgent condition.

FINDING
The call is deemed *in partial compliance* with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #5
Test call was placed on Tuesday, June 1, 2021, at 5:33 p.m. The call was answered after one (1) ring via phone tree providing language capabilities in English and the county's threshold languages. A recorded greeting provided instructions to hang up and dial 911 experiencing a life-threatening emergency. After selecting the appropriate language option, the caller selected mental health services to speak with someone about obtaining a refill for anxiety medication. When the caller selected the service type option, the call ended abruptly. The caller attempted two (2) additional times, once at 5:34 and again at 5:39 p.m. On one attempt, the caller selected zero (0) for operator. On the other, the caller did not make any selections in an effort to reach the operator. Both additional calls were unsuccessful and were disconnected.

The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information on how to treat an urgent condition.

FINDING
The call is deemed *in partial compliance* with the regulatory requirement with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #6
Test call was placed on Tuesday, June 1, 2021, at 5:12 p.m. The call was answered after one (1) ring via phone tree providing language capabilities in English and the county's threshold languages. The phone tree greeting identified that the caller had reached Fresno County Behavioral Health Access Line. The phone tree menu provided the caller with a list services from which to select, including mental health and substance use disorder services. The caller selected mental health services to obtain information regarding the beneficiary grievance process. After the caller selected the service type option, the call was disconnected. The caller attempted the call two (2) additional times at 5:25 p.m. and 5:27 p.m. On one attempt, the caller selected zero (0)

for operator. On the other, the caller did not make any selections in an effort to reach the operator. Both additional calls were unsuccessful and were disconnected.

The caller was unable to obtain information about how to use the beneficiary problem resolution and fair hearing process.

FINDING
The call is *out of compliance* with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

TEST CALL #7
Test call was placed on Wednesday, March 17, 2021, at 3:36 p.m. The call was answered after more than six (6) rings via phone tree providing language capabilities in English and the county's threshold languages. After selecting the appropriate language and mental health services options, the call disconnected. The caller made an additional attempt to reach the MHP by telephone again at 3:37 p.m. This call disconnected after selecting the option for mental health services.

The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process.

FINDING
The call is deemed *out of compliance* with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	IN	NA	NA	NA	NA	NA	NA	20%
2	IN	OOC	OOC	OOC	OOC	NA	NA	20%
3	IN	IN	IN	IN	IN	NA	NA	100%
4	NA	NA	NA	NA	NA	OOC	OOC	0%

Based on the test calls, DHCS deems the MHP *in partial compliance* with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

The MHP must comply with CAP requirement addressing this finding of partial/non-compliance.

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.2.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026 (MHSUDS 19-026). The MHP is required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services for the below:

1. MHPs shall conduct concurrent review of treatment authorizations following the first day of admission.
2. MHPs may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.

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

- PPG 4.3.1 Concurrent Review and Claims Processing for Psychiatry
- TBS Referral Authorization Log 01.01.2020 through 01.31.2021
- 50 Sample TARs
- 25 Sample SARs
- Signature of individuals who are approved to review payment service authorizations
- Name, Licenses
- Beneficiary Handbook
- IHBS Authorization Implementation 2021 Presentation
- IHBS Authorization Notification
- Provider Manual
- Concurrent Review
- Concurrent Review - Inpatient Psychiatric Admission

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its policies and procedures to comply with MHSUDS 19-026. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Question 5.2.4

FINDING

The MHP did not furnish complete evidence to demonstrate compliance with MHSUDS 19-026. The MHP shall make decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision for the below:

1. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination.
2. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

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

- PPG 4.3.1 Concurrent Review and Claims
- PPG 4.2.4 MHP Referral & Authorization, requirement not documented
- PPG 1.2.12 Notice of Adverse Benefit Determination
- Signature of individuals who are approved to review payment service authorizations
- Sample TARs
- Sample SARs
- TBS Referral Authorization Log 01.01.2020 through 01.31.2021
- Concurrent Review
- Concurrent Review - Inpatient Psychiatric Admission

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures that care continues until a beneficiary's treatment treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. This requirement was not included in any evidence provided by the MHP. Per discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Question 5.2.5

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS 19-026. The MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status for the below requirements:

1. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
2. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.
3. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

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

- PPG 4.3.1 Concurrent Review and Claims
- PPG 4.2.4 MHP Referral & Authorization,
- PPG 1.2.12 Notice of Adverse Benefit Determination
- Signature of individuals who are approved to review payment service authorizations
- Sample TARs
- Sample SARs
- TBS Referral Authorization Log 01.01.2020 through 01.31.2021
- Concurrent Review
- Concurrent Review - Inpatient Psychiatric Admission

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its policies and procedures to comply with MHSUDS 19-026. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Question 5.2.6

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS 19-026. The MHP must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization for the below:

1. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.
2. The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

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

- PPG 4.3.1 Concurrent Review and Claims,
- PPG 4.2.4 MHP Referral & Authorization
- PPG 1.2.12 Notice of Adverse Benefit Determination
- Signature of individuals who are approved to review payment service authorizations
- Sample TARs
- Sample SARs
- TBS Referral Authorization Log 01.01.2020 through 01.31.2021
- Concurrent Review
- Concurrent Review - Inpatient Psychiatric Admission

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its policies and procedures to comply with MHSUDS 19-026 related to utilizing referral and/or concurrent review and authorization for all CRTS and ARTS. This requirement was not included in any evidence provided by the MHP. Per discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Question 5.4.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination (NOABD) under the circumstances listed below:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.
2. The reduction, suspension or termination of a previously authorized service.
3. The denial, in whole or in part, of a payment for service.
4. The failure to provide services in a timely manner.
5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

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

- Sample Timely Access Contract Analyst Minutes, CAPs
- NOA-NOABD Tracking Log
- Service Request Log
- Service Request Responses
- Sample Timely Access Contract Analyst Minutes, CAPs
- Individual Service Authorizations
- Individual NOABDs
- NOABD Samples
- PPG 1.2.12 Notice of Adverse Benefit Determination
- NOABD Templates (English, Spanish, Hmong)
- NOABD Your Rights
- NOABD Templates

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP issued to each beneficiary, or each beneficiary's representative and provider, the appropriate NOABD. DHCS identified five (5) instances where timely access requirements were not met in which it failed to provide the NOABDs for failure to provide services in a timely. Per the discussion during the review, the MHP stated it would research the missing NOABDs. The MHP submitted evidence demonstrating that it had issued two (2) of the five (5) NOABDs when it failed to provide services in a timely manner. The MHP could not substantiate the remaining three (3) NOABDs in question; therefore, it was unable to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Repeat deficiency Yes

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.2.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

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

- PPG 1.2.11 Person Served Problem Resolution System – Grievance Process
- PPG 1.2.18 Person Served Problem Resolution System – Appeal Process
- PPG 1.2.16 State Fair Hearing and Aid Paid Pending
- HTG 6.1.008 Grievance Forwarding & Resolution
- Access Line Complaint Flow Chart
- Grievance, Appeals, and Ex Appeals Log
- Sample Grievances, Appeals, Ex Appeals
- Individual Grievance Case Documentation
- Mental Health Directive Problem Resolution System
- Beneficiary Handbook
- Grievance Brochure (English, Spanish, Hmong)
- Appeal Brochure (English, Spanish, Hmong)
- Problem Resolution System Poster (English, Spanish, Hmong)
- MHP Website
- Problem Resolution System Acknowledgement Letter
- QIC Agenda 9-9-2020
- QIC Minutes
- Grievance Annual Report FY19-20
- Notice of Grievance Resolution

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP logged all grievances within one day during the triennial review period. DHCS found one (1) out of thirty-five (35) grievances (3%) that did not meet the 24 hour logging requirement (97% compliance). This grievance was logged three (3) working days after receipt. Per the discussion during the review, the MHP stated it would research the circumstances of this grievance. The MHP submitted evidence that the contracted access line staff delayed forwarding a grievance to its clinic staff for three working days. Upon the MHP receiving the grievance in January 2020, MHP staff addressed the timeliness standard issue with the access line staff, logged the grievance, and mailed the acknowledgement letter. While the additional evidence demonstrated that the MHP responded appropriately to an internal problem with a corrective action, the MHP was unable to demonstrate compliance with the requirement.

DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Repeat deficiency Yes