CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE GLENN COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: March 22, 2022 to March 23, 2022

Glenn County Mental Health Plan
FY 2021/2022 Medi-Cal SMHS Triennial Review
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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 Glenn County MHP's Medi-Cal SMHS programs on March 22, 2022 to March 23, 2022. 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) 2021/2022 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 Glenn County MHP. The report is organized according to the findings from each section of the FY 2021/2022 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. Urgent 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:

- Glenn_1.1_BH1030 - Network Adequacy, pages 2 and 3
- Glenn_1.1_MH105-Intake Process for Outpatient MH Services, page 3
- Glenn_1.1_Time from crisis to request response Sept to Nov 2021
- Glenn_1.1_Time from Inpatient Discharge to Follow-up Sept to Nov 2021
- Glenn_1.1_Timeliness and Access Data Sept to Nov 2021
- Glenn_1.1_Timely Access CAPs Info
- Glenn_Large Documents_Psychiatry Request Log
- Glenn_Large Documents_Crisis Log
- Glenn_5.4_All NOABDs Issues Jan- Dec 2021

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by the MHP that the MHP met the department standards for timely access to care for psychiatry appointments. Of the 50 psychiatry appointments reviewed by DHCS, 12 did not meet timeliness standards. Per the discussion during the review, the MHP stated it tracks service requests via a spreadsheet and performs follow up calls to verify appointments. The MHP was provided the opportunity to submit additional evidence to demonstrate compliance, including Notice of Adverse Beneficiary Determinations (NOABD) for appointments that did not meet timeliness standards, however the additional evidence provided did not address the untimely appointments.

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

Repeat deficiency Yes

Question 1.4.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

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

- Glenn_1.4_MH150-Medi-Cal Cert & Re-Cert of Medi-Cal Organizational Providers, pages 3 and 4
- Glenn_1.4_Glenn County Medi-Cal Certification and Transmittal
- Glenn_1.4_Provider Master Certifications
- Glenn_1.4_Provider Monitoring Log
- Glenn_Medi-Cal Cert & Transmittal Termination Mountain Valley Provi 1165

LIST ANY INTERNAL DOCUMENTS REVIEWED:

- Glenn County Provider Monitoring Report SR 3-10-22

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certified, or uses another MHP's certification documents to certify the organizational providers that subcontract with the MHP to provide SMHS. Of the 15 MHP providers, two (2) providers had overdue certifications. Per the discussion during the review, the MHP no longer contracts with either of the two (2) overdue providers. Post review, the MHP submitted a termination transmittal for one provider which was dated post review, no additional evidence was provided for the second overdue provider.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

Repeat deficiency Yes

CARE COORDINATION AND CONTINUITY OF CARE

Question 2.2.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, section 438, subdivision 208(b)(4). The MHP must share with the Department or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.

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

- Glenn_2.1_MH156-Coordination &Continuity of Medi-Cal Specialty MH Services page 4
- Glenn_2.2_BH1019 - Universal Release of Information
- Glenn_2.2_MOU with MCP CA Health & Wellness MOU Addendum
- Glenn_2.2_MOU with MCP CA Health & Wellness MOU page 8, 42 and 43
- Glenn_2.2_Sample of Completed URI
- Glenn_2.2_Notice of Privacy Practices Eng & Sp, page 4
- Glenn_2.2.1_MH 156 Coordination and Continuity of MC SMHS

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP shares results of any identification or assessments with the Department or other managed care entities to prevent duplication of services. Per the discussion during the review, the MHP acknowledged that its policy was missing this requirement and that it would submit an updated policy post review. Post review, the MHP submitted a compliant policy that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, section 438, subdivision 208(b) (4).

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 Monday, December 20, 2021 at 5:08 p.m. The call was answered after one (1) ring via a live operator. The operator asked the caller if he/she was calling in regards to a crisis or emergency, the caller replied in the negative. The caller requested information about accessing mental health services in the county for his/her son. The operator verified the caller's residence within the county and provided the phone number and hours of operation for the clinic. The operator provided the caller an overview of the assessment and screening process.

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 California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

TEST CALL #2
Test call was place on Wednesday January 5, 2022 at 3:40 p.m. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county for his/her son. The operator explained the process to obtain services, provided the address and hours of operation for two (2) childrens services locations, and informed the caller of the availability of walk-in services at the county.

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 California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

TEST CALL #3

Test call was placed on Tuesday, December 21, 2021, at 3:49 p.m. The call was answered after two (2) rings via a live operator. The operator asked the caller if he/she was calling in regards to a crisis or emergency, to which the caller responded in the negative. The caller requested assistance with refilling an anxiety prescription as a new Medi-Cal beneficiary in the county who had not yet established a provider. The operator requested personal identifying information, which the caller provided. The operator asked the caller if he/she needed to see a clinician immediately, which the caller declined. The operator explained the assessment and referral process to determine the caller's medical needs so that he/she may receive a medication refill. The operator explained the timeline for the assessment process, clinical location and hours of operation, and availability of walk-in services for urgent care.

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.

FINDING

The call is deemed *in 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 #4

Test call was placed on Wednesday, December 22, 2021, at 7:23 a.m. The call was answered after two (2) rings via a live operator. The operator asked the caller if he/she was calling in regards to a crisis or emergency, the caller replied in the negative. The caller asked the operator for information about mental health services in the county and explained that he/she had been depressed and his/her doctor suggested that he/she contact the county for help. The operator informed the caller that he/she could complete a referral over the phone or go to a clinic for an assessment. The operator asked the caller if he/she would like to proceed with a referral, to which the caller replied in the negative. The operator provided the caller the clinic address.

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.

FINDING

The call is deemed *in 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 #5

Test call was placed on Monday, December 27, 2021, at 2:30 p.m. The call was answered after two (2) rings via a live operator. The operator asked the caller if he/she was calling in regards to a crisis or emergency, the caller replied in the negative. The caller requested information about services in the county because he/she was feeling

down and his/her friend suggested he/she call the county. The operator requested personal identifying information, which the caller provided. The operator offered the caller the option to speak to counselor for a referral, to which the caller declined. The operator provided an overview of services available and explained the assessment process. The operator provided the caller office locations and reminded the caller he/she could call back 24/7 for assistance.

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 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 #6
Test call was placed on Friday, November 12, 2021 at 7:33 a.m. The call was answered after two (2) rings via a live operator. The operator asked the caller if he/she was calling in regards to a crisis or emergency, the caller replied in the negative. The caller informed the operator that he/she wanted to file a complaint against a therapist. The operator explained that he/she could complete the grievance form for the caller over the phone or the caller could go to a clinic and pick up a grievance form.

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

FINDING
The call is deemed *in 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 Tuesday, November 30, 2021, at 9:23 a.m., 11:55 a.m., and 12:34 p.m. After several attempts from multiple phone lines the test caller was unable to reach the MHP's access line.

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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	IN	IN	IN	IN	N/A	N/A	100%
3	IN	IN	IN	IN	IN	N/A	N/A	100%
4	N/A	N/A	N/A	N/A	N/A	IN	OOC	50%

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

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

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 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:

- Glenn_1.1_BH1030 - Network Adequacy, pages 2 and 3
- Glenn_1.1_MH105-Intake Process for Outpatient MH Services, page 3
- Glenn_1.1_Time from crisis to request response Sept to Nov 2021
- Glenn_1.1_Time from Inpatient Discharge to Follow-up Sept to Nov 2021
- Glenn_1.1_Timeliness and Access Data Sept to Nov 2021
- Glenn_1.1_Timely Access CAPs Info
- Glenn_Large Documents_Psychiatry Request Log

- Glenn_Large Documents_Crisis Log
- Glenn_5.4_All NOABDs Issues Jan- Dec 2021

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP provides beneficiaries with a Notice of Adverse Beneficiary Determination (NOABD) for failure to provide services in a timely manner. Of the 50 psychiatry appointments reviewed, 12 did not meet the timeliness standard and NOABDs were not provided. Per the discussion during the review, the MHP stated it has a tracking process for logging and tracking NOABDs. The MHP was provided the opportunity submit the missing NOABDs post review, however no additional evidence was provided.

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

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements:

1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.
2. The acknowledgment letter shall include the following:
    a. Date of receipt
    b. Name of representative to contact
    c. Telephone number of contact representative
    d. Address of Contractor
3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

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

- Glenn_6.1_BH1002-Client Problem Resolution Process
- Glenn_6.1.5_Acknowledgement Letter Eng & Sp
- 6.1.5 Pre Review Acknowledgement Letters

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP sends beneficiaries acknowledgement of receipt of grievance within five (5) calendar days of receiving a grievance. Of the 14 grievances

reviewed, one (1) acknowledgment letter was not sent within five (5) calendar days. Per the discussion during the review, the MHP stated its grievance process includes sending beneficiary acknowledgement letters within one (1) to two (2) business days of receipt. The MHP was provided the opportunity to submit additional evidence to demonstrate compliance with the requirement, however no additional evidence was received.

In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below;

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**14**	**13**	**1**	**93%**

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E.

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:

- Glenn_6.1_BH1002-Client Problem Resolution Process
- Glenn_6.2_Grievance, Appeals, Expedited Appeals Log Jan-Dec 2021
- Samples of Grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by the MHP that the MHP logs and records grievances within one (1) working day of the receipt of grievance. Of the 14 grievances reviewed, six (6) were not logged within one (1) working day of receipt. The MHP stated it is in a transition period due to staffing changes and this may have contributed to the delay in logging grievances timely. The MHP was provided the

opportunity to submit additional evidence to demonstrate compliance with the requirement, however no additional evidence was received.

In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below;

	# OF SAMPLE REVIEWED	LOGGED WITHIN ONE (1) WORKING DAY		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**14**	**8**	**6**	**57%**

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.