CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE LOS ANGELES COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: September 27, 2022 to September 30, 2022

Los Angeles 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 Los Angeles County MHP's Medi-Cal SMHS programs on September 27, 2022 to September 30, 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.

Los Angeles County Mental Health Plan
FY 2021/2022 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

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 Los Angeles 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:

- Policy 302.14 Responding to Initial Request for Services
- Policy 302.7 Access to Care
- Sample Medication service requests 2022-08-11
- Sample Urgent service requests 2022-08-11
- A2C & Chart Review Data Meeting 8-17-21
- A2C & Chart Review Data Meeting 9-16-21
- Service Accessibility
- Urgent service requests 2022-09-14
- Provider Subcontracts Amendments
- 2021 Q3 POCs
- Access Center Test Calls Bulletins CY2020-CY2021
- Performance Outcomes IHBS TBS 2022-08-02
- Service Availability by Language
- Sample Medication Service Requests 2022-08-11
- Sample Urgent Service Requests 2022-08-11
- Access to Care Data and Track Results

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implements Department standards for timely access to care and services, taking into account the urgency of need for services. Of the 50 physician appointments reviewed by DHCS, six (6) did not meet timeliness standards. Of the 50

urgent appointments reviewed, 33 did not meet timeliness standards. Per the discussion during the review, the MHP is aware that some appointments are not meeting the timeliness standard and acknowledged that it experiences challenges due to the large number of requests received by the county on a monthly basis.

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 1.1.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(ii). The MHP must require sub contracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP.

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

- LE Contract 2022-23 (Provider contract Boilerplate)
- Policy 302.7 Access to Care
- Policy 302.14 Responding to Initial Request for Services
- Policy 201.01 Beneficiary Rights and Responsibilities
- Policy 401.03 Clinical Documentation for All Payer Source
- Policy 1100.01 QI Program
- LACDMH Implementation Plan FY 21-22
- 1974Y 66 - Jun 21
- 7418 Foothill COP 6-21

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires its subcontracted providers to have hours of operation no less than the hours the provider makes available to non-Medi-Cal beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged the need to update its policies and processes to include this requirement moving forward.

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

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:

- Master Certification Log 8-24-22
- Blank-Cat1-8 Protocol
- Medi-Cal Certification Documents Submission Guideline for Contract Providers
- Overview and Instructions for New Certifications revised 8-2019
- SDMC Provider Cert Application
- 19JD - Category 2 - 2022
- 19JD - Category 3 - 2022
- 19JD - Category 7 - 2022
- Sample of completed certification documents

LIST ANY INTERNAL DOCUMENTS REVIEWED.

- Los Angeles County Provider Monitoring Report 9-14-22

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certifies, or uses another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS. Of the 781 MHP provider sites, 39 had overdue certifications. Per the discussion during the review, the MHP utilizes a master checklist to monitor the certification of providers; however, it acknowledged that it had overdue providers it would need to address. No additional evidence of certification was submitted post review.

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

CARE COORDINATION AND CONTINUITY OF CARE

Question 2.1.2

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)(1). The MHP must provide the beneficiary information on how to contact their designated person or entity.

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

- Organizational Providers Manual 1-1-22_3
- IFCCS Starview Facilitator job description
- Minutes from Beacon Meeting 5.2022 - 8.2022
- Policy 201.01 Beneficiary Rights and Responsibilities
- Policy 302.03 Coordination of Care
- IBHIS Screen Shot
- Exchange of Information (Beneficiary Medical Records)
- Sample Monitoring Report for Primary Contact

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides the beneficiary information on how to contact their designated person or entity. Per the discussion during the review, the MHP stated that it has a policy that includes this requirement but it does not have a process to ensure this information is being provided to the beneficiary. Post review, the MHP did not submit additional evidence demonstrating clients are provided information on how to contact their designated person or entity.

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)(1).

Question 2.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. The MHP must establish continuity of care procedures in accordance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. The procedures must address the below listed requirements:

1. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the MHP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (e.g., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner);

2. SMHS shall continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice;
3. A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to the MHP for continuity of care;
4. Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request; and,
5. The MHP must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

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

- 1125204 MH756 Continuity of Care Request
- Continuity of Care Log
- QA Bulletin 22-03 Continuity of Care
- xxx.xx Continuity of Care 8-6-21 Draft
- 2.5 Continuity of Care Policy Updated Draft (002)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update its policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with the Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059.

Question 2.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. Following identification of a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary.

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

- 1125204 MH756 Continuity of Care Request
- Continuity of Care Log
- QA Bulletin 22-03 Continuity of Care
- xxx.xx Continuity of Care 8-6-21 Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes a good faith effort to enter into a contract with a provider if a pre-existing relationship is identified. The MHP provided a draft policy that included this requirement. Per the discussion during the review, the MHP stated that it is in the process of finalizing and implementing the draft policy.

DHCS deems the MHP out of compliance with the Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059.

Question 2.5.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-059. The MHP must ensure each continuity of care request is completed within the below listed timelines:

1. Thirty calendar days from the date the MHP received the request;
2. Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
3. Three calendar days if there is a risk of harm to the beneficiary.

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

- 1125204 MH756 Continuity of Care Request
- Continuity of Care Log
- QA Bulletin 22-03 Continuity of Care
- xxx.xx Continuity of Care 8-6-21 Draft
- 2.1 DMH SFC Flow Chart 6-17-21
- 2.1 Exhibit A. DMH CSAT Referral Portal Workflow
- 2.1 SFC Manual Letter Section 1 –Katie A Version 11-5 QA signed LW (002)
- Sample Monitoring Report for Primary Contact
- 2.5 Continuity of Care Policy Updated Draft (002)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that each continuity of care request is completed within the required timelines. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update its policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-059.

Question 2.5.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-059. When the continuity of care agreement has been established, the MHP must work with the provider to establish a Client Plan and transition plan for the beneficiary.

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

- 1125204 MH756 Continuity of Care Request
- Continuity of Care Log
- QA Bulletin 22-03 Continuity of Care
- xxx.xx Continuity of Care 8-6-21 Draft
- 2.1 DMH SFC Flow Chart 6-17-21
- 2.1 Exhibit A. DMH CSAT Referral Portal Workflow
- 2.1 SFC Manual Letter Section 1 –Katie A Version 11-5 QA signed LW (002)
- Sample Monitoring Report for Primary Contact
- 2.5 Continuity of Care Policy Updated Draft (002)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP works with the out-of-network provider to establish a Client Plan and a transition plan for the beneficiary once the continuity of care agreement has been established. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update its policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-059.

Question 2.5.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Service, Information Notice, No.18-059. Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, as specified below listed requirements:

1. The MHP's approval of the continuity of care request;
2. The duration of the continuity of care arrangement;
3. The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and,
4. The beneficiary's right to choose a different provider from the MHP's provider network.

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

- 1125204 MH756 Continuity of Care Request
- Continuity of Care Log
- QA Bulletin 22-03 Continuity of Care
- xxx.xx Continuity of Care 8-6-21 Draft
- 2.1 DMH SFC Flow Chart 6-17-21
- 2.1 Exhibit A. DMH CSAT Referral Portal Workflow
- 2.1 SFC Manual Letter Section 1 –Katie A Version 11-5 QA signed LW (002)
- Sample Monitoring Report for Primary Contact
- 2.5 Continuity of Care Policy Updated Draft (002)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures the beneficiary and/or the beneficiary's authorized representative is notified in writing upon approval of a continuity of care request. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update its policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Service, Information Notice, No.18-059.

Question 2.5.8

FINDING

The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period.

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

- 1125204 MH756 Continuity of Care Request
- Continuity of Care Log
- QA Bulletin 22-03 Continuity of Care
- xxx.xx Continuity of Care 8-6-21 Draft
- 2.1 DMH SFC Flow Chart 6-17-21
- 2.1 Exhibit A. DMH CSAT Referral Portal Workflow
- 2.1 SFC Manual Letter Section 1 –Katie A Version 11-5 QA signed LW (002)
- Sample Monitoring Report for Primary Contact
- 2.5 Continuity of Care Policy Updated Draft (002)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition the beneficiary's care at the end of the continuity of care period. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update its policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.1.8

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must implement mechanisms to monitor the safety and effectiveness of medication practices meeting the below listed requirements:

1. Under the supervision of a person licensed to prescribe or dispense medication.
2. Performed at least annually.
3. Inclusive of medications prescribed to adults and youth.

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

- LAC Department of Mental Health Practice Parameter Antidepressant Medications
- LAC Department of Mental Health Practice Parameter Anxiolytic Medications
- LAC Department of Mental Health Practice Parameter Mood Stabilizing Medications
- LAC Department of Mental Health Practice Parameter Antipsychotic Medications
- LAC Department of Mental Health Practice Parameter Pharmaceutical Trials
- LAC Department of Mental Health Practice Parameter Psychotropic Medications in Children & Adolescents
- Medication Evaluation Decision Tree Pilot Rio Hondo
- Practice guidelines Training Material Policy 609.05
- Statewide TX Plan Coalition
- Peer Review Procedure
- Handout - DMH_EQRO_Pharm_CY2020
- Quality of concerns monitoring mechanisms (multiple)
- Policy 400.01
- QIP Proposal PDSA MedEva Tree Rio Hondo & Worksheet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has implemented mechanisms to monitor the safety and effectiveness of medication practices. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not have a mechanism of monitoring medication practices for contracted provider sites.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5.

Question 3.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

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

- Organizational Provider Manual (7/1/93: updated 1/1/22)
- Contract Boilerplate
- Q.A Bulletin: Eating Disorders & Access to Care
- Clinical Practice Parameters
- LAC Department of Mental Health Practice Parameter Antidepressant Medications
- LAC Department of Mental Health Practice Parameter Anxiolytic Medications
- LAC Department of Mental Health Practice Parameter Mood Stabilizing Medications
- LAC Department of Mental Health Practice Parameter Antipsychotic Medications
- LAC Department of Mental Health Practice Parameter Pharmaceutical Trials
- LAC Department of Mental Health Practice Parameter Psychotropic Medications in Children & Adolescents
- Medication Evaluation Decision Tree Pilot Rio Hondo
- Practice guidelines Training Material Policy 609.05
- Statewide TX Plan Coalition
- PPT How to ask about SOGI: Sexual Orientation & Gender Identity
- Guidelines for the use of DMH Practice Parameters
- 1102954_PEIOutcomeMeasuresTABLE2-19-2021 (1)
- PEI EBP Matrix September 2021
- PEI Training Protocols revised 6-29-22
- Provider PEI Practice List - Sept. 1, 2022

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the guidelines to all beneficiaries and potential beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not have a process to disseminate practice guidelines to beneficiaries. Post review, the MHP provided evidence that it disseminates practice guidelines to providers; however, no evidence was provided to demonstrate that practice guidelines are disseminated to affected beneficiaries or potential beneficiaries.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.2.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(d)(2). The MHP must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided.

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

- Policy 200.09 culturally and linguistically inclusive services Procedures, Sep 04, 2019
- Policy 200.03 Language Translation and Interpreter Services Procedures
- Policy 200.04 Beneficiary Problem Resolution Process
- Policy 200.05 Request for Change of Provider Procedures
- Language Line Services Inc. – PH-004287-1
- Master Agreement- Language Line Services Inc. - PH-004287 v8.21
- Master Agreement Vendors for Language Assistance Services
- Beneficiary Handbooks
- Antelope Valley Welcome Packet
- Coastal Welcome Packet
- MH 500 Consent for services 7-7-22
- San Antonio Welcome Packet
- Santa Clarita Welcome Packet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP include taglines in large print, explaining the availability of written translation or oral interpretation to understand the information provided. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit documentation to meet this requirement. Post review, the MHP submitted evidence; however, it did not include large print material or information regarding the availability of translated material.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(d)(2).

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, June 13, 2022, at 3:29 p.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was placed on hold. The caller disconnected the call after being placed on hold for approximately eight (8) minutes.

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

FINDING

The call is deemed in *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 #2

Test call was placed on Tuesday, June 21, 2022, at 4:15 p.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was placed on hold. The caller disconnected the call after being placed on hold for approximately 10 minutes.

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 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 Monday, December 28, 2021, at 7:11 a.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was connected to a liver operator. The caller asked the operator for information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling overwhelmed, isolated, and hopeless. The operator assessed the caller's need for urgent services, which the caller responded in the negative. The operator explained the screening and assessment process. The operator explained that walk-ins are available and provided the hours of operation and address to the MHP offices. The operator explained that someone is available to assist 24-hours a day via the after-hours line.

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 Friday, December 10, 2021 at 10:48 a.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was connected to a liver operator. The caller requested information about accessing mental health services and how to refill his/her anxiety medication. The operator assessed the caller's need for urgent services, which the caller responded in the negative. The operator requested personally identifying information, which the caller provided. The operator explained the screening and assessment process. The operator explained that walk-ins are available at an urgent care site and that the caller could get assistance with a prescription refill at this location.

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 7:42 a.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was connected to a liver operator. The caller requested information about accessing mental health services and how to refill his/her anxiety medication. The operator assessed the caller's need for urgent services, which the caller responded in the negative. The operator explained the screening and assessment process to establish care. The operator explained that walk-ins are available at an urgent care site and that the caller could get assistance with a prescription refill at this location.

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 #6
Test call was placed on Thursday, June 16, 2022 at 4:30 p.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was placed on hold. The caller disconnected the call after being placed on hold for approximately six (6) minutes.

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).

TEST CALL #7

Test call was placed on Friday, June 24, 2022, at 5:11 p.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The recorded message stated to call 9-1-1 if the caller was experiencing an emergency. After hearing several options, the caller was connected to a liver operator. The caller asked how to file a complaint in the county. The operator advised the caller that the grievance forms are located in clinic lobbies. The operator stated that the grievances could be completed online, mailed to the caller, or taken over the phone.

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).

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	IN	IN	IN	IN	IN	N/A	N/A	100%
2	OOC	OOC	IN	IN	IN	N/A	N/A	60%
3	N/A	IN	IN	IN	IN	N/A	N/A	100%
4	N/A	N/A	N/A	N/A	N/A	OOC	IN	50%

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).

Repeat deficiency Yes

Question 4.3.4

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request.

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

- Access Log Access from 2022-08-10
- Access Log Dynamics 2022-08-10
- Access Log Non Identified 2022-08-09

While the MHP submitted evidence to demonstrate compliance with this requirement, two (2) of the five (5) required DHCS test calls were not logged on the MHP's written log of initial request. 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	6/13/2022	3:29 p.m.	OOC	OOC	OOC
2	6/21/2022	4:15 p.m.	OOC	OOC	OOC
3	12/28/2021	7:11 a.m.	OOC	IN	IN
4	12/10/2021	10:48 a.m.	OOC	IN	IN
5	12/27/2021	7:42 a.m.	OOC	IN	IN
Compliance Percentage			**0%**	**60%**	**60%**

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, section 1810, subdivision 405(f).

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.2.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish and implement written policies and procedures addressing the authorization of SMHS.

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established and implemented written policies and procedures addressing the authorization of SMHS. The MHP provided a draft policy that included this requirement. Per the discussion during the review, the MHP stated that it is in the process of finalizing and implementing the draft policy moving forward.

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

Question 5.2.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must comply with the following communication requirements:

1. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2. Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization.
3. A physician shall be available for consultation and for resolving disputed requests for authorizations;

4. Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting these online;
5. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
6. MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP complies with the communication requirements outlined in MHSUDS IN 19-026. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update the policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

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

Question 5.2.6

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 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:

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has utilized referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). The MHP provided a draft policy that included this requirement. Per the discussion during the review, the MHP stated that it will finalize and implement the draft policy moving forward.

Question 5.2.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS

a. MHPs may not require prior authorization for the following services/service activities:
    i. Crisis Intervention;
    ii. Crisis Stabilization;
    iii. Mental Health Services -;
    iv. Targeted Case Management;
    v. Intensive Care Coordination; and,
    vi. Medication Support Services.

b. Prior authorization or MHP referral is required for the following services:
    i. Intensive Home-Based Services
    ii. Day Treatment Intensive
    iii. Day Rehabilitation
    iv. Therapeutic Behavioral Services
    v. Therapeutic Foster Care

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established and implemented written policies and procedures regarding prior authorization and/or MHP referral requirements for outpatient SMHS. The MHP provided a draft policy that included this requirement. Per

the discussion during the review, the MHP stated that it is in the process of finalizing and implementing the draft policy moving forward.

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

Question 5.2.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft
- 5.2.8 SAR Timestamps for System Review

DHCS reviewed samples of authorizations to verify compliance with regulatory requirements. The service authorization sample verification findings are detailed below:

Requirement	# of Services Authorizations in compliance	# of Service Authorizations out of compliance	Compliance Percentage
Regular Authorization: The MHP makes a decision regarding a provider's request for prior authorization not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.	24	1	96%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP reviews and makes decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information. Of the 25 Service Authorization Requests (SAR) reviewed by DHCS, one (1) was not completed within the timeframe. Per the discussion during the review, the MHP stated it would review its internal documentation and provide additional evidence to demonstrate this timeline was met. Post review, the MHP submitted timestamps documentation for SARs in question; however, one (1) remained out of compliance.

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

Question 5.2.9

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2). In cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. The MHP provided a draft policy that included this requirement. Per the discussion during the review, the MHP stated that it is in the process of finalizing and implementing the draft policy moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2).

Question 5.2.10

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized.

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual

- Day Treatment Day Rehab Authorizers
- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft
- QA Bulletin 20-05 RICC IHBS TBS TFC Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP specifies the amount, scope, and duration of treatment that the MHP has authorized for referral or prior authorization. This requirement was not included in any evidence provided the MHP. Per the discussion during the review, the MHP stated it will update its policy and process with the required language to meet this requirement. Post review, the MHP submitted a compliant draft policy that it will implement moving forward.

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

Question 5.2.11

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,
4. Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

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

- Authorization Policy Draft 8-23-22 Final Draft
- Authorization Request Widget Screenshots
- Authorization Tracking Formal for the IHBS TBS process v4.4
- IHBS TBS MBAuth Prog Staff Approver
- QA Bulletin 22-01 Updated Pre-Authorizations Requirements
- End User Training Manual
- Day Treatment Day Rehab Authorizers

- Licenses for Authorization Team
- Sample authorizations 2022-08-03
- IMD Exclusion Utilization FY 19-20
- IMD Exclusion Utilization FY 20-21
- IMD Exclusion Utilization FY 21-22
- 5.2 Authorization Policy Updated Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). The MHP provided a draft policy that included this requirement. Per the discussion during the review, the MHP stated that it is in the process of finalizing and implementing the draft policy moving forward.

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

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:

- Sample NOABD 2022-08-05
- Notice Advanced Find View 6-24-2022 8-25-50 AM ALL
- Policy 200.04
- NOABD Templates
- Sample Medication Service Requests 2022-08-11
- Sample Urgent Service Requests 2022-08-11

- 200.04 Beneficiary Problem Resolution Process Procedures
- FY 2021-22 (8-16-2022)vq (Grievance log)
- Samples of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides Notice of Adverse Beneficiary Determination (NOABDs) to beneficiaries for failure to provide services in a timely manner and the failure to act within timeframes regarding the standard resolution of grievances and appeals. Of the 50 physician appointments reviewed by DHCS, six (6) did not meet timeliness standards; of the 50 urgent appointments reviewed, 33 did not meet timeliness standards. It was not evident that NOABDs were provided to these beneficiaries. Of the 33 grievances reviewed, it was not evident that NOABDs were provided for the 16 grievances that were not resolved within DHCS timeframes.

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

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 402(b) and 228(a). The MHP must have only one level of appeal for beneficiaries.

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

- Policy 200.04 Beneficiary Problem Resolution Process
- Grievance, Appeal Form English
- Home Patient Complaints and Grievances.html (Web site link)
- Mental Health Plan-Beneficiary Handbook (1)
- Languages on nondiscrimination from Contract
- County wide QIC Meeting Minutes 1.2021-5.2022
- Sample of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has only one level of appeal for beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update its policy and process to include this requirement. The MHP was provided the opportunity to submit additional evidence, including an updated policy; however, no additional evidence was provided post review.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 402(b) and 228(a).

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:

- Policy 200.04 Beneficiary Problem Resolution Process
- Policy 201.02 Non-Discrimination of Beneficiaries
- Grievance, Appeal Form English
- Home Patient Complaints and Grievances.html (Web site link)
- Mental Health Plan-Beneficiary Handbook-all languages
- Samples of grievances
- FY 2021-22 (8-16-2022)vq
- County wide QIC Meeting Minutes 1.2021-5.2022
- Language on nondiscrimination from Contract

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP sends acknowledgement of receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing within five (5) calendar days of receipt. Of the 33 grievances reviewed, 31 acknowledgement letters were sent beyond the five (5) calendar day timeline or were missing. Per the discussion during the review, the MHP stated it uses

the Out of Purview letter as the Resolution Notice, in lieu of the Acknowledgment of Receipt letter, when it is determined the grievance cannot be addressed by the MHP. The MHP was provided the opportunity to submit evidence of this process; including a policy that identifies the process for the Out of Purview letter and evidence the timelines were met for the grievances in question; however, no additional evidence was provided post review.

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	**33**	**2**	**31**	**6%**

DHCS deems the MHP out of 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.

Repeat deficiency Yes

Question 6.1.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12. At the beneficiary's request, the MHP must identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal.

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

- Policy 200.04 Beneficiary Problem Resolution Process
- Policy 201.02 Non-Discrimination of Beneficiaries
- Grievance, Appeal Form English
- Home Patient Complaints and Grievances.html (Web site link)
- Mental Health Plan-Beneficiary Handbook-all languages
- Samples of grievances
- FY 2021-22 (8-16-2022)vq
- County wide QIC Meeting Minutes 1.2021-5.2022
- Language on nondiscrimination from Contract

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP identifies staff or another individuals, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would update the policy and process to include this requirement. Post review, the MHP submitted Grievance Appeal Procedure Brochure; however; the evidence did not include the required language.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12.

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:

- 200.04 Beneficiary Problem Resolution Process Procedures
- FY 2021-22 (8-16-2022)vq (Grievance log)
- Samples of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains a grievance and appeal log and records grievances within one (1) working day of the date of receipt of the grievance. Of the 33 grievances reviewed by DHCS, zero (0) were logged within one (1) working day of the date of receipt of the grievance. Per the discussion during the review, the MHP acknowledged this deficiency. The MHP was provided the opportunity to submit additional evidence to demonstrate its effort to meet this requirement; however, no additional evidence was provide post review.

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

Repeat deficiency Yes

Question 6.3.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance

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

- 200.04 Beneficiary Problem Resolution Process
- FY 2021-22 (8-16-2022)vq (Grievance log)
- Samples of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each grievance within the 90-day timeliness standard. Of the 33 grievances reviewed by DHCS, 16 were not resolved within the timeframe. Per the discussion during the review, the MHP acknowledged its process was inconsistent during the review period and it is working to improve timeliness moving forward.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below;

	RESOLVED WITHIN TIMEFRAMES			REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
	# OF SAMPLE REVIEWED	# IN COMPLIANCE	# OOC		
GRIEVANCES	**33**	**17**	**16**		**52%**

DHCS deems the MHP in out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1).

Question 6.3.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-010E. The MHP must use a written Notice of Grievance Resolution to notify beneficiary of the results of a grievance resolution, which shall contain a clear and concise explanation of the Plan's decision.

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

- 200.04 Beneficiary Problem Resolution Process Procedures
- FY 2021-22 (8-16-2022)vq (Grievance log)
- Samples of grievances

While the MHP submitted evidence to demonstrate with this requirement, it is not evident that the MHP uses a written Notice of Grievance Resolution to notify beneficiary of the results of a grievance resolution, which shall contain a clear and concise explanation of the Plan's decision. It was not evident that one (1) of 33 required resolution letters was sent to the beneficiary. Per the discussion during the review, the MHP stated clerical staff is responsible for logging and sending resolution notices and it would review its process. The MHP was provided the opportunity to submit evidence of this process; however, no additional evidence was provided post review.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-010E.

Repeat deficiency Yes

Question 6.4.13

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 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:

- 200.04 Beneficiary Problem Resolution Process Procedures
- FY 2021-22 (8-16-2022)vq (Grievance log)
- Samples of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP it will update the policy and process with the required language to meet this requirement. No additional evidence was provided post review.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 410(b).

Repeat deficiency Yes

Question 6.4.16

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(d)(2); California Code of Regulations, title 9, section 1850, subdivision 207(h). The MHP must provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative.

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

- 200.04 Beneficiary Problem Resolution Process Procedures
- FY 2021-22 (8-16-2022)vq (Grievance log)
- Samples of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP will update the policy and process with the required language to meet this requirement. No additional evidence was provided post review.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(d)(2); California Code of Regulations, title 9, section 1850, subdivision 207(h).