CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE NAPA COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: January 25, 2022 to January 26, 2022

Napa 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 Napa County MHP's Medi-Cal SMHS programs on January 25, 2022 to January 26, 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 Napa 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:

- 1.1.3 50 Psychiatry Requests Log - Rev ColumnHeadings
- 1.1.3 50 Urgent Access Requests Log - Rev ColumnHeadings
- 1.1.3 NOABD_50__Urgent
- 1.1.3 BOILERPLATE CONTRACT - Timeliness Requirement for Contractors
- 1.1.3 CAAT Log December 2020-December 2021
- 1.1.3 P&P_ Network Adequacy Reporting and Monitoring
- 1.1.3 50 Psychiatry Requests
- 1.1.3 50 Urgent Access Requests
- 1.1.3-1.1.4 TADT_28_MHP_Napa_2021_
- Copy of 50 Urgent Access Requests (002)
- Copy of 50 Psychiatry Requests

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. Per the discussion during the review, the MHP stated that timeliness for urgent and psychiatric appointments are tracked by assessing date of first assessment to date of first offered appointment. Post review the MHP submitted service request logs for psychiatric and urgent appointments. Of the submitted service requests, 29 psychiatric appointments and 21 urgent appointment were outside the Department's standards which assesses timeliness from date of initial request for service to date of first offered appointment.

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

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:

- 1.4.4 Provider Certification Report 10-8-2021
- 1.4.4 NCMH Site Certification PROTOCOL
- 1.4.4 SAMPLE COMPL CERT -BuckelewRecert_4.7.21
- 1.4.4 SAMPLE COMPL CERT Crestwood_CSS_SiteCert_6.1.21

Internal documents reviewed:

- Napa County Provider Monitoring Report 1-14-2022

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors and updates the certifications of its contracted SMHS providers. Six (6) MHP contracted providers have overdue certifications. Per the discussion during the review, the MHP stated it was aware that two (2) residential sites were overdue due to COVID-19 related issues. The MHP stated it would investigate the other provider sites to address the discrepancies.

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

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 six (6) of the seven (7) test calls are summarized below. One of the calls has been removed from the report.

TEST CALL #1

Test call was placed on Wednesday, October 27, 2021, at 2:13 p.m. The call was answered after one (1) ring via a live operator. The caller requested information regarding mental health services as he/she was feeling down, lacked an appetite, and was crying a lot. The operator provided information for the MHP's walk-in clinic and provided the address, hours, and days of operation. The operator explained the caller would be assessed by a clinician to determine need for mental health services. The operator requested personally identifying information, which the caller provided. The operator asked if the caller was in crisis, for which the caller responded in the negative. The operator provided the crisis line phone number and informed the caller it was available 24/7. The caller ended the call.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was 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 #2

Test call was placed on Thursday, October 28, 2021, at 9:09 a.m. The call was answered after four (4) rings via a phone tree, which included the option to dial one (1) if experiencing an emergency, and three (3) for information about accessing mental health services. The message was repeated in Spanish, the county's threshold language. After selecting three (3), the call was answered via a live operator. The caller requested information about accessing mental health services and how to refill his/her anxiety medication. The operator provided telephone numbers for two (2) local clinics and informed the caller to contact one to see if it would be able to assist. The caller thanked the operator and ended the call.

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 Thursday, October 28, 2021, at 9:08 a.m. The call was answered after one (1) ring via a live operator. The caller explained that he/she had recently moved to the county and needed a refill for an anxiety prescription but had not established a care provider. The operator stated that MHP could not prescribe or refill medication without first performing an assessment and meeting with a clinician. The operator stated that the caller's Medi-Cal would need to be transferred to the county and explained the process. The operator requested personally identifying information, which the caller provided. The operator informed the caller that once his/her Medi-Cal was transferred to the county the caller could go to the county's walk-in clinic. The operator provided information for the walk-in clinic including hours and days of operation.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

FINDING
The call is deemed *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 #4
Test call was placed on Monday, November 1, 2021, at 9:30 p.m. The call was answered after four (4) rings via a phone tree, which included the option to dial one (1) if experiencing an emergency, and three (3) for information about accessing mental health services. The message was repeated in Spanish, the county's threshold language. After selecting three (3), the call was transferred to a live operator. The caller requested information regarding receiving mental health services in the county. The operator requested that the caller call back the next morning because the operator was new to the MHP.

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 *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 #5
Test call was placed on Friday, October 9, 2021, at 2:00 p.m. The call was answered after two (2) rings via a live operator. The caller asked how to file a complaint in the county. The operator explained the beneficiary problem resolution process. The operator advised the caller that the grievance forms are located in the clinic lobby and provided the address and the hours of operation. The operator also offered to mail a grievance form to the caller, which the caller declined.

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 #6
Test call was placed on Monday, November 1, 2021, at 7:50 a.m. The call was answered after two (2) rings via a live operator. The caller asked how to file a complaint in the county. The operator explained the beneficiary problem resolution and state fair hearing processes. The operator advised the caller that the grievance forms are located in the clinic lobby and provided the address and the hours of operation. The operator also offered to mail a grievance form to the caller, which the caller declined.

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	
1	N/A	IN	N/A	IN	N/A	N/A	100%
2	IN	OOC	IN	OOC	N/A	N/A	50%
3	IN	IN	OOC	IN	N/A	N/A	75%
4	N/A	N/A	N/A	N/A	IN	IN	100%

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

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 Call Script 7.2021
- 4.3.4 CAAT Log_December 2020-December 2021
- 4.3.4 P&P_Availability and Accessibility of MHP Specialty Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged on the MHP's written log of initial requests. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	10/27/2021	2:13 p.m.	IN	IN	IN
2	10/28/2021	9:09 a.m.	OOC	OOC	OOC
3	10/28/2021	9:08 a.m.	IN	IN	IN
4	11/1/2021	9:30 p.m.	OOC	OOC	OOC
Compliance Percentage			**50%**	**50%**	**50%**

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 partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.1.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c). The MHP must notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

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

- 5.1.1 (SAMPLE) TAR
- 5.1.1 (SAMPLE2) TAR
- 5.1.2 Approver Licenses
- September 2020 TAR - APRIL 2021 TAR

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP gives requesting providers or beneficiaries written notice of any decision to deny a treatment authorization request (TAR), or to authorize a service in an amount, duration, or scope that is less than requested. Of the 25 TARs reviewed, denial notices were not provided for two (2) requests. Per the discussion during the review, the MHP stated it would provide additional documentation for the TARs in question. No additional evidence was received post review.

DHCS deems the MHP out of compliance with MHP contract; exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c).

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:

- Auth Approver Licenses
- 3 Aldea SARs
- 2 Buckelew SARs
- 1 Progress SAR

- 3 Side By Side SARs
- 1 Stanford SAR

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.	8	2	80%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, not to exceed five (5) business days from the MHP's receipt of the information. Two (2) of the ten (10) service authorizations were not completed within the required timeframe. Per the discussion during the review, the MHP acknowledged this finding.

DHCS deems the MHP in partial 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:

- 1.1.3 50 Psychiatry Requests Log - Rev ColumnHeadings
- 1.1.3 50 Urgent Access Requests Log - Rev ColumnHeadings
- 1.1.3 NOABD_50__Urgent
- 5.4.1 (SAMPLES) NOABDs
- 5.4.1 (SAMPLES2) NOABDs
- 5.4.1 NOABD FY 20-21 Tracking Log
- 5.4.1 P&P_Notice of Adverse Benefit Determination (NOABD)

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. Per the discussion during the review, the MHP stated it would provide evidence of NOABDs for failure to provide psychiatry and urgent care appointments in a timely manner. Post review the MHP submitted a single failure to meet medical necessity NOABD, however no timely access NOABDs were submitted.

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

Question 5.5.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 405(e). The MHP must ensure, at the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse).

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

- 5.5.2 P&P_ MHP Second Opinion_Appeals_SFH (pp. 3-4)
- 5.5.2 (SAMPLE POSTER) Patients' Rights Sheet (ENGLISH)
- 5.5.2 BENEFICIARY HANDBOOK_English (P. 54)
- 5.5.2 P&P_ Second Opinions Appeals and State Fair Hearings
- 5.5.2 Second Opinion Log FY 19-20 (NO REQUESTS)

- 5.5.2 Second Opinion Log FY 20-21 (NO REQUESTS)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP, at the beneficiary's request, provides a second opinion from a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse) when it is determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it has never had this type of request occur and that it would review its policy. Post review, the MHP submitted a compliant policy that it will implement moving forward.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 405(e).

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:

- 6.1.4 MHP Beneficiary Handbook_English (p.44)
- 6.1.4 BENEFICIARY HANDBOOK_English (Pp. 40-51)
- 6.1.4 P&P_ Second Opinions Appeals and State Fair Hearings (P.4)

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. Per the discussion during the review, the MHP acknowledge this language is present in the MHP policy, however it is not clearly included in the beneficiary handbook. Post review, the MHP submitted an updated beneficiary handbook with the required language that it will implement moving forward.

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 6.4.16

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:

- 6.4.16 P&P_ MHP Second Opinions_Appeals_SFH (pp. 7-8)
- 6.4.16 P&P_ Second Opinions Appeals and State Fair Hearings (p.7)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes reasonable efforts to provide oral notice to the beneficiary and/or his or her representative regarding expedited appeal dispositions. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that there has been instances when the MHP communicated orally with a beneficiary's representative, however, it was acknowledged that this requirement was not included in the policy. Post review, the MHP submitted a compliant policy that it will implement moving forward.

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).