CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE RIVERSIDE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: June 7, 2022 to June 9, 2022

Riverside 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 an onsite review of the Riverside County MHP's Medi-Cal SMHS programs on June 7, 2022 to June 9, 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 Riverside 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:

- Riverside 1.1.3c Policy 267- Access to Services
- Riverside 1.1.3b Monitoring Timely Access to Requests
- Riverside 1.1.2e Recovery Innovations Inc. - CRT Desert - Contract
- Riverside 1.1.3d FIRST ENCOUNTER TIMELINESS REPORT_Oct21
- Riverside 1.1.4e 50PsychiatricRequests_final
- Riverside 1.1.3e 50UrgentRequests_final

Internal Documents Reviewed

- Riverside_MHP_FY21.22_CAPTool_DR_1.26.22

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP meets the Department standards for timely access to care for psychiatry and urgent care services. Of appointments reviewed by DHCS, nine (9) of the 50 physician appointments and 45 of the 50 urgent appointments did not meet timeliness standards. Per the discussion during the review, the MHP stated the county's ongoing growth and the national shortage of providers has affected its ability to meet timely access standards. The MHP was provided the opportunity to submit additional evidence to demonstrate compliance with this requirement, including Notice of Adverse Beneficiary Determinations (NOABD) for appointments that did not meet timeliness standards, however, no additional evidence was not provided.

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:

- Riverside 1.4.4a Certification Protocol Cat 1-5 & 7 Protocol_10 15 2019 Riverside
- Riverside 1.4.4b Completed protocol from site visit
- Riverside 1.4.4c Sample file for completed certification
- Riverside 1.4.4d Sample Program Statement for completed certification
- Riverside 1.4.4e Sample self-survey form for County Owned and Operated recertification
- Riverside 1.4.4f Medi-Cal Providers List All (Tracking Log)

INTERNAL DOCUMENTS REVIEWED

- Riverside provider monitoring report 5.24.22
- Riverside Overdue Provider Monitoring Report 060622

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 168 MHP providers, seven (7) providers had overdue certifications. Per the discussion during the review, the MHP stated that providers were experiencing difficulty meeting certification deadlines due to COVID-19, specifically when scheduling fire inspections. Post review, DHCS received an updated Provider Monitoring report showing six (6) provider certifications remained overdue.

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:

- Riverside 2.1.2a Safety Plan blank
- Riverside 2.1.2b ISF Team
- Riverside 2.1.2c LTC Brochure
- Riverside 2.1.2d Youth Connect contact information
- Riverside 2.1.2e Youth Connect Contact Information

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors its contracted providers to ensure beneficiaries receive contact information for their designated person or entity. The evidence provided, which includes samples of provider contact information and brochures, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated that it has not established standards or a monitoring process for its contracted providers.

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 2.2.1

FINDING

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

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

- Riverside 2.2.1a Policy 241 - Release of Client Records and Subpoenas
- Riverside 2.2.1b Release of Information 2018 PDF
- Riverside 2.2.1c Completed ROI Form-redacted
- Riverside 2.2.1d IEHP MOU-2018
- Riverside 2.2.1e BH Policy #239 Confidentiality - Draft 06.14.22.doc

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP shares with the Department, or other managed care entities serving the beneficiary, the results of any identification and assessment of a beneficiary's needs to prevent duplication of those activities. Per the discussion during the review, the MHP has been waiting to update its policies and procedures until the implementation of California Advancing and Innovating Medi-Cal (CalAIM). Post review, the MHP submitted a compliant draft of the confidentiality policy that it will implement moving forward.

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

Question 2.5.7

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 the written notification to a beneficiary regarding his/her continuity of care request complies with the below listed requirements:

1. The MHP's denial of the beneficiary's continuity of care request;
2. A clear explanation of the reasons for the denial;
3. The availability of in-network SMHS;
4. How and where to access SMHS from the MHP;
5. The beneficiary's right to file an appeal based on the adverse benefit determination; and,
6. The MHP's beneficiary handbook and provider directory.

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

- Riverside 2.5.7a Appeal Acknowledgement Letter
- Riverside 2.5.7b Appeal Denial Letter
- Riverside 2.5.6 CONTINUITY OF CARE PROCEDURES - Final 10-24-19
- Riverside 2.5.1a Policy 267- Access to Services
- Riverside 2.5.4b Beneficiary Handbook English
- Riverside 2.5.1d Continuity of care request 1
- Riverside 2.5.1e Continuity of care request 2
- Riverside 2.5.1f Continuity of Care Tracking
- Riverside 5.1dd NOABD Your Rights Attachment
- Riverside 5.1ee Non-Discrimination Notice
- Riverside 5.1ff Language Assistance Taglines 5-2018

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the written notification the MHP provides the beneficiary regarding the continuity of care request includes information regarding the beneficiary's right to file an appeal based on the adverse benefit determination or the MHP's beneficiary handbook and provider directory. Per the discussion during the review, the MHP explained that the required information is included with the denial letter. The MHP stated it would provide evidence that this information is sent with the denial letters; however, no additional evidence was submitted post review.

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:

- Riverside 2.5.8 Continuity of Care Termination Template
- Riverside 5.1dd NOABD Your Rights Attachment
- Riverside 5.1ee Non-Discrimination Notice
- Riverside 5.1ff Language Assistance Taglines 5-2018

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 prior to the end of the continuity of care period about the process that will occur to transition his or her care. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, this process rarely occurs. The MHP was provided the opportunity to demonstrate its compliance with this requirement by submitting its continuity of care request tracking log or other evidence of practice, however, no additional evidence was submitted post review.

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

Repeat deficiency Yes

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.1.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(a)(e)(2). The MHP must have a written description of the Quality Assessment and Performance Improvement Program addressing the below listed requirements:

1. Clearly defines its structure and elements,
2. Assigns responsibility to appropriate individuals, and
3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement.

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

- Riverside QI WORK PLAN 2021-22
- Riverside 3.2.3 QI Work Plan 2019-20
- Riverside 3.3.1a QI Work Plan 20-21
- Riverside 3.1.9c QI Work Plan Goal
- QIC Agendas & Minutes

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a written Quality Assessment and Performance Improvement Program that adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement. Per the discussion during the review, the MHP described its quality and performance improvement process as a cycle of refinement wherein it reviews, modifies, and establishes goals on a continuous basis. The MHP was provided the opportunity to submit evidence demonstrating compliance to this requirement, including identifying quantifiable goals within its Quality Improvement Work Plan; however, no additional evidence was submitted.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(a)(e)(2).

Question 3.2.5

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals listed in the below requirements:

1. Responsiveness for the Contractor's 24-hour toll-free telephone number.
2. Timeliness for scheduling of routine appointments.
3. Timeliness of services for urgent conditions.
4. Access to after-hours care.

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

- Riverside 3.2.5e Access Slot-Integrated Referral Pilot Guidelines 3-1-22
- Riverside 3.2.5f E-mails on initial status
- Riverside 3.2.5g Test Call Training Materials_v2
- Riverside 3.2.5h FIRST ENCOUNTER TIMELINESS REPORT_Oct21
- Riverside 3.2.5i Monitoring Timely Access to Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a QAPI Work Plan that includes a description of the mechanisms it uses to assess the accessibility of services within its service delivery area, including goals related to the 24-hour toll-free telephone number. Per the discussion during the review, the MHP explained that it does not establish annual measurable goals in its QAPI Work Plan for the access line but instead uses a process of continuous modifications to goals based on its current needs and outcomes. The MHP was provided the opportunity to submit evidence of this process; however, no additional evidence was submitted.

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

ACCESS AND INFORMATION REQUIREMENTS

Question 4.3.2

FINDING
DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The toll-free telephone number provides information to beneficiaries to the below listed requirements:

1. The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2. The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3. The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4. The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

The seven (7) test calls are summarized below.

TEST CALL #1
Test call was placed on Monday, February 28, 2022, at 12:23 p.m. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. After selecting the option to speak to a live operator, the caller was placed on hold for approximately three (3) minutes before being instructed to leave a message for a return call or to continue to hold for the next

available representative. The caller continued to hold for two (2) additional minutes before ending the call.

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 *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, March 8, at 5:13 p.m. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. After selecting the option to speak to a live operator, the caller was placed on hold for approximately eight (8) minutes before being connected to an operator. The caller asked for assistance with self-described symptoms of depression that had lasted approximately two weeks. The operator asked for personally identifiable information, which the caller provided. The operator explained the intake and screening process that would be conducted by a behavioral health specialist. The operator provided the hours of operation for intake appointments.

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 #3
Test call was placed on Friday, March 11, at 1:44 p.m. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. After selecting the option to speak to a live operator, the call was answered immediately. The caller stated he/she needed help with feelings of depression and isolation he/she had been experiencing since becoming the sole caretaker of his/her mother. The operator asked for personally identifiable information, which the caller provided. The operator informed the caller of clinic locations throughout the county and explained the initial screening process. The operator explained that after the initial assessment, a referral would be placed to an appropriate provider for treatment.

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 Monday, March 14, 2022, at 7:12 a.m. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. After selecting the option to speak to a live operator the call was answered after five (5) rings. The caller informed the operator that he/she had recently moved to the county and asked for assistance with refilling his/her anxiety medication. The operator asked for personally identifiable information, which the caller provided. The operator informed the caller to go to urgent care. The operator also informed the caller he/she would need to change his/her Medi-Cal to Riverside County and if he/she was unsure how to make this change he/she should Google it. Throughout the phone call the operator informed the caller to hold for brief periods as the operator was driving.

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 #5
Test call was placed on Wednesday, March 9, 2022, at 11:52 a.m. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. After selecting the option to speak to a live operator the call was answered after a brief hold. The operator immediately requested personally identifiable information, which the caller provided. The caller requested assistance with refilling his/her anxiety medication as a new beneficiary in the county. The operator provided instructions for how to request a Medi-Cal case transfer and report a move of residence. The operator advised the caller that the transfer of benefits would not be immediate and provided information for urgent care providers including 24/7 walk in clinics. The operator also suggested the caller reach out to the physician listed on the medication bottle to request a refill while waiting for his/her benefits to transfer.

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 Wednesday, November 3, 2021, at 4:00 pm. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. The phone tree presented an option for filing a complaint, filing a grievance, or to appeal a denied service. After selecting this option, the caller was transferred to a recorded message for the Outpatient Quality Improvement Appeal Line, which instructed the caller to leave his/her name and phone number for a return call.

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 Thursday, March 10, 2022, at 3:47 pm. The call was answered immediately via a phone tree with a recorded greeting that provided instructions to dial 9-1-1 if experiencing an emergency and the option to continue the call in Spanish, the MHP's threshold language. After selecting the option to speak to a live operator the call was answered after three (3) rings. The caller requested information on how to file a complaint about a therapist he/she was seeing through the county. The operator instructed the caller to call the Quality Improvement line and provided the number, however when this number was called the caller was able to get through to a live person.

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

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

SUMMARY OF TEST CALL FINDINGS

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

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

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:

- Riverside 4.3.4a CARES Call Log
- Riverside 4.3.4b CARES Sample Calls
- Riverside 4.3.3a Policy 354 24-7 Access Line
- Riverside 4.3.3b 24-7 Access Line Procedures

While the MHP submitted evidence to demonstrate compliance with this requirement, zero (0) of five (5) required DHCS test calls were 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	02/28/2022	12:23 p.m.	OOC	OOC	OOC
2	03/08/2022	5:13 p.m.	OOC	OOC	OOC
3	03/11/2022	1:44 p.m.	OOC	OOC	OOC
4	03/14/2022	7:12 a.m.	OOC	OOC	OOC
5	03/09/2022	11:32 a.m.	OOC	OOC	OOC
Compliance Percentage			**0%**	**0%**	**0%**

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

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.1.2

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(b)(3). The MHP must have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.

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

- Riverside 5.1.2a Authorization of Specialty MH Services June 2020 v2 – Copy
- Riverside 5.1.2b N.H. 11-1-21 Initial Authorization
- Riverside 5.1.2c N.H. NOABD
- Riverside 5.1.2d CT License Herrera
- Riverside 5.1.2e Herrera Signature
- Riverside 5.1.2f Cheeley License
- Riverside 5.1.2g Cheeley Signature
- Riverside 5.1.2h CT License Elliott
- Riverside 5.1.2i Elliott Signature

- Riverside 5.1d IHBS Auth.pdf
- Riverside 5.1e IHBS Auth.pdf
- Riverside 5.1f IHBS Auth.pdf
- Riverside 5.1gIHBS Auth.pdf
- Riverside 5.1h IHBS Auth.pdf
- Riverside 5.1i IHBS Auth.pdf
- Riverside 5.1j IHBS Auth.pdf
- Riverside 5.1k IHBS Auth.pdf
- Riverside 5.1l IHBS Auth.pdf
- Riverside 5.1m IHBS Auth.pdf
- Riverside 5.1n IHBS Auth.pdf
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- Riverside 5.1p IHBS Auth.pdf
- Riverside 5.1q IHBS Auth.pdf
- Riverside 5.1r IHBS Auth.pdf
- Riverside 5.1s IHBS Auth.pdf
- Riverside 5.1t IHBS Auth.pdf
- Riverside 5.1u IHBS Auth.pdf
- Riverside 5.1v IHBS Auth.pdf
- Riverside 5.1w IHBS Auth.pdf
- Riverside 5.1x IHBS Auth.pdf
- Riverside 5.1.2j Inpatient Approvers 122021
- Riverside 5.1d-x IHBS Auth
- Riverside 5.1i TBS
- Riverside 5.1.2k Approvers 122021

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures a health care professional, who has appropriate clinical expertise in addressing a beneficiary's behavioral health needs, denies or authorizes a service in an amount, duration, or scope that is less than requested. Of the 21 service authorization requests submitted, one (1) authorization signature could not be verified with the licensure and signature documentation provided by the MHP. Per the discussion during the review, the MHP stated that all service authorization requests are approved by licensed health care professionals and it would submit additional sample signatures and license verifications for any service authorization in question. No additional evidence was submitted post review.

In addition, DHCS inspected a sample of service authorizations to verify compliance with regulatory requirements.

The service authorization samples review findings are detailed below:

Requirement	# of Services Authorizations in compliance	# of Service Authorizations out of compliance	Compliance Percentage
Service authorization approved or denied by licensed mental health or waivered/registered professionals	20	1	95%

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(b)(3).

Repeat deficiency Yes

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:

- Riverside 5.2.8a Authorization of Specialty MH Services June 2020 v2 (pg 2)
- Riverside 5.1d-x IHBS Auth

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.	1	20	5%

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, and not exceeding five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. Of the 21 service authorization requests reviewed, 20 did not include evidence that the beneficiary was notified within the timeframe. Per the discussion during the review, the MHP stated it would provide electronic time stamps showing the date of receipt for each service authorization in question to demonstrate this timeliness requirement was met. No additional evidence was submitted post review.

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

Repeat deficiency Yes

Question 5.3.5

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, the DHCS standards for timely access to care and services for children/youth presumptively transferred to the MHP's responsibility.

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

- Riverside 5.3.5 FY 21-22 Boilerplate MHS SAPT
- Riverside 5.3.3 Policy 351 Presumptive Transfer
- Riverside 5.3.5c Presumptive Transfer Referrals

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP met the Department standards for timely access to care and services for children/youth presumptively transferred to the MHP's responsibility. Per the discussion during the review, the MHP acknowledged it experiences challenges for placement of presumptive transfers in and out of county due to communication breakdowns with other agencies. Post review, the MHP submitted a sample presumptive transfer tracking report showing each of the children and youth placed in Riverside County for a sample timeframe. The report was deficient in demonstrating that the MHP meets the Department's standards for timely access to care and services for children and youth.

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

Question 5.4.1

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

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

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

- Riverside 5.4.1a NOTICE OF ADVERSE BENEFIT DETERMINATION-County 2019
- Riverside 5.4.1b NOTICE OF ADVERSE BENEFIT DETERMINATION-Contractors 2019
- Riverside 5.4.1c NOABD Timely Access Notice
- Riverside 5.4.1d NOABD-Delivery System Notice English template
- Riverside 5.4.1e NOABD-Denial Notice English template
- Riverside 5.4.1f NOABD-Modification Notice English template
- Riverside 5.4.1g NOABD-Termination Notice English template
- Riverside 5.4.1h NOABD Payment Denial Notice
- Riverside 5.4.1i NOABD Your Rights Attachment

- Riverside 5.4.1j Non-Discrimination Notice
- Riverside 5.4.1k NOABD Letter Tracker

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides beneficiaries with a NOABD for a denial or limited authorization of a requested service, or the failure to provide services within a timely manner. Of the 50 urgent care appointments reviewed by DHCS, 45 did not meet timeliness standards and the MHP determined that one (1) did not meet medical necessity criteria. Of the 50 psychiatric care appointments reviewed, nine (9) did not meet timeliness standards, one (1) was denied by the MHP, and the MHP determined that two (2) did not meet medical necessity criteria. Of the 50 treatment authorization requests (TARs) reviewed, one (1) TAR was denied. Evidence that the required NOABDs were provided to these beneficiaries was not provided prior to the review. The MHP was provided the opportunity to submit these NOABDs post review, however, no additional evidence was provided.

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

Repeat deficiency Yes

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.2.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one (1) 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:

- 6.2.1a Policy 295 Beneficiary Consumer Issue Resolution Process (pgs. 4-7)
- 6.2.1b Consumer Grievance Appeals Workflow (pgs. 2-3)
- 6.2.1c Grievance Tracking Log screenshot
- 6.2.1d Grievance Appeal Tracking Log screenshot

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, appeals, and expedited appeals in the log within one (1) working day of the date of receipt of 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 discussed how it logs and tracks grievances and appeals in its electronic

health record and stated it would submit a tracking report post review. No additional evidence was submitted 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.

Question 6.4.4

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4). The MHP must allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing. The MHP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in §438.408(b) and (c) in the case of expedited resolution.

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

- 6.4.4a Policy 295 Beneficiary Consumer Issue Resolution Process -Page 2 of 6
- 6.4.4b Beneficiary Handbook 2018 Final English
- Riverside 6.4.4c Policy #295 - Beneficiary - Consumer Issue Resolut....doc

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP allows the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing, sufficiently in advance of the resolution timeframe for appeals and expedited resolution. Per the discussion during the review, the MHP acknowledged that its policy was deficient and lacking the required language. Post review, the MHP submitted a compliant draft beneficiary problem resolution policy it will implement moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4).

Question 6.4.6

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(b)-(c); MHP Contract Exhibit A, Att. 12. The MHP must provide the beneficiary and his or her representative the beneficiary’s case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

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

- 6.4.4a Policy 295 Beneficiary Consumer Issue Resolution Process -Page 2 of 6
- 6.4.4b Beneficiary Handbook 2018 Final English
- Riverside 6.4.6 Policy #295 - Beneficiary - Consumer Issue Resolut....doc

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the appeal resolution timeframe for standard and expedited appeal resolutions. Per the discussion during the review, the MHP acknowledged the need to update its policy with the required language. Post review, the MHP submitted a compliant draft beneficiary problem resolution policy it will implement moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(b)-(c) and MHP Contract Exhibit A, Att. 12.

Repeat deficiency Yes

Question 6.4.14

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c). The MHP must inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal.

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

- 6.4.14a Policy 295 Beneficiary Consumer Issue Resolution Process-page 7 of 11
- 6.4.14b Beneficiary Handbook - Page 11
- Riverside 6.4.14c Policy 295 Beneficiary Consumer Issue Resolution Process

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP informs beneficiaries of the limited time available to present evidence and testimony sufficiently in advance of the expedited appeal resolution timeframe. Per the discussion during the review, the MHP acknowledged the need to update its policy with the required language. Post review, the MHP submitted a compliant draft beneficiary problem resolution policy it will implement moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c).

PROGRAM INTEGRITY

Question 7.4.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

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

- Riverside 7.2.4 21-22 Boilerplate MHS SAPT
- Riverside 7.4.2b Policy 282 - Credentialing Policy
- Riverside 7.4.5a Provider Contact Sheet and Disclosures Procedure
- Riverside 7.4.5b Provider Contact Sheet and Disclosures
- Riverside 7.4.6d Policy #282-Credentialing 06.15.22.doc

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosures and updated disclosures to the Department or Health and Human Services, including information regarding certain business transactions within 35 days, upon request. Per the discussion during the review, the MHP stated that it collects disclosures annually. The MHP requires each of its contracted providers to collect its own disclosures and report findings to the MHP. Post review, the MHP submitted a disclosure form template, policies and procedures, and the updated credentialing policy that it will implement moving forward, however, the MHP did not submit a sample of completed disclosure forms to demonstrate this process was in place during the review period.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Question 7.4.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2). The MHP must submit disclosure to DHCS of identity of any person who is a managing employee of the

MHP who has been convicted of a crime related to federal health care programs, and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

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

- 7.4.6a Policy 101 Compliance Plan
- 7.4.6b Policy 282 Credentialing
- Riverside 7.4.6d Policy #282-Credentialing 06.15.22.doc

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosures to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and the identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. Per the discussion during the review, the MHP explained that it uses its Board of Supervisor's policy and acknowledged that it would develop a policy to meet the requirements specific to the contract. Post review, the MHP submitted a compliant credentialing policy that it will implemented moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2).

Repeat deficiency Yes

Questions 7.5.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4). The MHP promptly notify DHCS if the MHP finds a party that is excluded.

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

- Riverside 7.2.4 21-22 Contract Boilerplate MHS SAPT
- Riverside 7.5.3a Policy 101 - Compliance Plan
- Riverside 7.5.3c 101 - Compliance Plan - 06.14.22

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if it finds an excluded party. Per the discussion during the review, the MHP explained its informal practice to notify DHCS if an excluded party is found. Post review, the MHP submitted an updated compliance plan policy that includes notifying DHCS, which it will implement moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4).