CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SAN BERNARDINO COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: August 30, 2022 to September 1, 2022

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY 2

FINDINGS 4

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES 4

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT 6

ACCESS AND INFORMATION REQUIREMENTS 8

COVERAGE AND AUTHORIZATION OF SERVICES 13

BENEFICIARY RIGHTS AND PROTECTIONS 18

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

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 San Bernardino County MHP's Medi-Cal SMHS programs on August 30, 2022 to September 1, 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 San Bernardino 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 QM Service Request Log
- 1.1.3 CCRT MHSA ATT DBH 6-9-20 MHSA Plan FY20-23 Full Signed
- 1.1.3 Clinic Monthly Report-Mariposa-December-2020
- 1.1.3 Clinic Trend Report – Vista Community Counseling – April 2022
- 1.1.3 CSCC Valley Star Behavioral Health, INC CRT Admission Policy
- 1.1.3 MHSA FSP Program Structure
- 1.1.3 Mesa Timely Access NOABD log July 2021 –April 2022
- 1.1.3 Mesa Supervisor Monthly Report Nov-Dec 2020
- 1.1.3 OCAYS MonthlyClinicReports-Mesa Counseling Services (36911) 2021-22
- 1.1.3 OCAYS MonthlyClinicReports-Phoenix Counseling Services(36B31)21-22
- 1.1.3 OCAYS MonthlyClinicSupervisor-Phoenix Counseling Srvs (36B31) 2020
- 1.1.3 PEI Improving Timely Access for Underserved Populations Activity Sheet
- 1.1.3 I Report Summary FY 19-20
- 1.1.3 PEI Access and Linkage to Treatment Activity Sheet
- 1.1.3 QM Timely Access Policy
- 1.1.3 QM Urgent and Emergency Conditions Procedures
- 1.1.3 OCAYS Mesa Timely Access NOABD log July 2021-April 2022
- Large Documents: Additional Documentation SRL NOABDs

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, 22 did not meet timeliness standards. Of the 50

urgent appointments reviewed, 19 did not meet timeliness standards. Per the discussion during the review, the MHP stated that timely access data is compiled from various platforms within the electronic health record system and it is aware that appointments are not meeting the timeliness standard. The MHP has identified gaps in data collection and is implementing new processes to improve timeliness and analysis of appointment data moving forward.

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

Repeat deficiency Yes

Question 1.4.4

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

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

- 1.4.4 QM 2022 Re-certification Expiration schedule 4.27.22
- 1.4.4 QM 2021 Recertification Expiration schedule FINAL
- 1.4.4 QM Blissful Living Group Home Completed Certification
- 1.4.4 QM BOP024 Mode of Service
- 1.4.4 QM Certification-Recertification Protocol
- 1.4.4 QM Health and Safety Inspection Form (Medi-Cal certification)
- 1.4.4 QM HIPAA NPI Policy
- 1.4.4 QM HIPAA NPI Procedure
- 1.4.4 QM Medi-Cal Certification and Transmittal
- 1.4.4 QM Medi-Cal Site Certification Checklist
- 1.4.4 QM Medi-Cal Site Certification Policy
- 1.4.4 QM Medi-Cal Certification Packet Approval Form
- 1.4.4 QM Medi-Cal Site Certification Procedure
- 1.4.4 QM Request for Cost Center Number Form

LIST ANY INTERNAL DOCUMENTS REVIEWED.

- San Bernardino County Provider Monitoring Report 8-16-22

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 162 MHP providers sites, five (5) had overdue certifications. Per the discussion during the review, the MHP stated it was aware of these overdue providers and was in the process of submitting documentation to DHCS for processing. Post review, the MHP submitted additional evidence demonstrating the certification for the five (5) contracted providers were renewed; however, the renewal occurred after the review period.

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

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.5.1

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 have practice guidelines, which meet the requirements of the MHP Contract.

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

- 1.4.5 QM Outpatient Chart Manual Scope of Practice Manual
- 1.4.5 QM Scope of Practice & Billing Guide
- 3.5.1 MS Antidepressant Prescribing Guidelines-Draft June 2022
- 3.5.1 MS Antipsychotic Practice Guidelines-Draft
- 3.5.1 MS Introduction to Practice Guidelines 20-0219 Draft
- 3.5.1 MS MDS2007-Practice Guideline-Benzodiazepine
- 3.5.1 MS MDS2025-Practice Guideline-Clozapine
- 3.5.1 MS Mood Stabilizer Prescribing Guidelines for Adults-Draft 2.19.2020

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established practice guidelines that meet the requirements of the MHP Contract. Per the discussion during the review, the MHP stated it has established and implemented practice guidelines. Post review, the MHP submitted several medication clinical guidelines; however, no evidence was provided demonstrating that the MHP has practice guidelines established.

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.

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:

- 3.5.2_MS_2019-SUD-Clinical-Practice-Guidelines
- 3.5.2_MS_2019-SUD-Clinical-Practice-Guidelines
- 3.5.2_MS_Antidepressant Prescribing Guidelines-DRAFT- June 2022
- 3.5.2_MS_Antipsychotic Practice Guidelines – Draft
- 3.5.2_MS_Contract Physicians Contract Template FY19-22 pg. 7
- 3.5.2_MS_Introduction to Practice Guidelines 20-0219 DRAFT
- 3.5.2_MS_MDS2007 - Practice Guideline – Benzodiazepine
- 3.5.2_MS_MDS2025 - Practice Guideline – Clozapine
- 3.5.2_MS_Mood Stabilizer Prescribing Guidelines for Adults_Draft 2.19.2020
- 3.5.2_MS_Practice for Children - 1103669_Parameters3.8UseofPsychotropicMedicationinChildrenandAdolescents.docx
- 3.5.2_MS_Sedative Hypnotics Practice Guidelines – DRAFT
- 3.3.3 QIPP Subcommittee Med Practices minutes (multiple clinnics overview)
- 3.3.3 Monitoring the Delivery System of Medication Monitoring
- 1.4.5 Outpatientchartmanual-11-5-19-AC
- 3.1.8 Medication Practice Minutes
- 3.1.8 Medical Services Quality Assurance and Monthly Staff Meeting

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. Per the discussion during the review, the MHP stated that practice guidelines are discussed in the medical services meetings and are disseminated to providers via email. Post review, the MHP provided evidence that it disseminates it clinical guidelines to its providers; however, no evidence was provide that demonstrated practice guidelines are disseminated to affected providers, 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 4.3.2

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

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

The seven (7) test calls are summarized below.

TEST CALL #1
Test call was placed on Monday, December 20, 2021, at 7:52 a.m. The call was answered after one (1) ring via a phone tree. The phone tree directed 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 live operator. The caller requested information about accessing mental health services in the county concerning his/her child's mental health and his disruptive behavior in school. The operator assessed the child's need for urgent care services. The operator asked for the child's personally identifying information, which the caller provided. The operator transferred the caller to an operator who explained the assessment process for receiving services and provided the caller with the location and hours for a walk-in clinic.

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

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

TEST CALL #2

Test call was placed on Wednesday, April 27, 2022, at 10:03 a.m. The call was answered after one (1) ring via a phone tree. The phone tree directed 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 live operator. The caller requested information about accessing mental health services due to lack of appetite, inability to sleep, and bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the screening and assessment process. The operator provided office locations and hours of operation. The operator explained that someone would be available 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 #3

Test call was placed on Wednesday, June 1, 2022 at 9:57 p.m. The call was answered after one (1) ring via a phone tree. The phone tree directed 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 live 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 care services, which the caller responded in the negative. The operator verified insurance coverage and advised the caller that he/she had reached a licensed clinician. The operator provided the caller a phone number for the county Family Caregiver Support Program. The caller was then transferred to another operator who provided further information including clinic locations and hours of operations for services.

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, May 2, 2022, at 7:45 a.m. The call was answered after one (1) ring via a phone tree. The phone tree directed 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 live operator. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator asked for the caller's personally identifying information, which the caller provided. The caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator explained the process for accessing mental health services including walk-in services for crisis, mental health services, and provided the address and hours of operation for the clinic.

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 Friday, May 27, 2022 at 2:09 p.m. The call was answered after one (1) ring via a phone tree. The phone tree directed 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 live operator. The caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator asked for the caller's personally identifying information, which the caller provided. The operator explained the process to transfer insurance to the county. The caller asked about the timeline of the transfer process as he/she was almost out of medication. The operator offered to transfer the caller to a therapist for a referral, which the caller responded in the negative. The operator informed the caller that the 24/7 crisis line is available if he/she needed to speak with staff for an immediate medication refill.

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

The call was placed on Wednesday May 25, 2022, at 12:04 p.m. The call was answered after three (3) rings via a live operator. The caller asked how to file a complaint in the county. The operator requested personal identifying information, which the caller provided. The caller was transferred to another operator. The second operator explained the beneficiary problem resolution and state fair hearing processes. The operator provided instructions on how to obtain and complete a grievance form at the clinic or via the MHP website.

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

FINDING

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

TEST CALL #7

Test call was placed on Monday, April 18, 2022, at 2:59 p.m. The call was answered after one (1) ring via a phone tree. The phone tree directed 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 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 of information required to complete the form including his/her personally identifiable information as well as the clinic's name, therapist's name, and details of the complaint. The caller requested to file the complaint anonymously and the operator advised that grievance forms are available on the website and provide the option to mail in the grievance.

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	IN	IN	IN	IN	IN	N/A	N/A	100%
3	IN	IN	IN	IN	IN	N/A	N/A	100%
4	N/A	N/A	N/A	N/A	N/A	IN	IN	100%

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

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:

- 4.3.4 QM ICL Screenshots 5.2.22 pg.18
- 4.3.4 QM ICL Screenshots 5.27.22 pg.19
- 4.3.4 QM ICL Screenshots 6.1.22 pg.8
- 4.3.4 QM ICL Screenshots 12.20.21 pg.5

While the MHP submitted evidence to demonstrate compliance with this requirement, one (1) of the five (5) required DHCS test calls was 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	12/20/2021	7:52 a.m.	IN	IN	IN
2	04/27/2022	10:03 a.m.	OOC	OOC	OOC
3	06/01/2022	9:57 p.m.	IN	IN	IN
4	05/02/2022	7:45 a.m.	IN	IN	IN
5	05/27/2022	2:09 p.m.	IIN	IN	IN
Compliance Percentage			**80%**	**80%**	**80%**

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 5.1.3

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:

- 5.1.3 QM CHD0319 Prior Authorization for Therapeutic Behavioral Services (TBS) Procedure
- 5.1.3 QM CHD0320 Prior Authorization for Therapeutic Foster Care (TFC) Procedure
- 5.1.3 QM CHD0321 Prior Authorization for Intensive Home Based Services (IHBS) Procedure
- 5.1.3 QM Clinician TAR & SAR Tracking Log
- 5.1.3 QM CLP0839 Authorization of Adult Residential Treatment (ART) and Crisis Residential Treatment (CRT) Services Procedure
- 5.1.3 QM CLP0840 Authorization of Day Rehabilitation and Day Treatment Intensive Procedure
- 5.1.3 QM Notification of denied IHBS PHI
- 5.1.3 QM Notification of denied TBS PHI
- 5.1.3 QM Authorization of Specialty Mental Health Services Policy

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 service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Of the 50 Treatment Authorization Requests (TARs) reviewed, 17 were modified. DHCS was not provided evidence of the required Notice of Adverse Beneficiary Determinations (NOABD) sent to the providers or beneficiaries for these TARs. Per the discussion during the review, the MHP acknowledged that there was no record of NOABDs sent for the 17 modified authorizations in question.

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:

- 5.2.8 QM Authorization of Day Rehab and DTI Procedure
- 5.2.8 QM CHD0319 Prior Authorization for TBS Procedure
- 5.2.8 QM CHD0320 Prior Authorization for TFC
- 5.2.8 QM CHD0321 Prior Authorization for IHBS Procedure
- 5.2.8 QM Clinician TAR & SAR Tracking Log
- 5.2.8 QM SAR Approver Licenses & Signature List
- 5.1 Service Authorization Requests (SARS):
- San Bernardino_Additional Documentation_SARs_Clinician Tracking Log
- April 2021
- February 2021
- January 2021
- July 2021
- March 2021
- November 2021
- Day Rehab SAR 1-5
- IHBS SAR 1-5
- TBS SAR 1-10
- TFC SAR 1-5
- CAT 5 Additional Documentation SARs Clinician Tracking Log
- CAT 5 Additional Documentation SARs OA Tracking Log

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.	23	2	92%

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 reasonably necessary and requested by the MHP to make the determination. Of the 25 Service Authorization Requests (SARs) reviewed, two (2) were not approved within the required timeframe. The MHP stated that due to staff working remotely, the SAR receipt dates are being documented via email as well as date stamp and it would review the SARs in question to submit evidence of compliance. Post review, the MHP submitted a tracking log that included highlighted receipt dates for the SARs in questions; however, the evidence did not demonstrate that two (2) SARs were completed within five (5) business days of receipt of request.

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

Question 5.3.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Welfare and Institution Code, section 14717, subdivision 1(f). The MHP must ensure the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP in the county in which the foster child resides shall accept that assessment

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

- CYCS AB1299 Services for Children Placer Out-of-County, Foster and Probationary Youth Procedure (02/03/2021)
- CYCS AB1299 Services for Children Placer Out-of-County, Policy (02/03/2021)
- CYCS AB1299 Services for Children Placer Out-of-County, AAP and Kin GAP Procedure(02/03/2021)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that when the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP accepts that assessment. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated this is a rare occurrence and it will update the policy with the required language to meet this requirement. No additional evidence was provided post review.

DHCS deems the MHP out of compliance with California Welfare and Institution Code, section 14717, subdivision 1(f).

Question 5.3.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-027, and California Welfare and Institution Code, section 14717, subdivision 1(b). The MHP must have a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction.

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

- CYCS AB1299 Services for Children Placer Out-of-County, Foster and Probationary Youth Procedure (02/03/2021)
- CYCS AB1299 Services for Children Placer Out-of-County, Policy (02/03/2021)
- CYCS AB1299 Process for Expedite Referral(02/03/2021)
- CYCS AB1299 Disposition Form Expedite Box(02/03/2021)
- CYCS AB1299 Signaturel(02/03/2021)
- Quality Management Division Provider Signature Log for Children and Youth Collaborative Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction. 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 with the required language to meet this requirement. 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. 18-027, and California Welfare and Institution Code, section 14717, subdivision 1(b).

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:

- 5.4 NOABDs Issued for SARs / Tracking Log
- 5.4 NOABDs Issued for TARs / Tracking Log
- 5.4.1 QM_Authorization of ART_CRT Services Procedure
- 5.4.1 QM_Authorization of Day Rehab and DTI Procedure
- 5.4.1 QM_Authorization of SMHS Policy
- 5.4.1 QM_NOABD Procedure
- 5.4.1_QM_Prior Authorization for IHBS Procedure
- 5.4.1_QM_Prior Authorization for TBS Procedure
- 5.4.1_QM_Prior Authorization for TFC Procedure

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides NOABDs to beneficiaries for the denial or limited authorization of a requested service. Of the 50 TARs reviewed, 17 were modified or limited. The MHP did not provide evidence that the required NOABDs were provided to the beneficiaries.

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:

- 6.1.4_QM_Grievance and Appeal Policy page 5-8
- 6.1.4_QM_MHP_Beneficiary_Handbook page 33-35
- 6.1.4_QM_Link to Website Problem Resolution Informing Materials
- 6.1.4_QM_Grievance and Appeal Procedure
- 6.1.4_QM_Standard and Expedited Appeals Procedure

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 the policy with the required language to meet this requirement. 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:

- 6.1.5_QM_Grievance and Appeal Policy page 3
- 6.1.5_QM_MHP_Beneficiary_Handbook
- 6.1.5_QM_Link to Website Problem Resolution Informing Materials
- 6.1.5_QM_Grievance and Appeal Procedure page 2
- 6.1.5_QM_Standard and Expedited Appeals Procedure
- 6.1.1_QM_Grievance Form
- 6.1.5_QM Training 12.1.21_FINAL
- 6.1.1_QM_Acknowledgement Letter Template English
- Appeal Log
- Appeal Samples FY 19-20
- Grievance Samples Part 1
- Grievance Samples Part 2

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 35 grievances and appeals reviewed, it was not evident that acknowledgement letters were sent upon receipt for each grievance and appeal. Per the discussion during the review, the MHP stated it would research the grievances and appeals in question and provide additional evidence. Post review, the MHP provided additional acknowledgement letters; however, two (2) appeals remained out of compliance.

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	**27**	**27**	**0**	**100%**
APPEALS	**8**	**6**	**2**	**75%**

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

Repeat deficiency Yes

Question 6.1.9

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, and California Code of Regulations, title 9, section 1850, subdivision 205(c)(6). The MHP must ensure the procedures for the beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information

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

- 6.1.9_QM_Grievance and Appeal Policy page 3
- 6.1.9_QM_Standard and Expedited Appeals Procedure page 3
- 6.1.7_QM_Grievance and Appeal Procedure
- 6.1.8_QM_MHP_Beneficiary_Handbook page 29
- 6.1.1_QM_Link to Website Problem Resolution Informing Materials

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures procedures for the beneficiary problem resolution processes maintains the confidentiality of each beneficiary's information. This requirement was not included in any evidence provided by the MHP. 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. No additional evidence was provided post review.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, and California Code of Regulations, title 9, section 1850, subdivision 205(c)(6).

Question 6.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c). At the beneficiary's request, the MHP must continue or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until all of the below listed occurs:

1. The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
2. The appeal involves the termination, suspension, or reduction of previously authorized services;
3. The services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired; and,
5. The beneficiary timely files for continuation of benefits.

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

- 6.5.1_QM_Grievance and Appeal Policy page 3-4
- 6.5.1_QM_MHP_Beneficiary_Handbook
- 6.5.1_QM_YourRights_English
- 6.5.3_State Hearing Procedure

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending. 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 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 420(c).