
**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES**

**FISCAL YEAR 2020/2021**

# MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW OF THE SAN DIEGO COUNTY MENTAL HEALTH PLAN

## SYSTEM FINDINGS REPORT

**Review Dates: June 8, 2021 to June 10, 2021**

**San Diego County Mental Health Plan**
**FY 2020/2021 Medi-Cal SMHS Triennial Review**
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## EXECUTIVE SUMMARY

The California Department of Health Care Services' (DHCS) mission is to provide Californians with access to affordable, integrated, high-quality health care including medical, dental, mental health, substance use treatment services, and long-term care. Our vision is to preserve and improve the overall health and well-being of all Californians.

DHCS helps provide Californians access to quality health care services that are delivered effectively and efficiently. As the single state Medicaid agency, DHCS administers California's Medicaid program (Medi-Cal). DHCS is responsible for administering the Medi-Cal Specialty Mental Health Services (SMHS) Waiver Program. SMHS are "carved-out" of the broader Medi-Cal program. The SMHS program operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act.

Medi-Cal is a federal/state partnership providing comprehensive health care to individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of important services to approximately 13.2 million Californians.

The SMHS program which provides SMHS to Medi-Cal beneficiaries through county Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries' in their counties that meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiaries client plan.

In accordance with the California Code of Regulations, title 9, chapter 11, § 1810.380, DHCS conducts monitoring and oversight activities such as the Medi-Cal SMHS Triennial System and Chart Reviews to determine if the county MHPs are in compliance with state and federal laws and regulations and/or the contract between DHCS and the MHP.

DHCS conducted a WebEx review of the San Diego County MHP's Medi-Cal SMHS programs on June 8, 2021 to June 10, 2021. 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) 2020/2021 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 Diego County MHP. The report is organized according to the findings from each section of the FY 2020/2021 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 SERVICE

### 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:

- Timeliness of Urgent and Routine Services Access to Service Journal for April – June 2020
- Access Times – Emergent Urgent Routine – Organizational Provider Operations Handbook
- Accessing Services - Time - Organizational Provider Operations Handbook

While the MHP submitted evidence to demonstrate this requirement, it is not evident that the MHP meets and requires its providers to meet, Department standards for timely access to care and services, taking into account the urgency of the need for services. During the facilitated discussion, the MHP shared details of monitoring urgent and emergent appointments in the Access to Service log within the MHP's electronic health record. The Timeliness of Urgent and Routine Services Access to Service Journal for April – June 2020 provided by the MHP included Urgent and Physician appointments outside of Department standards for timely access.

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

The MHP must comply with CAP requirement addressing this finding of non-compliance.

## ACCESS AND INFORMATION REQUIREMENTS

**Question 4.2.1**

**FINDING**

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(d)(6)(ii). The MHP must provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point.

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

- Advanced Directive Arabic Intake Packet
- Advanced Directive English-Intake Packet
- Advance Directive Farsi Intake Packet
- Advance Directive Tagalog Intake Packet
- Advance Directive Vietnamese Intake Packet
- MHP Beneficiary Handbook Spanish
- Notice of Privacy Practice Acknowledgement English Intake Packet
- Notice of Privacy Practice Acknowledgement Spanish Intake Packet
- Notice of Privacy Practices Acknowledgement Farsi Intake Packet
- Notice of Privacy Practices Acknowledgement Tagalog Intake Packet
- Provider Directories Walk-in clinic hours region
- Quick Guide MHP Final Rv 5_15_19 ARABIC Intake Packet
- Quick Guide MHP Final Rv 5_15_19 English Intake Packet
- Quick Guide MHP Final Rv 5_15_19 FARSI Intake Packet
- Quick Guide MHP Final Rv 5_15_19 Spanish Intake Packet
- Quick Guide MHP Final Rv 5_15_19 TAGALOG Intake Packet
- Quick Guide MHP Final Rv 5_15_19 VIETNAMESE Intake Packet
- Quick Guide MHP Final Rv 5_06_19 English Intake Packet

While the MHP submitted evidence to demonstrate this requirement, it is not evident that the MHP provides all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 points. The listed evidence above does not meet the 12-point font requirement. The MHP was allowed to submit additional evidence after the WebEx review for this requirement. During post-review discussions, the MHP confirmed font was made smaller due to formatting into threshold languages. The MHP plans to update the formatting as necessary to meet the requirement of 12-point font

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(d)(6)(ii).

The MHP must comply with CAP requirement addressing this finding of non-compliance.

## 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 Wednesday, February 3, 2021, at 10:10 a.m. The call was answered after one (1) ring via phone tree directing the caller to select an option for threshold languages, crisis, mental health services, and substance use disorder services. After choosing the option for mental health services, the caller heard a recorded greeting and instructions to call 911 in an emergency. The caller was placed on hold for two (2) minutes and 30 seconds before the call was transferred to a live operator. The operator identified themselves, asked for the caller's name, age, and if the caller was calling for him/herself or someone else. The caller provided his/her name, age, and he/she was calling for him/herself. The caller requested information about accessing mental health services for emotional distress and loss of appetite that he/she has experienced over the past several weeks. The operator asked the caller if he/she was in crisis. The caller replied in the negative. The operator requested the caller's zip code to provide the caller with information on how to access SMHS. The caller provided his/her zip code. The operator advised the caller of the screening process, including information regarding the walk-in process, clinic location(s), and hours of operation. The operator provided information about accessing SMHS, including SMHS required to assess whether medical necessity criteria are met. The operator provided information about services needed to treat a beneficiary's urgent condition.

### FINDING

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

**TEST CALL #2**

Test call was placed on Tuesday, February 9, 2021, at 6:10 p.m. The call was answered after one (1) ring via phone tree, directing the caller to select an option for threshold languages, crisis, mental health services, and substance use disorder services. The caller was placed on hold for two (2) minutes before being answered via a live operator. The caller asked how to access SMHS for anxiety and depression related to being a caregiver for an ill family member. The operator asked the caller if he/she was in crisis. The caller replied in the negative. The operator asked for the caller's zip code. The caller provided his/her zip code. The operator advised the caller of the screening process, including information regarding the walk-in process, clinic location(s), hours of operation, counseling for family caregivers, and advice for self-care. The caller was provided information about accessing SMHS, including SMHS required to assess whether medical necessity criteria are met. The operator 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, February 12, 2021, at 2:52 p.m. The call was answered after one (1) ring via phone tree, directing the caller to select an option for threshold languages, crisis, mental health services, and substance use disorder services. The caller was transferred to a live operator. The caller explained that he/she was new to the county and needed to refill a prescribed anxiety medication. The operator asked the caller if he/she was in crisis. The caller replied in the negative. The operator asked for the caller's zip code, which the caller provided. The operator advised the caller of the screening process, including information regarding the walk-in process at two specific clinic locations in his/her area to get prescriptions filled, and provided their hours of operation. The caller was provided information about accessing SMHS, including SMHS required to assess whether medical necessity criteria are met. The operator provided information about services needed to treat a beneficiary's urgent condition.

**FINDING**

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

**TEST CALL #4**

Test call was placed on Friday, February 19, 2021, at 7:50 a.m. The call was answered after one (1) ring via phone tree, directing the caller to select an option for threshold languages, crisis, mental health services, and substance use disorder services. After four (4) rings, the caller was transferred to a live operator. The caller requested information about how to access mental health services for his/her son, who was having behavioral issues in school and adapting to distance learning. The operator confirmed

the child's age, zip code, and type of insurance information with the caller and proceeded to explain the children's assessment and intake screening process, locations, business hours, and phone numbers for the mental health clinic within the caller's zip code area. The caller was provided information on how to access SMHS, including SMHS required assessing whether medical necessity criteria are met, and provided information on treating an 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 Wednesday, February 17, 2021, at 10:37 p.m. The call was answered after one (1) ring via phone tree, directing the caller to select an option for threshold language, crisis, mental health services, and substance use disorder services. After nine (9) rings, the caller was transferred to a live operator. The operator identified themselves, asked for the caller's name, age, and if the caller was calling for themselves or someone else. The caller provided his/her name, age, and stated he/she was calling for him/herself. The operator asked if the caller had Medi-Cal. The caller responded in the affirmative. The caller asked how to access SMHS for emotional distress and loss of appetite that he/she has been experiencing for the past weeks. The operator asked the caller if he/she were in crisis. The caller replied in the negative. The operator requested personally-identifying information to effectively provide the caller with information on how to access SMHS. The caller provided his/her date of birth and zip code. The caller was provided information about accessing SMHS, including SMHS required to assess whether medical necessity criteria are met. The operator provided information about services needed to treat a beneficiary's urgent condition.

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

**TEST CALL #6**
Test call was placed on Thursday, February 18, 2021, at 7:08 a.m. The call was answered after one (1) ring via phone tree directing the caller to select an option for threshold languages, crisis, mental health services, and substance use disorder services. The caller chose the option to speak to a live operator. The call was transferred and answered after four (4) rings. The caller asked how he/she could file a complaint against a therapist. The operator provided the caller with the telephone number of the Board of Behavioral Science. No additional information about SMHS was supplied to the caller. The caller thanked the operator and ceased the call. The operator did not provide the caller with information about using 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, February 18, 2021, at 12:31 p.m. The call was answered after two (2) rings via phone tree directing the caller to select an option for threshold language, crisis, mental health services, and substance use disorder services. The caller chose the option to speak to an operator and was transferred to a live operator. The caller requested information about how to file a complaint in the county. The operator informed the caller that to file a complaint, the caller needed to call the Consumer Center for Health Education Advocacy and provided the phone number. No additional information about SMHS was supplied to the caller. 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 | IN | IN | 100% |
| 2 | IN | IN | IN | IN | IN | NA | NA | 100% |
| 3 | IN | IN | IN | NA | NA | NA | NA | 100% |
| 4 | NA | NA | NA | NA | NA | 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).

The MHP must comply with CAP requirement addressing this finding of partial compliance.

**COVERAGE AND AUTHORIZATION OF SERVICES**

**Question 5.4.1**

**FINDING**

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries

with a Notice of Adverse Beneficiary Determination under the circumstances listed below:

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

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

- Timeliness of Urgent and Routine Services Access to Service Journal for April – June 2020
- Access Times – Emergent Urgent Routine – Organizational Provider Operations Handbook
- Accessing Services - Time - Organizational Provider Operations Handbook
- Optum NOABD Log FY 20-21
- Organizational Provider Operations Handbook, Section F
- Optum NOABD Denial Notice Form
- QM Memo NOABD Log
- San Diego NOABD Delivery System Notice April 1-June 30,2020

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provided beneficiaries with a NOABD upon failure to provide services in a timely manner. The NOABD logs for the fiscal year did not reflect that any NOABDs were sent to the six (6) beneficiaries related to timeliness. Of the Six (6) Notice of Adverse Benefit Determinations (NOABD), five (5) were missing for urgent/emergent services, and one (1) for a psychiatry appointment. During the post-review discussions, the MHP confirmed that they are out of compliance with this requirement and did not submit additional evidence after the WebEx review for this requirement.

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

The MHP must comply with CAP requirement addressing this finding of non-compliance.