CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2020/2021

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SAN JOAQUIN COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: December 14, 2021 to December 16, 2021

San Joaquin 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 virtual onsite review of the San Joaquin County MHP's Medi-Cal SMHS programs on December 14, 2021 to December 16, 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 Joaquin 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

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 Wednesday, December 16, 2020, at 9:08 am. The call was answered after one (1) ring via a live operator. The operator asked the caller how he/she could help. The caller asked the operator how to access children's mental health services for his/her son. The caller described the child's disruptive behavior at school and emotional outbursts at home and stated that his pediatrician had recommended calling county mental health services. The operator asked for the personal identifying information. The caller provided his/her name and did not provide a telephone number. The operator asked the type of insurance his/her son had and the caller stated that his/her son had Medi-Cal. The operator informed the caller that the child would go through a short screening. The operator provided locations for children services. The operator informed the caller that the MHP has a 24/7 crisis hotline and walk-in facility. The operator proceeded to ask how old the caller's son was and the caller replied with the age. The operator provided the crisis telephone number and address of the 24/7 walk-in facility. The operator recommended that the caller call 911 or go to the local emergency room to seek immediate help if the child's behavior worsened or if the caller's son began feeling suicidal or harming himself or others. The caller thanked the operator and ended the call.

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

FINDING
The call is deemed *in compliance* with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #2
Test call was placed on Tuesday, November 17, 2020, at 7:55 a.m. The call was answered after three (3) rings via 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 assessed the caller's current condition by asking if the beneficiary was in crisis. The caller responded in the negative. The operator informed the caller the offices were closed due to COVID-19 and was unsure when it would reopen, however someone would return his/her call and provide the information he/she was requesting. The operator advised the caller the process could be completed over phone and requested personal identifying information, which the caller provided.

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 CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #3
Test call was placed on Wednesday, December 9, 2020, at 1:14 p.m. The call was answered after seven (7) rings via a live operator. The operator informed the caller that he/she would be placed on a brief hold and that he/she was the next caller in the queue. The caller was on hold for approximately two (2) minutes. The caller requested information about accessing mental health services in the county. The caller explained he/she was the sole caregiver for his/her mom and was having a difficult time caring for her. The caller stated he/she was feeling depressed and needed assistance. The operator asked the caller to provide personal identifying information. The caller provided his/her name and date of birth but declined to provide his/her Medi-Cal number. The operator stated a Medi-Cal number is needed to conduct a brief screening and intake process. The operator advised the caller to call back with the Medi-Cal number. The operator ask if the caller was in a crisis and the caller replied in the negative. The operator provided a hotline number if he/she was in a crisis. The operator also provided the address to a walk-in facility if the caller preferred.

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 CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #4
Test call was placed on Tuesday, November 10, 2020, at 2:44 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller about his/her current needs and emotional state to assess what type of services might be appropriate. The caller stated a desire to receive information on all available services. The operator explained the different levels of services, the assessment process, and the availability of the 24/7 access line and warm line support services. The operator provided the caller with the warm line number and assisted with connecting the caller to the warm 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 CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #5
Test call was placed on Monday, March 22, 2021, at 7:49 a.m. The call was answered after two (2) rings via a live operator. The caller asked how to access mental health services because he/she was feeling down and was struggling to get out of bed. The operator asked for the caller's name, which was provided. The operator asked the caller if he/she had thoughts of harming himself/herself or others. The caller replied in the negative. The operator asked the type of insurance the caller had and the caller stated he/she had Medi-Cal through the county. The operator provided the caller with information regarding 24/7 access line for urgent and crisis services. The operator provided the caller with walk-in clinic locations and hours of operation for crisis and regular clinics.

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 requirement with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

TEST CALL #6

Test call was placed on Monday, December 7, 2020, at 11:53 p.m. The call was answered after one (1) ring via a recorded message advising the caller to enter an identification number. The caller verified the access line telephone number and called the number two additional times. The caller received the same message for the additional calls.

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, December 17, 2020, at 3:50 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about filing a complaint regarding a therapist. The operator informed the caller that he/she could file a complaint over the phone or come into the office and fill out the grievance form and drop it in the black box. The operator offered to mail the grievance form to the caller. The operator informed the caller that the office staff conducts a daily check of the grievance forms and provides all completed forms to the Grievance Coordinator. The operator stated that the Grievance Coordinator would contact the caller via telephone and send a letter to him/her once the grievance was received.

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 CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	OOC	IN	IN	IN	N/A	N/A	80%
3	IN	IN	IN	IN	IN	N/A	N/A	100%
4	N/A	N/A	N/A	N/A	N/A	OOC	IN	50%

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

Repeat deficiency Yes

Question 4.3.4

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

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

- 3-22-21 After hours call logs
- 3-22-21 Business hours call logs
- 11-10-20 Access log
- 4.3.4 11-17-20 Crisis Log

While the MHP submitted evidence to demonstrate compliance with this requirement, one (1) of five (5) required DHCS test calls were not logged on the MHP's written log of initial request. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	11/20/2020	2:44 PM	IN	IN	IN
2	11/17/2020	7:55 AM	OOC	OOC	OOC
3	12/9/2020	1:14 PM	IN	IN	IN
4	12/16/2020	9:08 AM	IN	IN	IN
5	3/22/2021	7:49 AM	IN	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 5.2.8

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:

- P&P Authorization of Specialty Mental Health Services

Internal Documents Reviewed:

- San Joaquin SAR_TAR Worksheet

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	1	96%

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 to exceed five (5) business days from the MHP's receipt of the information. One (1) of the 23 SARs exceeded the five (5)-business day requirement. Per the discussion during the review, SAR approval was recently transitioned from clerical staff to clinical staff to ensure timely and appropriate approval.

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

BENEFICIARY RIGHTS AND PROTECTIONS

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:

- P&P Beneficiary Problem Resolution Process
- Problem Resolution SJCBHS MHS Clinical Training Manual 2021
- Appeal Acknowledgement Form
- Grievance Acknowledgement Letter English
- Grievance Acknowledgment Letter Spanish
- G1920-35 Grievance Sample
- G1920-34 Grievance Sample
- G1920-33 Grievance Sample
- G1920-32 Grievance Sample
- G1920-31 Grievance Sample
- G1920-30 Grievance Sample
- Grievance Log Report FY 19/20

Internal Documents Reviewed:

- SR Grievance & Appeals Tracking Sheet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP acknowledges receipt of each grievance in writing within five (5) calendar days of receipt of the grievance. One (1) of the 35 grievances exceeded the five (5) calendar days.

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	**35**	**34**	**1**	**97%**

DHCS deems the MHP in 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.

Question 6.4.13

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 406(b)(2)(iii) and 228(a). The MHP must ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

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

- P&P Beneficiary Problem Resolution Process
- No Appeal Samples FY1920
- No Appeal Log FY1920
- E-mail Regarding Policy
- NOAB Policy 10.5.21 Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. This requirement was not included in any of the original evidence provided by the MHP. Per the discussion during the review, the MHP stated it will update this policy to adhere to this requirement. Post review, the MHP submitted a compliant policy that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a).

PROGRAM INTEGRITY

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:

- P&P: Standards of Conduct for Behavioral Health Services Employees
- Contract with Disclosure Requirements
- Compliance Sanction Revised

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosure forms 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. This requirement was not included in any of the evidence provided by the MHP. Per the discussion during the review, the MHP stated the submission of disclosure forms to DHCS is included in its process but it is not outlined in the policy. Post review, the MHP provided an updated policy which included the disclosure process and stated that it will be 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).