CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SAN LUIS OBISPO COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: February 1, 2022 to February 3, 2022

San Luis Obispo County Mental Health Plan
FY 2021/2022 Medi-Cal SMHS Triennial Review
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EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted a webinar review of the San Luis Obispo County MHP's Medi-Cal SMHS programs on February 1, 2022 to February 3, 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 Luis Obispo 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

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 Thursday, November 4, 2021, at 10:47 a.m. The call was immediately answered via a recorded greeting, which repeated in the county's threshold language. After the recorded messages, the caller was placed on hold for approximately two (2) minutes and was then transferred to a live operator. The caller requested information about accessing mental health services in the county for his/her child who was experiencing emotional and behavioral issues in school and at home. The operator asked the caller for personally identifying information. The caller provided the child's name, date of birth, and physical address. The caller declined providing the Medi-Cal number, social security number, or call back number. The operator forwarded the call to a counselor at which point the caller ended the call.

The caller was not provided information about how to access SMHS, including SHMS 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 Thursday, December 2, 2021, at 5:31 p.m. The call was answered via a phone tree with a recorded greeting which was repeated in the county's threshold language. The caller was prompted to select a language preference and then provided the option to speak with a live operator if he/she was experiencing a mental health or psychiatric emergency; to hear a recorded message regarding accessing mental health services and leaving a message to schedule an appointment; or to connect to the Patients' Rights Advocate's information line for information about the beneficiary resolution process. The caller selected the option for information regarding accessing mental health services. The caller was provided the option to leave a message to receive a call back from the county within 24 hours or to call back during business hours.

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

FINDING

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

TEST CALL #3

Test call was placed on Thursday, November 4, 2021, at 10:47 a.m. The call was immediately answered via a recorded greeting, which was repeated in the county's threshold language. The caller was placed on a brief hold then was transferred to a live operator. The caller asked the operator for information about mental health services in the county, explaining that he/she had been caring for his/her elderly mother and had been feeling depressed and isolated. The operator asked the caller for his/her Medi-Cal and social security numbers, which the caller declined. The operator stated he/she needed this information or the caller would be deemed a "self-pay." The caller reiterated that at this time, he/she was seeking information to understand the process of receiving mental health services. The operator stated he/she could transfer the caller to a counselor for advice, which the caller declined.

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 not provided information about services needed to treat a beneficiary's urgent condition.

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 #4
Test call was placed on Tuesday, November 9, 2021, at 5:08 p.m. The call was answered via a phone tree with a recorded greeting which was repeated in the county's threshold language. The caller was prompted to select a language preference and then provided the option to speak with a live operator if he/she was experiencing a mental health or psychiatric emergency; to hear a recorded message regarding accessing mental health services and leaving a message to schedule an appointment; or to connect to the Patients' Rights Advocate's information line for information about the beneficiary resolution process. The caller selected the option for information regarding accessing mental health services. The caller was provided the option to leave a message to receive a call back from the county within 24 hours or to call back during business hours.

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 Monday, November 8, 2021, at 10:10 a.m. The caller was placed on a brief hold before a live operator answered the call. The caller asked for information regarding accessing mental health services, describing his/her symptoms of a persistently feeling down over the past several weeks. The operator confirmed that the caller had Medi-Cal and that the caller could provide personal identifying information so he/she may be transferred to a counselor. The caller declined to provide personally identifying information and clarified he/she was requesting information about the process for receiving services. The operator informed the caller of the intake and assessment process as well as discussed the availability of medication services and individual counseling. The operator provided clinic hours, clinic locations, and informed the caller that he/she would be able to speak with a counselor on the day of the intake.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria were met. The caller was not 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 #6

Test call was placed on Wednesday, November 3, 2021, at 7:24 a.m. The call was immediately answered via a phone tree. The call was answered via a phone tree with a recorded greeting which was repeated in the county's threshold language. The caller was prompted to select a language preference and then provided the option to speak with a live operator if he/she was experiencing a mental health or psychiatric emergency; to hear a recorded message regarding accessing mental health services and leaving a message to schedule an appointment; or to connect to the Patients' Rights Advocate's information line for information about the beneficiary resolution process. The caller selected the option to reach the Patients' Rights Advocate. The call was transferred to a voicemail that instructed the caller to leave a message with personally identifiable information.

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 Friday, November 5, 2021, at 9:06 a.m. The call was answered immediately via a phone tree that directed the caller to select a language option, which included the all of the county's threshold languages. After a brief hold, a live operator answered the call. The caller requested information regarding how to file a complaint about a therapist he/she was seeing through the county. The operator stated that the caller would need to speak to the Patients' Rights Advocate. The operator transferred the caller to the Patients' Rights Advocate's voicemail without providing any additional information regarding the beneficiary problem resolution process. The Patients' Rights Advocate's voicemail recording provided instructions to leave a message containing personally identifying information for a return call within 24 hours.

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	N/A	N/A	N/A	100%
2	OOC	OOC	OOC	OOC	IN	N/A	N/A	20%
3	N/A	IN	OOC	IN	OOC	N/A	N/A	50%
4	N/A	N/A	N/A	N/A	N/A	OOC	OOC	0%

Post review, the MHP submitted updated Access Line scripts, phone tree menu options that allow callers to be connected to a live operator for any reason, as well as a more detailed beneficiary resolution process recording that the MHP will implemented moving forward.

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:

- Access Line_4.3_24-7 Access Line & Written Log of Requests for SMHS_Scripted responses – Hotline
- Access Line_4.3_24-7 Access Line & Written Log of Requests for SMHS_Scripted responses-CA
- Action Plan_4.3_24-7 Access Line and Written Log of Requests for SMHS_Central Access Action Plan
- P&P_4.3_24-7 Access Line & Written Log of Requests for SMHS_Access to Services
- P&P_4.4_Cultural Competence Requirements_Access to Services
- P&P_4.4_Cultural Competence Requirements_Bilingual Certification
- P&P_4.4_Cultural Competence Requirements_Culturally Competent, Multi-lingual Services

- P&P_4.4_Cultural Competence Requirements_Services for Clients with Impaired Hearing and Vision
- P&P_4.4_Cultural Competence Requirements_SLOHA Non-Discrimination and Language Access Plan
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_Managed Care Staff Meeting_4.28.2021
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_Managed Care Staff Meeting_5.5.2021
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_Managed Care Staff Meeting_8.11.2021
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_Managed Care Staff Meeting_9.29.2021
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_Managed Care Staff Meeting_10.27.2021
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_SLO Hotline Manager Email
- Access Line Training_4.3_24-7 Access Line & Written Log of Requests for SMHS_SLO Hotline Training_11.29.2021
- Interpretation_4.4_Cultural Competence Requirements_Utilzation Report Language Line
- Patients' Rights Advocate Outgoing Voicemail Message
- 800# VM Scripts

While the MHP submitted evidence to demonstrate compliance with this requirement, five (5) 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	11/4/2021	10 47 a.m.	OOC	OOC	OOC
2	11/5/2021	11:49 a.m.	OOC	OOC	OOC
3	11/8/2021	10:10 a.m.	OOC	OOC	OOC
4	11/9/2021	5:08 p.m.	OOC	OOC	OOC
5	12/02/2021	5:31 p.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 5.2.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status for the below requirements:

1. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
2. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.
3. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

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

- Authorization Tool_5.2_Concurrent Review and Prior Authorization Requirements_PHF Authorization Tool
- Authorization Worksheet_5.2_Concurrent Review and Prior Authorization Requirements_OOC Hospital Authorization Worksheet
- P&P_5.2_Concurrent Review and Prior Authorization Requirements_Medical Necessity & Concurrent Authorization
- P&P_5.2_Concurrent Review and Prior Authorization Requirements_Out-of-County Inpatient Hospital Authorization Requests (TAR)
- Authorization Tool_5.2_Concurrent Review and Prior Authorization Requirements_PHF Authorization Tool
- P&P_5.4_NOABD Requirements_Notices of Adverse Benefit Determination
- Authorization P&P_5.2.2_Authorization General Requirements_Authorization of Services & Medical Necessity
- Authorization P&P_5.2.5_Authorization General Requirements_Authorization of Services & Medical Necessity

- Inpatient Authorization Review P&P_5.2.2_Authorization General Requirements_Out of County Inpatient TAR
- Inpatient Authorization Review P&P_5.2.5_Authorization General Requirements_Out of County Inpatient TAR
- Admin Day UR P&P_5.2.5_Concurrent Review&Prior Authorization Requirements_Utilization Review for Medical Necessity
- P&P_5.2.5_Concurrent Review and Prior Authorization Requirements_Medical Necessity & Concurrent Authorization (updated post review)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by the MHP that it has a procedure for conducting concurrent review and authorization for administrative day service claims. Per the discussion during the review, the MHP acknowledged the need to update its existing authorization process to ensure the proper procedures are in place for concurrent reviews. Post review, the MHP submitted a compliant policy and procedure that it will implemented moving forward.

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

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:

- Authorization Tool_5.2_Concurrent Review and Prior Authorization Requirements_PHF Authorization Tool
- Authorization Worksheet_5.2_Concurrent Review and Prior Authorization Requirements_OOC Hospital Authorization Worksheet
- P&P_5.2_Concurrent Review and Prior Authorization Requirements_Medical Necessity & Concurrent Authorization
- P&P_5.2_Concurrent Review and Prior Authorization Requirements_Out-of-County Inpatient Hospital Authorization Requests (TAR)
- Authorization Tool_5.2_Concurrent Review and Prior Authorization Requirements_PHF Authorization Tool
- P&P_5.4_NOABD Requirements_Notices of Adverse Benefit Determination
- P&P_5.1_Authorization General Requirements_Medical Necessity & Authorization of SMHS

- CB Email_5.2.8_Concurrent Review&Prior Authorization Requirements_SAR Receipt
- SAR Log_5.2.8_Concurrent Review&Prior Authorization Requirements_Received Date Documented

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.	17	3	85%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by the MHP that it makes a determination for all Service Authorization Requests (SAR) within five (5) business days of receipt. Per the discussion during the review, the MHP explained its authorization process and acknowledged the need for a consistent practice for documenting receipt of SARs. Post review, the MHP submitted evidence of receipt date for one (1) of the four (4) SARs in question; demonstrating it was authorized within the time requirement. The MHP stated it will adopt a practice of date stamping or saving proof of receipt date for SARs moving forward.

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

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:

- P&P_5.3_Presumptive Transfer_Authorization, Documentation, Billing Process for Out-of-Plan Services (Youth) P&P_5.3_Presumptive Transfer_Procedure
- P&P_5.3_Presumptive Transfer_SLO DSS Presumptive Transfer
- Log_5.3_Presumptive Transfer_Presumptive Transfer Tracking Log
- Log_5.3.8_Presumptive Transfer_Presumptive Transfer Tracking Log
- Website_5.3.4_Presumptive Transfer_SLOBHD Point of Contact
- P&P_5.3.8_Presumptive Transfer_Authorization, Documentation, Billing Process for Out-of-Plan Services (Youth)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by the MHP that it had a procedure for expedited transfers. Per the discussion during the review, the MHP stated its practice would be to follow regulatory requirements, however it has not had any requests for expedited transfers. Post review, the MHP submitted a compliant policy and procedure and updated tracking mechanism that it has implemented moving forward.

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 5.5.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 2, and Federal Code of Regulations, title 42, section 438, subdivision 206(b). The MHP must provide a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary.

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

- P&P_5.5_Second Opinions_Second Opinions
- Log_5.5_Second Opinion_Second Opinion Request Log
- SLO_Overarching Documents_SLOBHD-MH-Beneficiary-Handbook_10-2018
- P&P_5.5.1_Second Opinions_Second Opinions
- P&P_5.1.6_Authorization General Requirements_Availability Timeliness Network Adequacy_Array of Services
- P&P_5.1.6_Second Opinions_Second Opinions
- Second Opinion Requirement_5.5.1_Second Opinions_SLOBHD-MH-Beneficiary-Handbook

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the submitted documentation that the MHP includes a provision for second opinions from outside the network at no additional cost to the beneficiary. Per the discussion during the review, the MHP stated it does allow second opinions from out of network providers at no cost to the beneficiary and that it would update its policy and beneficiary handbook to reflect this practice. Post review, the MHP submitted a compliant policy and an updated beneficiary handbook that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 2, and Federal Code of Regulations, title 42, section 438, subdivision 206(b).