CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2019/2020

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

SYSTEM FINDINGS REPORT

Review Dates: July 21, 2020 to July 23, 2020

San Mateo County Mental Health Plan
FY 2019/2020 Medi-Cal SMHS Triennial Review
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EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted an onsite review of the San Mateo County MHP's Medi-Cal SMHS programs on July 21, 2020 to July 23, 2020. 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) 2019/2020 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:

- Section A: Network Adequacy and Availability of Services
- Section B: Care Coordination and Continuity of Care
- Section C: Quality Assurance and Performance Improvement

- Section D: Access and Information Requirements
- Section E: Coverage and Authorization of Services
- Section F: Beneficiary Rights and Protections
- Section G: Program Integrity
- Section H: Other Regulatory and Contractual Requirement

This report details the findings from the Medi-Cal SMHS Triennial System Review of the San Mateo County MHP. The report is organized according to the findings from each section of the FY 2019/2020 Protocol and the Attestation 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.

Review Findings Overview

- During the DHCS review, the San Mateo County MHP demonstrated numerous strengths, including but not limited to the following examples:
    - MHP has a "No Wrong Door" policy. The MHP indicated that it does not turn away anyone when requesting services, including those without Medi-Cal.
    - MHP indicated that it is engaged with their community and that outreach extends to a large majority of their community.

- MHP has a robust compliance program.
- MHP demonstrated whole person care in multiple areas.

- DHCS identified opportunities for improvement in various areas, including:
  - Developing a process for determining the need for ICC/IHBS and TFC.
  - Tracking and monitoring mechanism for the grievances received by the sub-contractors.
  - Service verification process.

Questions about this report may be directed to DHCS via email to MCBHDMonitoring@dhcs.ca.gov.

FINDINGS

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
The MHP shall make its written materials that are critical to obtaining services available in the prevalent non-English languages in the county. This includes, at a minimum, the following: 4) denial and termination notices, and, (MHP contract, Ex. A, Att. 11; Fed. Code Regs., tit.42, § 438, subd.10(d)(3).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 11, and Federal Code of Regulations, title 42, section 438, subdivision 10(d)(3). The MHP must make its written materials that are critical to obtaining services available in the prevalent non-English languages in the county. This includes, at a minimum, the above listed materials.

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

- Letter of termination to provider

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has written materials that are critical to obtaining services available in the prevalent non-English languages in the county. Specifically, denial and termination notices.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 11, and Federal Code of Regulations, title 42, section 438, subdivision 10(d)(3). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (Cal. Code Regs., tit. 9, chap. 11, § 1810, subd.405(d) and 410(e)(1).)
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.
The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

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). Each MHP must provide a statewide, toll-free telephone number 24 hours a day, seven days per week that will provide information to beneficiaries about how to access SMHS and how to use the beneficiary problem resolution and fair hearing processes. The seven (7) test calls are summarized below.

TEST CALL #1

Test call #1 was placed on Friday, October 25, 2019, at 12:08 a.m. The call was answered after one (1) ring via a phone tree directing the DHCS test caller to select a language option, which included the MHP's threshold languages. The caller then heard a recorded greeting and instructions to call 911 in case of an emergency. After navigating through a series of prompts, the call was then answered via a live operator. The caller requested information about accessing mental health services in the county. The operator assessed the caller's current condition by asking if the caller felt suicidal or using any type of substance. The caller replied in the negative. The operator proceeded to provide information regarding the assessment and referral process. The operator also provided the hours of operation. The operator advised the caller that the 24/7 access line was available for crisis or urgent services. The caller was provided information about how to access SMHS and 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 #2

Test call #2 was placed on Wednesday, November 20, 2019 at 1:09 p.m. The call was answered via a phone tree directing the DHCS test caller to select language option, type of service, and to dial 911 in case of an emergency. After selecting the options for English and mental health services, the call was then answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller for personal information such as name, date of birth, social security number, and insurance information. The caller was placed on hold as the operator checked the information to locate caller in the system. The operator requested the caller to repeat their information because the operator was unable to locate the caller. The caller was placed on hold again while the operator rechecked the information. The caller disconnected the call after being on hold for 6 minutes. The caller was not provided information about how to access SMHS, including SMHS required assessing 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 #3 was placed on Wednesday, November 20, 2019, at 3:01 p.m. The call was answered after one (1) ring via a phone tree directing the DHCS test caller to select a language option, which included the MHP's threshold languages. After selecting the language, the caller heard a recorded greeting and instructions to call 911 in an emergency. The caller was then asked to select an option for Mental Health or Drug/Alcohol Services. The call was then answered via a live operator who asked the caller if this was a mental health emergency and the caller replied in the negative. The operator asked the caller if they were seeking mental health services to which the caller replied, "yes". The operator provided the caller with information on the intake process. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and information on how 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, December 13, 2019, at 7:09 a.m. The call was answered after one (1) ring via a phone tree directing the DHCS test caller to select a language option, which included the MHP's threshold languages and to dial 911 if it is an emergency. The phone tree also provided an option to select for mental health services. After selecting the option for mental health services, a live operator answered the call. The operator asked the caller for some personal information. The caller provided the information except for the telephone number. The caller requested information about how to access mental health services for their son. The operator informed the caller that they had reached the after-hours line and since the caller could not provide a call back number, the caller could call back during business hours for information. The operator informed the caller that they would perform a phone screening and possibly schedule a face-to-face screening. The caller informed the operator that they would call back. 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, and 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 Monday, December 30, 2019, at 7:25 a.m. The call was answered after one (1) ring via a phone tree directing the DHCS test caller to select a language option, which included the MHP's threshold language. After selecting the option for English, the caller chose the option to receive information about Mental Health and Drug or alcohol services. The phone tree transferred the caller to a counselor. The phone tree did not offer the caller numbers to press for additional options. The phone rang again approximately three (3) to four (4) times as it appeared to be transferring the call. The caller remained on the line as the call went silent with no response. After a while, the line was disconnected. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller 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 #6

Test call #6 was placed on Monday, December 2, 2019, at 12:20 p.m. The call was answered after one (1) ring via a phone tree directing the DHCS test caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the call was then transferred to a live operator. The caller requested information about how to file a complaint at the county. The operator advised the caller to contact the Consumer Affairs Department at the County and provided the toll free number. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

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 #7 was placed on Thursday, December 19, 2019, at 11:22 a.m. The call was answered after one (1) ring via a phone tree directing the DHCS test caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller heard a recorded greeting instructing the caller to dial 911 in case of an emergency. The caller was then instructed to select another option for grievances. After selecting the option for grievances, the caller received a voicemail box for a staff member. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

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	100%
2	IN	OOC	OOC	IN	OOC			40%
3	IN	IN	IN	IN	IN	IN	IN	100%
4						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 complete a CAP addressing this finding of partial compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (Cal. Code Regs., tit. 9, chap. 11, §1810, subd.405(f)). The written log(s) contain the following required elements:
Name of the beneficiary.
Date of the request.
Initial disposition of the request.

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:

- San Mateo Test Call Guidelines.
- After Hours DECEMBER 2019
- Daytime Logs 24/7 Access Line 2019

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) 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	10/25/2019	12:08 AM	OOC	OOC	OOC
2	11/20/2019	1:09 PM	IN	IN	IN
3	11/20/2019	3:01 PM	OOC	OOC	OOC
4	12/13/2019	7:09 AM	IN	IN	IN
5	12/30/2019	7:25 AM	OOC	OOC	OOC
Compliance Percentage			**40%**	**40%**	**40%**

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). The MHP must complete a CAP addressing this finding of partial compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS., IN., 18-010E)

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 above listed standards.

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

- Policy 19-01 Manual Final Amended
- Samples of acknowledgment letters
- Grievance log beginning July 2019

Internal Documents

- Grievance and Appeals worksheet
- Grievance and Appeals log

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	**48**	**46**	**2**	**96%**
APPEALS	**N/A**	**N/A**	**N/A**	**N/A**
EXPEDITED APPEALS	**N/A**	**N/A**	**N/A**	**N/A**

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. The MHP must complete a CAP addressing this finding of partial compliance.

REQUIREMENT
The MHP shall adhere to the following record keeping, monitoring, and review requirements:
Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (Fed. Code Regs., tit. 42, § 438, subd.416(a); Cal. Code Regs., tit. 9, § 1850, subd.205(d)(1).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must adhere to the record keeping, monitoring, and review requirements as listed above.

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

- Policy 19-01 Manual Final Amend
- Grievance log beginning July 2019

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP did not log grievances and appeals within one (1) working day of the date of receipt of the grievance, appeal, or expedited appeal. Specifically, five (5) of the 48 grievances reviewed were not logged within one (1) working day of the date of receipt of the grievance.

DHCS deems the MHP partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must complete a CAP addressing this finding of partial compliance.

REQUIREMENT
Resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (Fed. Code Regs., tit. 42, § 438, subd. 408(a)-(b)(1).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance

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

- Policy 19-01 Manual Final Amend
- Grievance log beginning July 2019

While the MHP submitted evidence to demonstrate compliance with this requirement, it was found that some of the grievances were not resolved within the 90 calendar days from the day the Contractor receives the grievance.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below;

	RESOLVED WITHIN TIMEFRAMES			REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
	# OF SAMPLE REVIEWED	# IN COMPLIANCE	# OOC		
GRIEVANCES	**48**	**37**	**11**		**77%**
APPEALS	**N/A**	**N/A**	**N/A**		**N/A**
EXPEDITED APPEALS	**N/A**	**N/A**	**N/A**		**N/A**

DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must complete a CAP addressing this finding of partial compliance.

PROGRAM INTEGRITY

REQUIREMENT
The MHP implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary. (Fed. Code Regs., tit. 42, § 438, subd.608(a)(5).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subd. 608(a)(5). The MHP must implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary.

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

- Policy 16-03-Compliance Plan and Program

While the MHP discussed the requirement during the review and submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary. Specifically, the MHP indicated it has a process to cross-reference the schedule with the progress note in the chart. The DHCS team requested additional evidence to verify if the MHP had a process to verify with the beneficiaries when services were provided but additional evidence was not submitted.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subd. 608(a)(5). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
If the MHP finds a party that is excluded, it must promptly notify DHCS. (Fed. Code Regs., tit.42, §438, subd.608(a)(2),(4).

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608 and section 455, subdivision 436. The MHP must comply with database check process for above listed circumstances. In addition, if the MHP finds a party that is excluded, the MHP must promptly notify DHCS.

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

- Policy 04-01 Compliance Policy for Funding Services Provided by Contracted Organizational Providers
- Policy 19-08 Credentialing and Re-Credentialing Providers

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded during the database check as the MHP does not include this requirement in their policy and procedure and did not submit evidence of practice.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608 and section 455, subdivision 436. The MHP must complete a CAP addressing this finding of non-compliance.

OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

REQUIREMENT
The MHP must comply with the requirements of California Welfare and Institution Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Welfare and Institution Code, section 14705(c) and 14712(e). The MHP must comply with the requirements of California Welfare and Institution Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

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

- Cost Reporting Analysis
- Cost Reporting Reminder Email
- Fiscal Cycle Calendar
- Fiscal Cycle Task Summary
- Information Notice 18-024

Internal Documents

- Cost Reporting report from DHCS Fiscal Reporting Branch (FAB)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submitted its annual cost reports timely. Specifically, the MHP sought an extension for FY 18/19 but did not meet extension deadline.

DHCS deems the MHP out of compliance with California Welfare and Institution Code, section 14705(c) and 14712(e). The MHP must complete a CAP addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

AUTHORIZATION REQUIREMENTS FOR CONCURRENT REVIEW AND PRIOR AUTHORIZATION

REQUIREMENT
MHPs must comply with the following communication requirements: (MHSUDS., IN., No. 19-026)
A physician shall be available for consultation and for resolving disputed requests for authorizations.

FINDING

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

- Policy 20-05 UM Program and Authorization of SMHS
- Policy 20-06 UM of Inpatient Psychiatric Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP complies with the communication requirement that a physician shall be available for consultation and for resolving disputed requests for authorization.

SUGGESTED ACTION

DHCS recommends, at a minimum, the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews:

- Update your policies to reflect the above requirements

REQUIREMENT
In order to conduct concurrent review and authorization for administrative day service claims, 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. 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. (MHSUDS., IN., No. 19-026)

FINDING

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

- Policy 20-05 UM Program and Authorization of SMHS
- Policy 20-06 UM of Inpatient Psychiatric Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews 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 administration day status. Specifically, 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. 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.

SUGGESTED ACTION

DHCS recommends, at a minimum, the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews:

- Update your policies to reflect the above requirements.