CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2019/2020

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW OF THE SUTTER-YUBA COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: October 29, 2019 to October 30, 2019

Sutter-Yuba County Mental Health Plan
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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, section 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 Sutter-Yuba County MHP's Medi-Cal SMHS programs on October 29, 2019 to October 30, 2019. 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 Sutter-Yuba 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 out-of-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 out-of-compliance. 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 Sutter-Yuba County MHP demonstrated numerous strengths, including but not limited to the following examples:

- The MHP successfully implemented the open-access clinic treating all open-access appointments as urgent requests. This open-access clinic resulted in improvement in timeliness for the initial appointments.
- The MHP demonstrated individualized, well-linked, and well written clinical documentation. This is partially a result of a plan of correction implemented to

address duration requirements in the clinical documentation after the last triennial review.

- The MHP demonstrated strong coordination of care initiatives as evidenced by the well-coordinated discharge and linkage process, the collaborative approach between different agencies, community providers providing wrap-around services for the beneficiaries, and a robust follow-up process that ensures coordination of care.
- The MHP completed a recent reorganization. As part of the reorganization, they hired a quality assurance analyst focusing on cultural competence, grievance/appeals coordination, and 24/7 access line training.
- The MHP initiated collaboration with the contractor (Kings View) to better utilize the data dashboard.

DHCS identified opportunities for improvement in various areas, including:

- The MHP may benefit from having a more effective mechanism to extract necessarily data for data/report submission to DHCS. It will also assist in better analyzing and aggregating data to determine effective quality improvement initiatives.
- The MHP may benefit from having a more systemic approach in monitoring and tracking compliance requirements.
- The MHP may benefit from continuous improvement in the monitoring and tracking of grievances and appeals.
- The MHP may benefit from continuous improvement in the monitoring and tracking mechanisms for the 24/7 tool free access line.

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

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
The MHP shall offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county (Fed. Code Regs., tit.42, § 438, subd. 207(b)(1)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with the Code of Federal Regulations, title 42, section 438, subdivision 207(b)(1). The MHP must offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county.

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

- Implementation Plan
- FY2017-2018 Penetration Report
- FY2018-2019 Penetration Report
- NACT Tool A-3 Tab Rendering Service Provider Tab AH-AM
- Performance Outcomes Systems Youth Data
- Performance Outcomes Systems Adult Data
- EQRO Report
- Cultural Competence Plan Annual Update/Report
- FY2018-2019 Short Doyle Medi-Cal Claims Performance Report
- Geo Maps to show Service Maps

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP offers an appropriate range of SMHS that is adequate for the number of beneficiaries in the county. In addition to the evidence submitted by the MHP, DHCS reviewed the most recent Network Adequacy Findings Report. The MHP received a conditional pass on the Network Adequacy Findings Report for Outpatient Specialty Mental Health Services (SMHS) Provider Capacity for Adult and Children/Youth, and is required to complete a Corrective Action Plan (CAP) for those two areas.

DHCS deems the MHP out-of-compliance with Code of Federal Regulations, title 42, section 438, subdivision 207(b)(1). The MHP must comply with the CAP requirement per the Network Adequacy Findings Report.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

REQUIREMENT

The MHP has a Quality Assurance and Performance Improvement (QAPI) work plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. (MHP Contract, Ex.A, Att.5)

FINDING

The MHP did not furnish evidence to demonstrate it complies with the Mental Health Plan (MHP) Contract, Ex.A, Att.5. The MHP must have a QAPI work plan covering the current contract cycle with documented annual evaluations and documented revisions as needed.

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

- FY2016-2017 QAPI Work Plan
- FY2016-2017 QAPI Work Plan Evaluation
- FY2017-2018 QAPI Work Plan
- FY2018-2019 QAPI Work Plan
- FY2019-2020 QAPI Work Plan
- A note from the MHP regarding QAPI Evaluation for FY2018-2019

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a QAPI work plan with a documented annual evaluation for FY 2018-2019. In the note submitted by the MHP, the MHP stated that “the Quality Assurance Office has gone through significant transitions”, “QIC has not been as data driven as it is needed to be”, and “Therefore, the QAPI Evaluation is not able to be completed”.

DHCS deems the MHP out-of-compliance with the MHP Contract, Ex. A, Att.5. The MHP must complete a CAP addressing this finding of non-compliance.

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number (Cal. Code Regs, tit 9, chapter 11, § 1810, subdivision 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 beneficiaries about services needed to treat a beneficiary’s urgent condition.

FINDINGS

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, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, 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 Monday, August 26, 2019, at 11:33 am. The call was answered immediately by a live operator. The operator identified the line as the county mental health psychiatric emergency line. The caller declined needing emergency assistance and stated she was attempting to obtain information to establish services for her young son who was acting out in school and at home. The operator said she would transfer the caller to the front desk. The caller was then placed on hold and heard five (5) rings, after which, the call was routed to an answering machine that instructed the caller to leave a name and telephone number for a return call. The caller terminated the call. The MHP did not provide information on how to access SMHS, including SMHS 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 #2 was placed on Tuesday, August 27, 2019, at 11:51 p.m. The call was answered after one (1) ring via a live operator. The DHCS test caller requested SMHS in the county. The operator requested the caller's name and asked if they had thoughts of harming themselves or others. The caller replied in the negative. The operator provided the address, hours of operation, and phone number of the clinic. The operator advised the caller that they could walk-in during business hours for SMHS. The operator advised the caller to obtain a primary care physician for medical treatment. The operator proceeded to provide information regarding the assessment process. The operator advised the caller that the 24/7 access line is available for crisis or urgent services. 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 #3

Test call #3 was placed on Tuesday, September 10, 2019, at 10:00 a.m. The call was answered after one (1) ring via a live operator who stated Psychiatric Emergency Services, this is Josh. The caller inquired if they called the correct Mental Health Services. The operator informed the caller they had reached the crisis help line. The caller requested information about accessing mental health services in the county. The operator provided the hours 8:00 a.m. to 2:00 p.m., Monday through Thursday for the Open Access Clinic, which provides services for therapist, medication support, group therapy and that the front desk could start the paperwork so services could start. The operator asked caller for their name and date-of-birth. The caller provided Vanessa Johnson, August 25, 1983. The operator informed the caller to bring identification and asked about insurance to which the caller stated Medi-Cal. The operator asked the caller if she wanted to hurt herself or others. The caller responded in the negative. 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 #4
Test call #4 was placed on Friday, August 30, 2019, at 7:48 a.m. The call was answered after one (1) ring via a live operator. The caller requested information about filing a complaint for mental health services received in the county. The operator stated the caller could come into the office and get a grievance form to file their complaint. The caller asked if there was anyone the caller could talk to about the process. The operator placed the caller on a brief hold; upon returning, the operator explained that a grievance could be filed in writing or over the phone and a response would be provided in about 60 days. The operator also stated the caller could contact the counties Quality Improvement Coordinator with any other questions. The caller was provided information about the beneficiary problem resolution and state fair hearing process.

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

TEST CALL #5
Test call #5 was placed on Monday, August 19, 2019, at 7:24 a.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 if she felt like hurting herself or others. The caller replied in the negative. The operator asked the caller if she had medical insurance. The caller stated yes, Medi-Cal. The operator informed the caller that the county offers an open walk-in access clinic Monday through Thursday, from 8:00 a.m. to 2:00 p.m., where an assessment would be conducted to determine what services where need for treatment. 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 #6
Test call #6 was placed on Tuesday, September 17, 2019, at 3:42 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about filing a grievance for mental health services received. The operator asked the caller for her name. The caller stated Laura. The operator informed caller that the forms could be mailed to her, or she could come to the Mental Health facility located at 1965 Live Oak Blvd, and pick up the forms at the front desk in the crisis area between the hours of 7:00 a.m. and 11:00 p.m. The caller was also informed that someone from administration will take care of the grievance within 24-hours and contact her. The caller was provided information about the beneficiary problem resolution and state fair hearing process.

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

TEST CALL #7
Test call #7 was placed on Wednesday, September 18, 2019, at 7:35 a.m. The call was answered after one (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller what type of insurance they had. The caller stated Medi-Cal. The operator asked the caller if they knew where to go for urgent care. The caller stated in the affirmative. The operator provided information for the crisis unit and hours of operation. The operator also asked the caller if she was in danger of hurting herself or others. The caller stated in the negative. The operator informed the caller of the walk-in services and provided the location and hours of operations. 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).

SUMMARY OF TEST CALL FINDINGS

Protocol Question	Test Call Findings	Compliance Percentage

	#1	#2	#3	#4	#5	#6	#7	
1								N/A
2	**OUT**	**IN**	**IN**		**IN**		**IN**	80%
3		**IN**	**IN**		**IN**		**IN**	100%
4				**IN**		**IN**		100%

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.

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, chapter 11, § 1810, subd 405(f)).
The written log(s) contain the following required elements: a) Name of the beneficiary. b) Date of the request. c) Initial disposition of the request. (Cal. Code Regs., tit. 9, chapter 11, §1810, subd. 405(f))

FINDING

The MHP did not furnish evidence to demonstrate it complies 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:

- 2018 Written logs of initial request
- 2019 Written logs of initial request
- Service Request Log for 10/1/2018 through 12/31/2018

While the MHP submitted evidence to demonstrate compliance with this requirement, one of five 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:

			Log Results		
Test Call #	**Date of Call**	**Time of Call**	**Name of the Beneficiary**	**Date of the Request**	**Initial Disposition of the Request**

1	8/26/2019	11:33 AM	OUT	OUT	OUT
2	8/27/2019	11:51 PM	IN	IN	IN
3	9/10/2019	10:00 AM	IN	IN	IN
4	8/19/2019	7:24 AM	IN	IN	IN
5	9/18/2019	7:35 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). The MHP must complete a CAP addressing this finding of partial compliance. This is a repeated deficiency identified in the previous triennial review.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing (MHP Contract, Ex. A, Att. 12; Fed. Code Regs, tit.42, § 438, subd. 406(b)(1)).
The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS, IN, No.18-010E)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, exhibit A, attachment 12; Code of Federal Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP shall acknowledge receipt of each grievance, appeal and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. 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:

- Policy 10-003 Grievance and Appeals Procedure
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Samples
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Samples
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Log
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Log
- FY 2019-2020 Grievances, Appeals, Expedited Appeals Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP sample verification identified inconsistency in providing acknowledgement letters postmarked within five (5) calendar days of receipt of the grievance, appeals, and expedited appeals.

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**70**	**62**	**8**	**89%**
APPEALS	**2**	**0**	**2**	**0%**
EXPEDITED APPEALS	**2**	**2**	**0**	**100%**

DHCS deems the MHP partial compliance with MHP Contract, exhibit. A, attachment. 12; Code of Federal 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)).
Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person for whom the appeal or grievance was filed (Fed. Code Regs. Tit. 42, § 438, subd. 416(b)(1)-(6)).
Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log (Cal. Code Regs., tit. 9, § 1850, subdivision 205(d)(2)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with Federal Code of Regulations, title 42, section 438, subdivision 416(a), and California Code of Regulations, title 9, section 1850, subdivision 205(d)(1). The MHP shall adhere to the record keeping, monitoring, and review requirements: at minimum

- 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;
- Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance, the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person for whom the appeal or grievance was filed; and,
- Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been a final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log.

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

- Policy 10-003 Grievance and Appeals Procedure
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Log
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Log
- FY 2019-2020 Grievances, Appeals, Expedited Appeals Log

While the MHP submitted evidence to demonstrate compliance with this requirement, FY 2017- 2018 and FY 2018-2019 log did not have mechanisms to track compliance for recording grievances, appeals, and expedited appeals in the log within one (1) working day of the date of receipt of the grievance, appeal, or expedited appeal. Both the FY 2017-2018 and FY 2018-2019 logs lacked the date of each review or review meeting, resolution information for each level of the appeal or grievance if applicable, and the final disposition or reason for not having final disposition.

During the review, the MHP shared that a dedicated grievance coordinator was recently hired, and the log was updated to include the missing information. The MHP submitted the log for FY 2019-2020 to demonstrate improvement made to address deficiencies.

DHCS deems the MHP out-of-compliance with Federal Code of Regulations, title 42, section 438, subdivision 416(a), and California Code of Regulations, title 9, section 1850, subdivision 205(d)(1).However, the MHP demonstrated corrections made in the log for FY 2019-2020 and has hired a dedicated grievance/appeal coordinator to monitor the process. Therefore, a CAP is not necessary for this deficiency. It is recommended that the MHP continue monitoring compliance utilizing the updated log.

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 it complies 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 10-003 Grievance and Appeals Procedure
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Samples
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Samples
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Log
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Log
- FY 2019-2020 Grievances, Appeals, Expedited Appeals Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the Grievance sample verification indicated some grievance samples did not have information necessary to verify the compliance in this area.

	RESOLVED WITHIN TIMEFRAMES			REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
	# OF SAMPLE REVIEWED	# IN COMPLIANCE	# OOC		
GRIEVANCES	**70**	**53**	**17**	**0**	**76%**
APPEALS	**2**	**1**	**1**	**0**	**50%**
EXPEDITED APPEALS	**2**	**0**	**2**	**0**	**0%**

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.

REQUIREMENT
Provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted (Cal. Code Regs., tit. 9, § 1850, 206 subd. (c)).

FINDING
The MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, section 1850, subdivision 206(c). The MHP must provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

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

- Policy 10-003 Grievance and Appeals Procedure
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Samples
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Samples
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Log
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Log
- FY 2019-2020 Grievances, Appeals, Expedited Appeals Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the Grievance sample verification indicated some missing written Notices of Grievance Resolutions. In addition, some of the Notices of Grievance Resolutions were missing the date that they were issued.

	# OF SAMPLE REVIEWED	RESOLUTION NOTICE		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**70**	**57**	**13**	**81%**
APPEALS	**2**	**1**	**1**	**50%**
EXPEDITED APPEALS	**2**	**2**	**0**	**100%**

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c). The MHP must complete a CAP addressing this finding of partial compliance.

REQUIREMENT
Resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal (Fed. Code Regs., tit. 42, § 438, subd. 408(a),(b)(2)).

FINDING
The MHP did not furnish evidence to demonstrate it complies with Federal Code of Regulations, title 42, section 438, subdivision 408(a) and (b)(2). The MHP must resolve

each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.

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

- Policy 10-003 Grievance and Appeals Procedure
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Samples
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Samples
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Log
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Log
- FY 2019-2020 Grievances, Appeals, Expedited Appeals Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the appeal samples verification indicated one appeal did not have the information necessary to verify compliance in this area.

DHCS deems the MHP out of compliance with Code of Federal Code of Regulations, title 42, section 438, subdivision 408(a) and (b)(2). The MHP must complete a CAP addressing this finding of out of compliance.

REQUIREMENT
Resolve an expedited appeal and notify the affected parties in writing, as expeditiously as the beneficiary's health condition requires and no later than 72 hours after the Contractor receives the appeal (Fed. Code Regs, tit. 42, § 438, subd. 408(b)(3)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with Code of Federal Regulations, title 42, section 438, subdivision 408(b)(3). The MHP must resolve an expedited appeal and notify the affected parties in writing, as expeditiously as the beneficiary's health condition requires and no later than 72 hours after the Contractor receives the appeal

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

- Policy 10-003 Grievance and Appeals Procedure
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Samples
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Samples
- FY 2017-2018 Grievances, Appeals, Expedited Appeals Log
- FY 2018-2019 Grievances, Appeals, Expedited Appeals Log
- FY 2019-2020 Grievances, Appeals, Expedited Appeals Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP failed to resolve two (2) cases of expedited appeals within 72 hours after the contractor received the appeal. In addition, there was no evidence that a Notice of Adverse Benefit Determination (NOABD) for Grievance and Appeal Timely Resolutions was provided for both of the expedited appeals.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 408(b)(3). The MHP must complete a CAP addressing this finding of out of 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 it complies 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 Report Submission Extension Request dated on 12/20/2018 to extend the due date from 12/31/2018 to 1/20/2019
- Signed County Certification Page of Year-End Cost Report for FY2017-2018, signed on 8/26/2019, uploaded on 6/25/2019.

In addition, DHCS reviewed internal data to determine compliance with the cost report submission date. The cost report for FY17-18 was due on 12/31/2018, however it was submitted on 6/25/2019. There was no documented evidence of a request for or approval of an extension. Therefore, cost report for FY17-18 was considered as late.

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.