CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2020/2021

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE TULARE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: October 5, 2021 to October 7, 2021

Tulare County Mental Health Plan
FY 2020/2021 Medi-Cal SMHS Triennial Review
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EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted a virtual onsite review of the Tulare County MHP's Medi-Cal SMHS programs on October 5, 2021 to October 7, 2021. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2020/2021 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

The Medi-Cal SMHS Triennial System Review evaluated the MHP's performance in the following categories:

- Category 1: Network Adequacy and Availability of Services
- Category 2: Care Coordination and Continuity of Care
- Category 3: Quality Assurance and Performance Improvement

- Category 4: Access and Information Requirements
- Category 5: Coverage and Authorization of Services
- Category 6: Beneficiary Rights and Protections
- Category 7: Program Integrity

This report details the findings from the Medi-Cal SMHS Triennial System Review of the Tulare County MHP. The report is organized according to the findings from each section of the FY 2020/2021 Protocol deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS.

For informational purposes, this findings report also includes additional information that may be useful for the MHP (e.g., a description of calls testing compliance of the MHP's 24/7 toll-free telephone line).

The MHP will have an opportunity to review the report for accuracy and appeal any of the findings of non-compliance (for both system review and chart review). The appeal must be submitted to DHCS in writing within 15 business days of receipt of the findings report. DHCS will adjudicate any appeals and/or technical corrections (e.g., calculation errors, etc.) submitted by the MHP and, if appropriate, send an amended report.

A Corrective Action Plan (CAP) is required for all items determined to be OOC or in partial compliance. The MHP is required to submit a CAP to DHCS within 60-days of receipt of the findings report for all system and chart review items deemed OOC. The CAP should include the following information:

(1) Description of corrective actions, including milestones;
(2) Timeline for implementation and/or completion of corrective actions;
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS;
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If the CAP is determined to be ineffective, the MHP should inform their county liaison of any additional corrective actions taken to ensure compliance; and
(5) A description of corrective actions required of the MHP's contracted providers to address findings.

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Question 1.1.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services.

Triennial review will focus on timeliness of all urgent appointments and physician appointments.

1. Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
2. Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment

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

- Policy and Procedure 00-68 Timely Access
- Service Request Log
- Notice of Adverse Benefit Determination (NOABD)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP meets timely access to care and services for urgent and physician appointments. There were 34 urgent and 27 physician appointments that did not meet the required timeliness standards. Per the discussion during the review, the MHP stated a shortage of staff has caused timeliness issues in providing services.

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

Question 1.1.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi). The MHP shall establish mechanisms to ensure that network providers comply with the below timely access requirements:

1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements.

2. The MHP shall take corrective action if there is a failure to comply with timely access requirements.

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

- Policy and Procedure (P&P) 00-68 Timely Access
- Service Request Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP monitors and takes corrective action of network providers if they fail to comply with timely access requirements. Per the discussion during the review, the MHP stated timely issues are discussed during children and adult system improvement meetings, but no evidence of these meetings was submitted.

DHCS deems the MHP out of compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi).

Question 1.2.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth meet medical necessity criteria need ICC and IHBS.

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

- P&P IA-002 ICC Policy
- ICC & IHBS POS Dashboard
- ICC Screening Tool
- ICC Caseload
- ICC Log
- ICC Service Delivery Flowchart

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth for medical necessity criteria for ICC services. During the clinical review of MHP's children service, it was determined that the MHP was not assessing children and youth for ICC services.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Question 1.2.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

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

- TFC Memo
- TFC sample scope of work
- TFC withdrawal memo
- GSFS PSA request form

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP is providing TFC services to children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated is has been unsuccessful in securing a TFC provider.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Question 1.2.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

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

- TFC Memo
- TFC Sample Scope of Work
- TFC Withdrawal Memo
- GSFS PSA Request Form

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth for medical necessity criteria for TFC services. Per the discussion during the review, the MHP stated that

children and youth are being assessed for the TFC services, however, the MHP did not submit any evidence of actual practice or use of a screening tool assessment.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Question 1.4.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a) (1). The MHP must comply with following;

- The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

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

- New Provider Application

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP gives practitioners or groups of practitioners written notice of the reason for a decision not to contract with a practitioner or practitioner group. Per the discussion during the review, the MHP stated it would provide additional evidence do demonstrate compliance for this requirement. However no additional evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a)(1).

Question 1.4.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

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

- Sample Recertification Packet
- P&P 45-10-04 Certification/Recertification Requirements for Mental Health Plan Providers

INTERNAL DOCUMENTS REVIEWED:

- Provider Monitoring Report

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP consistently recertifies its subcontract providers. This requirement was not included in any evidence provided by the MHP. According to the Provider Monitoring Report, 11 of 34 providers were overdue for recertification. Per the discussion during the review, the MHP stated recertification has been difficult due staffing shortages and the COVID-19 pandemic.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

CARE COORDINATION AND CONTINUITY OF CARE

Question 2.1.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP Contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, section 438, subdivision 208(b)(1). The MHP must provide the beneficiary information on how to contact their designated person or entity.

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

- P&P 00-13 Interface between Mental Health and Physical Health
- P&P 35-02-02 Post Acute Psychiatric Hospitalization
- Job Specifications-Clinical Social Worker I
- Job Specifications-Clinical Social Worker II
- Job Specifications-Mental Health Case Manager

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides the beneficiary information on how to contact their designated person or entity. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated the assigned clinician contacts the beneficiary via phone. The MHP did not submit evidence for this communication.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, section 438, subdivision 208(b)(1).

Question 2.3.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 415(a). The MHP must make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP.

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

- P&P 00-13 Interface between Mental Health and Physical Health Service Providers
- Quick Psych Guide

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides clinical consultation and training to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated prior to COVID-19, the MHP conducted monthly trainings and presentations. The MHP did not provide documented evidence of these trainings or presentations.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 415(a).

Question 2.4.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, subdivision 370(a)(5). The MHP must has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. Also, when the dispute involves an MCP continuing to provide services to a beneficiary the MCP believes requires SMHS from the MHP, the MHP shall identify and provide the MCP with the name and telephone number of a psychiatrist or other qualified LMHP available to provide clinical consultation, including consultation on medications to the MCP provider responsible for the beneficiary's care.

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

- Blue Cross of California Partnership Plan
- Blue Cross of CA-Mental Health Plan MOU Agreement
- Health Net Amendment

- Health Net MOU

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's Memorandum of Understanding (MOU) with Health Net includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while disputes are being resolved. Per the discussion during the review, the MHP stated it would update the Health Net MOU to meet this requirement.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, subdivision 370(a)(5).

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.1.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3). The MHP must have mechanisms to detect both underutilization and overutilization of services.

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

- Tulare ACA Approved Claims CY17-19
- Tulare FC Approved Claims Report CY17-19
- Tulare TAY Approved Claims Report CY 17-19
- P&P 45-04-01 Annual Review of Quality Improvement Program and Utilization Management Activities by the Mental Health Plan

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a mechanism to detect both underutilization and overutilization of services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it does not have a mechanism in place for this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3).

Question 3.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision

236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must have practice guidelines, which meet the requirements of the MHP Contract.

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

- P&P 42-09 Practice Guidelines
- Documentation Manual

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP has practice guidelines which meet the requirements of the MHP contract. Per the discussion during the review, the MHP stated it would submit additional evidence post review to demonstrate compliance, however no additional evidence was submitted.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Question 3.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

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

- P&P 42-09 Practice Guidelines
- Documentation Manual

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP disseminates practice guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. Per the discussion during the review, the MHP stated it would submit additional evidence post review to demonstrate compliance, however no evidence was submitted.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Question 3.5.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.

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

- P&P 42-09 Practice Guidelines
- Documentation Manual

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has taken steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. Per the discussion during the review, the MHP stated it would submit additional evidence post review to demonstrate compliance, however no evidence was submitted.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.1.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(f)(1). The MHP must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider.

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

- P&P 35-01-02 Termination of Tulare County Mental Health Plan Contract Provider

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides written notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice to

each beneficiary who was seen on a regular basis by the terminated provider. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would update the policy and procedure to reflect the 15-calendar day timeline. The updated document was not received by DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(f)(1).

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 Monday, October 26, 2020, at 11:26 a.m. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in crisis. The caller responded in the negative. The caller explained that he/she has been feeling depressed and isolated because he/she is the sole caregiver for a sick parent. The operator asked the caller for his/her personal identifying information and the caller provided the requested information. The operator informed the caller he/she has reached the crisis line and proceeded to look up the nearest clinic to the caller's address with business hours, phone number, and service information. The operator transferred the caller to the adult clinic. The call was answered within one (1) ring via a live operator. The operator requested personal identifying information and the caller provided the information. The caller informed the operator he/she was feeling depressed and isolated. The operator provided information on how to receive mental health services including the assessment and intake process.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING
The call is deemed *in compliance* with the regulatory requirements with 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 Monday, November 2, 2020 at 3:18 p.m. The caller received a message stating that call did not go through. The caller attempted to call again at 3:20 p.m. for which the caller received the same message.

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 #3
Test call was placed on Thursday, March 18, 2021, at 7:45 a.m. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in crisis and the caller replied in the negative. The caller explained that his/her son is having problems at school and has been more disruptive during distance learning. The operator asked for the caller's son's name, date of birth, city of residence, and if he has Medi-Cal. The caller provided the requested information. The operator proceeded to provide the caller with a clinic address and hours of operation. The operator explained to the caller to call the clinic after 8:00 a.m. to enroll his/her son in mental health services.

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

FINDING
The call is deemed in *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, June 11, 2021 at 9:59 am. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in a crisis and the caller replied in the negative. The caller explained that he/she recently moved to the county and needs assistance in refilling his/her anxiety medication. The operator asked the caller for his/her name and date of birth which the caller provided. The operator

proceeded to ask if the caller has Medi-Cal and what area of the county the caller resides in. The caller provided the requested information. The operator provided the caller with the phone number for Visalia Adult Integrated Services and explained the process for getting his/her anxiety medication refilled.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING
The call is deemed *in compliance* with the regulatory requirements with 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 Tuesday, July 13, 2021, at 12:02 p.m. The line rang seven (7) times and was not answered.

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 #6
Test call was placed on Friday, April 2, 2021, at 4:18 p.m. The call was answered after two (2) rings via a live operator. The operator immediately asked if the caller was experiencing a crisis and the caller responded in the negative. The caller asked for information on how to file a complaint about a therapist. The operator asked the caller for personally identifying information so that the call could be logged and the operator could return the call if they were disconnected. The caller provided his/her first and last name, but declined to provide a phone number. The operator was thorough in providing instructions and details on the grievance, appeal, expedited appeal, and State Fair Hearing processes. The operator provided help line numbers, office locations, and hours of operation where the caller could pick up the grievance forms and information, as well as how to find the forms and information online.

The operator provided the caller with information about how to use the beneficiary problem resolution and fair hearing process.

FINDING
The call is deemed *in compliance* with the regulatory requirements with 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, July 9, 2021, at 3:55 p.m. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in crisis and the caller replied in the negative. The caller requested information about how to file a complaint against a therapist in the county. The operator asked the caller to provide his/her name and phone number. The caller provided his/her name, but declined to provide a phone number. The operator asked if the caller was a Medi-Cal beneficiary and the caller replied yes. The operator explained that the caller could pick up a packet to file a grievance in the office or file a complaint by phone. The operator explained the process of completing the form and the appeal process.

The caller was provided information on how to use the beneficiary problem resolution and fair hearing processes.

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

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	OOC	IN	IN	OOC	N/A	N/A	60%
3	IN	OOC	N/A	IN	OOC	N/A	N/A	50%
4	N/A	N/A	N/A	N/A	N/A	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).

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:

- P&P 35-04-08 Procedure for Logging Every Request for Specialty Mental Health Services in Access Log
- Avatar Access Log

While the MHP submitted evidence to demonstrate compliance with this requirement, four (4) of five (5) required DHCS test calls were not logged on the MHP's written log of initial requests. 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	10/26/2020	11:26 AM	IN	IN	IN
2	11/2/2020	3:18 PM	OOC	OOC	OOC
3	3/18/2021	7:45 AM	OOC	OOC	OOC
4	6/11/2021	9:59 AM	OOC	OOC	OOC
5	7/13/2021	12:02 PM	OOC	OOC	OOC
Compliance Percentage			**20%**	**20%**	**20%**

Note: Only calls requesting information about SMHS, including services needed to treat a beneficiary's urgent condition, are required to be logged.

DHCS deems the MHP *in partial compliance* with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.1.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c). The MHP must notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

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

- P&P 00-02-02 Access to Specialty Mental Health Services
- P&P 45-04-01 Annual Review of Quality Improvement Program and Utilization Management Activities by the Mental Health Plan

- P&P 45-04-02 Utilization Review Committee Peer Review of Outpatient Medical Records
- P&P 45-06-06 Utilization Review of Inpatient Treatment Authorization Requests
- P&P 45-13 Prior Authorization for Outpatient Specialty Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP notifies the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no evidence was received by DHCS.

DHCS deems the MHP out of compliance with MHP contract; exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c).

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.5

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

1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.
2. The acknowledgment letter shall include the following:
    a. Date of receipt
    b. Name of representative to contact
    c. Telephone number of contact representative
    d. Address of Contractor
3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

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

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Sample Acknowledgement Letters
- Grievances and Appeal Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by that the MHP acknowledges receipt of each grievance and appeal within five (5) calendar days.

In addition, DHCS reviewed grievances, 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	**20**	**19**	**1**	**95%**
APPEALS	**11**	**7**	**4**	**64%**
EXPEDITED APPEALS	**N/A**	**N/A**	**N/A**	**N/A**

DHCS deems the MHP partial compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E.

Question 6.2.1

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 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.

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

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Grievances and Appeal Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP records grievances and appeals in the log within one (1) working day of the date of receipt of the grievance and appeal. Of the grievances and appeals reviewed, one (1) out of the 20 grievances and zero (0) out of the four (4) appeals were logged within one (1) working day. Per the discussion during the review, the MHP stated due to previous staffing issues, the grievance and appeal log was not maintained correctly.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

Question 6.3.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision BH IN No. 19-041b)(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:

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Grievances and Appeal Log
- Resolution Letters

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the MHP receives the grievance. Per the discussion during the review, the MHP stated due to previous staffing issues, the grievance and appeal log was not maintained correctly

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	**20**	**18**	**2**	**N/A**	**90%**
APPEALS	**11**	**11**	**0**	**N/A**	**100%**
EXPEDITED APPEALS	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

DHCS deems the MHP partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1).

Question 6.4.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a); 408(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:

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Grievances and Appeal Log
- Appeal Memo-missing appeals

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP resolves each appeal and provides notice to the beneficiary within 30 calendar days from the day the MHP receives the appeal. Per the discussion during the review, the MHP stated that due to the resignation of staff, the MHP was unable to locate nine (9) appeals from fiscal year 2019-2020, therefore, the MHP was unable to resolve them within the required appeal timeframe. The MHP submitted a memo post review supporting this claim.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a); 408(b)(2).

Question 6.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c). At the beneficiary's request, the MHP must continue or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until all of the below listed occurs:

1. The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
2. The appeal involves the termination, suspension, or reduction of previously authorized services;
3. The services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired; and,
5. The beneficiary timely files for continuation of benefits.

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

- P&P 00-46 Beneficiary Problem Resolution
- Appeal Receipt Template
- Beneficiary Handbook
- Appeal Form
- NAR-Your Rights
- SFH Pamphlet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending and continues benefits until all the requirements are met as stated in the regulation. The evidence, including policies and procedures, as well as other documentation, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated that additional evidence would be submitted to demonstrate compliance for this requirement, however no evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c).

Question 6.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c). At the beneficiary's request, the MHP must continue or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the below listed occurs:

1. The beneficiary withdraws the appeal or request for a State Hearing;
2. The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (e.g.), NAR) to the beneficiary's appeal;
3. A State Hearing office issues a hearing decision adverse to the beneficiary.

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

- P&P 00-46 Beneficiary Problem Resolution
- Appeal Receipt Template
- Beneficiary Handbook
- Appeal Form
- NAR-Your Rights
- SFH Pamphlet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending and continues benefits until at least one requirement is met as stated in the regulation. This requirement was not included in any evidence provided by the MHP. The evidence, including policies and procedures, as well as other documentation, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated that additional evidence would be submitted to demonstrate compliance for this requirement, however no evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c).

PROGRAM INTEGRITY

Question 7.2.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 14, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(4). The MHP must ensure the MHP, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the MHP Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to DHCS as listed below:

1. Any potential fraud, waste, or abuse.
2. All overpayments identified or recovered, specifying the overpayments due to potential fraud.
3. Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MHP.

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

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly reports to DHCS when information about a change in a network provider's circumstances affects the network provider's eligibility to participate in the managed care program. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional documentation was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 14, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(4).

Question 7.2.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. If the MHP identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying DHCS, the MHP must conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

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

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- P&P 45-04-03 Processing Disallowed Claims

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies DHCS if the MHP receives notification of a complaint concerning an incident of potential fraud, waste, or abuse. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no evidence was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Question 7.4.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a). As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

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

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges

- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires its providers to consent to criminal background checks including fingerprinting as a condition of enrollment. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it was not aware of this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a).

Question 7.4.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13. The MHP must require providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.

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

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures
- Provider contracts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires its network providers to submit updated disclosures to the MHP before renewing the network providers' contracts within 35 days of change of ownership and annually. This requirement was not included in any evidence provided

by the MHP. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13.

Question 7.4.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

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

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures
- Provider contracts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosures and updated disclosures to DHCS as required per regulations. This requirement was not included in any evidence provided by the MHP. The evidence, including disclosure forms, as well as other documentation, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated it would provide additional evidence, however no additional evidence was received.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Question 7.4.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2). The MHP must submit disclosure to DHCS of identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

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

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures
- Provider contracts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosure to DHCS of identity of any person who has been convicted of a crime related to federal health care programs. This requirement was not included in any evidence provided by the MHP. The evidence, including disclosure forms, as well as other documentation, was deficient in meeting the requirements.

Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2).

Questions 7.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 602(b)(d) and section 455, subdivision 436 and MHP Contact Exhibit A, Att. 13. The MHP must has a process, at the time of hiring/ contracting, to confirm the identity and exclusion status of all providers (employees, network providers, subcontractors, person's with ownership or control interest, managing employee/agent of the MHP). This includes checking the:

1. Social Security Administration's Death Master File.

2. National Plan and Provider Enumeration System (NPPES)
3. Office of the Inspector General List of Excluded Providers and Entities(LEIE)
4. System of Award Management (SAM)
5. Department's Medi-Cal Suspended and Ineligible List (S&I List). MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438.602(b)(d) and 455.436)

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

- P&P 45-10-15 Staff Credentialing
- Verification Log-Death Index
- Verification Log-Medi-Cal Ineligibility
- Verification Log-NPPES
- Verification Log-OIG
- Verification Log-SAM

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP has a process to confirm the identity and exclusion status of all providers at the time of hire. The policy and procedure submitted by the MHP only states that the Master Death Index is checked at the time of hire for all providers. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional evidence was received by DHCS. .

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 602(b)(d); section 455, subdivision 436 and MHP Contact Exhibit A, Att. 13.

Repeat deficiency Yes

Questions 7.5.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4). The MHP promptly notifies DHCS if the MHP finds a party that is excluded.

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

- P&P 45-10-15 Staff Credentialing

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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that additional evidence would be

submitted to demonstrate compliance for this requirement, however no additional evidence was received by DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4).