CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2019/2020

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE TUOLUMNE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: June 2, 2020 to June 3, 2020

Tuolumne County Mental Health Plan
FY 2019/2020 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

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EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted an onsite review of the Tuolumne County MHP's Medi-Cal SMHS programs on June 2, 2020 to June 3, 2020. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2019/2020 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

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

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

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

This report details the findings from the Medi-Cal SMHS Triennial System Review of the Tuolumne County MHP. The report is organized according to the findings from each section of the FY 2019/2020 Protocol and the Attestation deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS.

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

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

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

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

Review Findings Overview

- During the DHCS review, the Tuolumne County MHP demonstrated numerous strengths, including but not limited to the following examples:
    - Feedback from the Community Cultural Collaborative and collaboration with nearby counties positively influencing choice of cultural competence trainings

  - Establishing collaborative working relationships with education, probation, law enforcement departments and other community partners

- DHCS identified opportunities for improvement in various areas, including:
  - Recent changes in leadership
  - Vacancy in ICC/IHBS Coordinator position
  - Incomplete database check process
  - Some policies still in draft format needing finalization and implementation

Questions about this report may be directed to DHCS via email to MCBHDMonitoring@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 compliance with Federal Code of Regulation, title 24, 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:

- Policy: Access to Behavioral Health (1/17/2019)
- Behavioral Health Clinician I/II/III Recruitment Posting

In addition, DHCS reviewed the Network Adequacy Internal Compliance Data. Per internal compliance review, the MHP did not resolve the Network Adequacy CAP on children/youth outpatient SMHS provider capacity for FY18-19.

DHCS deems the MHP out of compliance with Federal Code of Regulation, Title 24, Section 438, subdivision 207(b)(1). The MHP must comply with CAP requirement per the Network Adequacy Findings Report addressing this finding of non-compliance.

REQUIREMENT
The MHP shall 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. (Fed. Code Regs, tit. 42, § 438, subd. 206(c)(1)(i).)

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.

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

- Policy: Access to Behavioral Health (1/17/2019)
- Policy: Urgent/ Emergent/Follow up care (12/16/2013)
- Sample of Urgent Request Log

- Urgent Request Reports

DHCS also reviewed Network Adequacy Internal Compliance Data.

The MHP's policies did not reflect the current timeliness standard for urgent appointments. During the review, the MHP acknowledged that the policy needs to be updated to reflect the current timeliness standard for urgent appointments.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must comply with the CAP requirements per Network Adequacy Findings Report addressing this finding of non-compliance.

REQUIREMENT
The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need ICC and IHBS. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

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 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:

- Katie A, ICC and IHBS CY 2020 List
- Katie A and ICC and IHBS CY 2019 List
- Katie A Subclass Eligibility Assessment
- Katie A Program Services Policy (2/21/2019)

Though the MHP submitted some evidence of compliance for this requirement, during the review, the MHP reported that they did not have specific tools to determine ICC/IHBS needs. The MHP reported that there is only one ICC coordinator position for the MHP, which has been vacant since January 2020. The MHP reported that the function for the vacant ICC coordinator position is covered by the managers and the other clinicians as needed. However, the list of ICC/IHBS service recipient for CY2019 (June 2019-December 2019) indicated eleven (11) beneficiaries received ICC/IHBS services, while the CY2020 (January 2020 to June 2020) list indicated zero (0) beneficiary received ICC/IHBS services.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for ICC, IHBS, and TFC for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
There is an established ICC Coordinator, as appropriate, who serves as the single point of accountability. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

FINDING

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an established ICC Coordinator, as appropriate, who serves as the single point of accountability.

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

- ICC Clinician Job Duties and Description
- ICC Clinician Duty Statement

Though the MHP submitted a copy of the ICC clinician's job description, during the review, the MHP reported that there is only one ICC Coordinator position allocated at the MHP and the position has been vacant since January 2020. The MHP reported that the function of the ICC coordinator is covered by the Managers and other clinicians as needed. There was no additional evidence of implementation submitted to ensure the covering clinician is trained in the ICC coordinator's job duties.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

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:

- Copy of report to CalEQRO regarding TFC

Though the MHP submitted some evidence, during the review, the MHP reported that the MHP does not have any TFC providers and is not providing TFC services at this time.

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

REQUIREMENT
The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

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:

- Copy of report to CalEQRO regarding TFC

Though the MHP submitted some evidence for this requirement, the MHP reported during the review that the MHP currently does not have any TFC providers and does not have an established mechanism to take an affirmative responsibility to determine TFC needs.

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

REQUIREMENT
The MHP shall have written policies and procedures for selection and retention of providers. (Fed. Code Regs., tit. 42, § 438, subd. 214(a).)
The MHP's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (Fed. Code Regs., tit. 42,§ 438, subd.12(a)(2) and 214(c).)
The MHP may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. (Fed. Code Regs., tit. 42, § 438, subd. 12(a)(1).)
The MHP must follow a documented process for credentialing and re-credentialing of network providers. (MHSUDS., IN., No. 18-019; Fed. Code Regs., tit. 42,§ 438, subd.12(a)(2) and 214(b).)
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. (Fed. Code Regs., tit. 42 § 438, subd.12(a)(1).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 214(a), (b), (c), (d) and 12(a)(2), and (1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-019. The MHP must comply with following;

- The MHP shall have written policies and procedures for selection and retention of providers.
- The MHP's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- The MHP may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
- The MHP must follow a documented process for credentialing and re-credentialing of network providers.
- The MHP shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
- 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:

- A letter with Subject: Appointment as Deputy Purchasing Agent & Authority Levels
- Telepsychiatry Service RFP Final
- Draft Policy: Provider Credentialing
- RFP's rating sheets for Telepsychiatry contract
- Policy: Civil Rights/Non Discrimination/Harassment (No. 01-16)
- TCBH Contract Training Document
- Policy: Monitoring for Exclusion or Office of Inspector General Debarment (Section III. 10, 12/15/2004)
- Policy: Clinical Staff Licensure (Section III.11, 10/2004)
- SD/MC Provider Certification & Re-

There were no policies and procedures provided for the selection and retention of providers. As such, there was no policy to review to verify that the procedures for selection and retention of providers do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. There was no evidence indicating the MHP's compliance with no discrimination in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The policy on provider credentialing was provided in draft and needs to be finalized and implemented.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 214(a), (b), (c), (d) and 12(a)(2), and (1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-019. 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, chap. 11, § 1810, subd.405(d) and 410(e)(1).)
The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.

FINDING

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). Each MHP must provide a statewide, toll-free telephone number 24 hours a day, seven days per week, 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 January 9, 2020, at 10:01 a.m. The call was initially answered after two (2) rings via a live operator who identified herself as Liz. The caller requested information about the complaint/grievance process. The operator asked the caller if they were inquiring about Behavioral Health. The caller stated in the affirmative. The operator then transferred the caller to the QI Coordinator (Lindsey). The QI Coordinator came on the line, and the caller inquired about the complaint/grievance process. The QI Coordinator informed the caller they could take their complaint by phone, mail the forms to them, or they could come into the office. The caller informed the operator they would come in to pick up the forms. The QI Coordinator informed the caller the forms are near the receptionist and if they could not locate them to ask the receptionist for assistance. The caller was provided information about 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).

TEST CALL #2

Test call #2 was placed on Thursday, February 13, 2020, at 7:18 a.m. The call was answered after nine (9) rings via a live operator. The operator asked the caller if he/she was in crisis at the moment, and the caller replied in the negative. The caller requested information about refilling his anxiety medication. The operator asked for the caller's name and date-of-birth. The caller provided the operator his name and date-of-birth. The operator provided the mental health clinic address, telephone number, hours-of-operation, and the telephone number for the county medication service line. The caller thanked the operator and ceased the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

FINDING

The call is deemed in compliance with the regulatory requirements with 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 Thursday, February 13, 2020, at 12:18 p.m. The call was initially 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 they had Medi-Cal. The caller stated yes. The operator asked the caller to provide their

Medi-Cal number and date-of-birth. The caller stated that she did not feel comfortable and that she only wanted information. The operator advised the caller that she could connect her to the Crisis line if she needs to talk to someone. The caller stated no, that she is not in crisis, was only looking for information, and would like to get an appointment. The operator informed the caller they could call and talk to someone and they would do an assessment. The operator also informed the caller that they have walk-in appointments and provided the address and the phone number. The operator also informed the caller that an assessment is conducted, and if they meet medical necessity, they would call her to see a therapist or psychologist. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and 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, February 21, 2020, at 7:38 a.m. The call was answered after eight (8) rings via a live operator. The operator stated that the caller had reached the Tuolumne County Behavioral Health after-hours line. The caller requested information about accessing mental health services in the county for her son. The operator informed the caller that they had reached the after-hours line and the office would be open in 20 minutes for assistance. The operator inquired as to how old the caller's son was, the caller stated eleven (11). The operator informed the caller that she thought the Tuolumne Behavioral Health Provider took all ages, but needed to check, and placed the caller on a brief hold. After about 28 seconds, the operator came back on the line and informed the caller that they took all ages but suggested the caller call back after 8:00 a.m. to make sure. The operator informed the caller that walk-in appointments are from 8 a.m. to 7 p.m. and asked if the caller had their address. The caller replied in the negative. The operator provided the address. The caller thanked the operator and terminated the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

FINDING
The call is deemed in compliance with the regulatory requirements with 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 Wednesday, February 26, 2020, at 12:05 p.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about refilling her prescription for anxiety medication and that she just moved to the

county and was not established with a doctor yet. The operator asked the caller if she had Medi-Cal. The caller stated yes. The operator asked the caller for her name. The caller provided Shannon. The operator informed the test caller that she could look up her information in the system and connect here with someone from the access team, who could determine how to assist her with the refill. The test caller stated she just wanted to speak to someone. The operator said yes, and placed the test caller on a brief hold. A second operator came on the line, identified herself as Stephanie, and asked how she could help. The test caller informed the second operator with the same information as the first operator. The operator informed the caller that the process could be lengthy and that she did not want the caller to wait for her medication. The operator then explained the intake, assessment, and referral process along with providing the following suggestions: 1) call other clinics in the area, or 2) call her pervious doctor to explain that the caller wouldn't be able to see a new doctor for at least three weeks and ask for a refill. The operator provided several phone numbers for the clinics as well as hours of operations. The caller thanked the operator and terminated the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and 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 Friday, March 6, 2020, at 3:29 p.m. The call was initially answered after eight (8) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator inquired from the caller if they were in crisis. The caller stated in the negative. The operator informed the caller they had reached the after-hours call center because the MHP must be busy and to call back within five (5) minutes. The caller was not provided information about 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 #7
Test call #7 was placed on Tuesday, March 10, 2020, at 9:09 a.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about filing a grievance in the county. The operator informed the caller that there were three ways the caller could receive the forms; they could be mailed; find them on-line, or pick them up in the lobby. The caller was provided information about 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	NA	NA	NA	NA	NA	NA	NA	NA
2	NA	IN	IN	IN	IN	OOC	NA	80%
3	NA	NA	IN	NA	IN	NA	NA	100%
4	IN	NA	NA	NA	NA	NA	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, chap. 11, §1810, subd.405(f)). The written log(s) contain the following required elements:
Name of the beneficiary.
Date of the request.
Initial disposition of the request.

FINDING

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

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

- Access to Behavioral Health Services Policy
- What you will see when you open the Access to care log
- Tuolumne County Behavioral Health Access to Care Log (Blank)
- Procedure: Access to Care Log
- Service Request Log

While the MHP submitted evidence to demonstrate compliance with this requirement, two 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:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
2	2/13/2020	7:18 a.m.	OOC	OOC	OOC
3	2/13/2020	12:18 p.m.	IN	IN	IN
4	2/21/2020	7:44 a.m.	IN	IN	IN
5	2/26/2020	12:05 p.m.	IN	IN	IN
6	3/6/2020	3:39 p.m.	OOC	OOC	OOC
Compliance Percentage			**60%**	**60%**	**60%**

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 in the previous triennial review.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
The MHP must provide beneficiaries with a NOABD under the following circumstances:
The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.(Fed. Code Regs., tit.42, § 438, subd.400(b)(1))

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination under the circumstances listed above.

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

- NOABD Samples from April-Sept 2019
- NOABD Policy
- NOABD blank forms

Though the MHP submitted evidence to demonstrate compliance, DHCS was not able to find the NOABD for 1 out of 63 requests for authorization. At the review, the MHP confirmed that the MHP could not find the NOABD for this particular request.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must complete a CAP addressing this finding of non-compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
The MHP's appeal process shall, at a minimum:
Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the beneficiary (Fed. Code Regs., tit. 42, § 438, subd.406(b)(5).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 402, 406 and 408. The MHP must ensure the MHP's appeal process meets above listed standards.

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

- Draft Beneficiary Rights Policy (No date)
- Appeal form (Blank)
- Client Information: What is an Appeal?
- The Appeal Process (Standard and Expedited)
- Beneficiary Grievance, Appeal, and State Fair Hearing Policy (4/30/2018)
- Beneficiary Appeal Procedure (10/29/2018)
- Notice of Appeal Resolution form (Blank)

Though the MHP provided evidence to demonstrate compliance with this requirement, current policies did not include this requirement. The MHP submitted a draft Beneficiary Rights Policy addressing requirements which had not been implemented at the time of the review. The draft policy needs to be finalized, implemented, and monitored to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 402, 406 and 408. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP's expedited appeal process shall, at a minimum:
Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (Fed. Code Regs., tit 42, § 438, subd.410(b).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, and subdivision 402, 410, 408, and California Code of Regulations, title 9, section 1850, subdivision 207(h). The MHP must ensure the MHP's expedited appeal process complies above mentioned requirements.

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

- Draft Beneficiary Rights Policy (No date)
- The Appeal Process (Standard and Expedited)
- Beneficiary Appeal Procedure (10/29/2018)
- Acknowledgement form (Blank)
- Beneficiary Grievance Process (7/27/2018)
- State Fair Hearing Procedure (6/2018)

Though the MHP provided evidence to demonstrate compliance with this requirement, current policies did not include this requirement. The MHP submitted a draft Beneficiary Rights Policy addressing requirements which had not been implemented at the time of the review. The draft policy needs to be finalized, implemented, and monitored to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, and subdivision 402, 410, 408, and California Code of Regulations, title 9, section 1850, subdivision 207(h). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP must continue the beneficiary's benefits if all of the following occur: a) The beneficiary files the request of an appeal timely in accordance with Federal Code of Regulations, title 42, section 438, subdivision 402(c)(1)(ii) and (c)(2)(ii); b) The appeal involves the termination, suspension, or reduction of previously authorized services; c) The services were ordered by an authorized provider; d) The period covered by the original authorization has not expired; and, e) The beneficiary timely files for continuation of benefits. (Fed. Code Regs., tit. 42, § 438, subd. 420(b).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(b). The MHP must continue the beneficiary's benefits if all of the above listed circumstance occur.

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

- Draft Beneficiary Rights Policy (No date)
- Appeal Form
- The Appeal Process (Standard and Expedited)
- Client Information: What is an Appeal?
- NOABD Policy (6/2018)
- Beneficiary Appeal Procedure (10/29/2018)
- Acknowledgement Form (Blank)

Though the MHP provided evidence to demonstrate compliance with this requirement, current policies did not include this requirement. The MHP submitted a draft Beneficiary Rights Policy addressing requirements which had not been implemented at the time of the review. The draft policy needs to be finalized, implemented, and monitored to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(b). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
If, at the beneficiary's request, the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs: a) The beneficiary withdraws the appeal or request for a State Hearing; b) 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 (i.e., NAR) to the beneficiary's appeal; c) A State Hearing office issues a hearing decision adverse to the beneficiary. (Fed. Code Regs., tit. 42, § 438, subd.420(c).)

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 above listed circumstance.

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

- Draft Beneficiary Rights Policy (No date)
- Appeal Form (Blank)
- The Appeal Process (Standard and Expedited)
- Client Information: What is an Appeal?
- Beneficiary Appeal Procedure (10/29/2018)
- Acknowledgement Form (Blank)
- State Fair Hearing Procedure (6/2018)

Though the MHP provided evidence to demonstrate compliance with this requirement, current policies did not include this requirement. The MHP submitted a draft Beneficiary Rights Policy addressing requirements which had not been implemented at the time of the review. The draft policy needs to be finalized, implemented, and monitored to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c). The MHP must complete a CAP addressing this finding of non-compliance.

PROGRAM INTEGRITY

REQUIREMENT
The MHP shall submit the following disclosures to DHCS regarding the MHP's management:
The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. (Fed. Code Regs., tit.42, § 455, subd.106(a)(1), (2).)
The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. (Fed. Code Regs., tit. 42, § 455, subd.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in Federal Code of Regulations, title 42, section 455, sbud.101.

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106. 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:

- County Policy: Conflict of Interests
- Sample of completed Conflict of Interests forms
- Tuolumne County Human Service Agency, Manual of Policies and Procedures, 08-01: Conflict of Interest and Professional Conduct

Though the MHP submitted some evidence to demonstrate compliance with this requirement, the policy and other evidence submitted did not include mechanisms to submit disclosures to DHCS as needed to comply with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP 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: a) Social Security Administration's Death Master File. b) National Plan and Provider Enumeration System (NPPES) c) Office of the Inspector General List of Excluded Providers and Entities(LEIE) d) System of Award Management (SAM) e) Department's Medi-Cal Suspended and Ineligible List (S&I List). (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438, subd. 602(b)(d) and §455, subd.436)
The MHP has a process to confirm monthly that no providers is on the: a) OIG List of Excluded Individuals/Entities (LEIE). b) System of Award Management (SAM) Excluded Parties List System (EPLS). c) DHCS Medi-Cal List of Suspended or Ineligible Providers (S&I List). (Fed. Code Regs., tit. 42, § 438, subd. 608(d) and §455, subd.436)
If the MHP finds a party that is excluded, it must promptly notify DHCS. (Fed. Code Regs., tit.42, §438, subd.608(a)(2),(4).

FINDING

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

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

- III.10 Monitoring for Exclusion or Office of Inspector General Debarment
- Draft Credentialing Policy

- Sample of new hire documents including following: I-9, Compliance program, computer & ethics, HIPAA, Information security, Oath of confidentiality, orientation checklist, safety program, service documentation and billing certification, vehicle usage
- False Claims act and related state laws policy
- Procedure for Verification of Provider Status
- Breeze Verification Sample End of Month (EOM)
- Provider License Public Record Tracking (102019)
- Provider License Tracking
- Hiring NPI Request form
- Hiring Request NPI Number example
- Procedure EOM_8 Staff listing NPI Verification

Though the MHP submitted multiple evidence to address compliance with this requirement, none of the documents addressed mechanisms and evidence of database checks of the Social Security Administration's Death Master File at the time of hiring/contracting. Also, during the review, the MHP stated that the OIG LEIE is checked only quarterly, not monthly as required. The MHP's policy stated OIG LEIE and EPLS are reviewed on an annual basis for the existing providers. There was no evidence submitted indicating that the MHP has a process to conduct all required database checks on a monthly basis to confirm that no providers are on the LEIE, SAM/EPLS, and S&I List.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608 and section 455, subdivision 436. The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.