CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2018/2019

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE ALPINE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: May 6, 2019 and May 7, 2019

Alpine County Mental Health Plan
FY 2018/2019 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, section 1810.380; DHCS conducts monitoring and oversight activities such as the Medi-Cal SMHS Triennial System and Chart Reviews to determine if the county MHPs are in compliance with Federal and State laws and regulations and/or the contract between DHCS and the MHP.

DHCS conducted an onsite review of the Alpine County MHPs Medi-Cal SMHS programs on May 6, 2019 through May 7, 2019. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2018/2019 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

The Medi-Cal 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

The report is organized according to the findings from each section of the FY 2018/2019 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services, specifically Sections A-H and the Attestation. This report details the requirements 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, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone line and a section detailing information gathered for the "SURVEY ONLY" questions in the Protocol.

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 Plan of Correction (POC) is required for all items determined to be out-of-compliance. The MHP is required to submit a POC to DHCS within 60-days of receipt of the findings report for all system and chart review items deemed out-of-compliance. The POC 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 POC determined not to be effective, the MHP should purpose an alternative corrective action plan to DHCS; and
(5) Description of corrective actions required of the MHP's contracted providers to address findings.

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

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
A.IV.A-The County uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e).).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e). The County uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e).).

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

- Network Adequacy Certification Tool.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations.

DHCS deems the MHP out-of-compliance with the MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
A.IV.B-The MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009. The MHP is required to cover acute

psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009).

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

- Network Adequacy Certification Tool.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older.

DHCS deems the MHP out-of-compliance with the MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
A.VI.C5-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. (42 C.F.R. § 438.214(d).).

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.214(d). 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. (42 C.F.R. § 438.214(d).).

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

- Policy AC-407 Individual and Organizational Provider Selection and Credentialing; and
- Policy AC-353 Provider Contract Development and Monitoring.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that 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.

DHCS deems the MHP out-of-compliance with 442 C.F.R. § 438.214(d). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
A.VI.D8-Do all contracts or written agreements between the MHP and any network provider specify the following: 1) The delegated activities or obligations, and related reporting responsibilities? 2) The subcontractor agrees to perform the delegated activities and reporting responsibilities in compliance with the MHP's contract obligations? 3) Remedies in instances where the State or the MHP determine the subcontractor has not performed satisfactorily? 4) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, and contract provisions, including the terms of the 1915(b) Waiver and any Special Terms and Conditions? 5) The subcontractor may be subject to audit, evaluation and inspection of any books, records, contracts, computer or electronic systems that pertain to any aspect of the services and activities performed, in accordance with 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)? 6) The subcontractor will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medi-Cal beneficiaries? 7) The right to audit will exist through 10 years from the final data of the contract period or from the date of completion of any audit, whichever is later? **8) If the State, CMS, or the HHS Inspector General (Office of Inspector General) determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. (MHP Contract, Ex. A, Att. 1; 42 C.F.R. § 438.230)**

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 1; 42 C.F.R. § 438.230. All contracts or written agreements between the MHP and any network provider specify if the State, CMS, or the HHS Inspector General (Office of Inspector General) determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. (MHP Contract, Ex. A, Att. 1; 42 C.F.R. § 438.230).

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

- Policy and Procedure AC-353 Provider Contract Development and Monitoring; and
- Contract with Kingsview Tele-Psychiatry.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that all contracts or written agreements between the MHP and any network provider specify:

- If the State, CMS, or the HHS Inspector General (Office of Inspector General) determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 1; 42 C.F.R. § 438.230. The MHP must complete a POC addressing this finding of non-compliance.

CARE COORDINATION AND CONTINUITY OF CARE

REQUIREMENT
B.II.A-The MHP shall share with the Department or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(4).).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(4). The MHP shall share with the Department or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(4).).

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

- Policy and Procedure AC-2075 Request for Release of Information or Records;
- Release of Information form; and
- MOU-Blue Cross of California Partnership Plan Inc.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall share with the Department or other managed care entities serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.

DHCS deems the MHP out-of-compliance with the contractual requirements in the MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(4). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
B.II.B-The MHP shall ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(5).).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(5). The MHP shall ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(5).).

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

- Policy and Procedure AC-2075 Request for Release of Information or Records;
- Release of Information form; and
- MOU-Blue Cross-of California Partnership Plan Inc.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.

DHCS deems the MHP out-of-compliance with the contractual requirements in the MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(5). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
B.II.C-The MHP shall ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(6).).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(6). The MHP shall ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(6).).

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

- Policy and Procedure AC-2075 Request for Release of Information or Records;
- Release of Information form; and
- MOU-Blue Cross of California Partnership Plan Inc.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable.

DHCS deems the MHP out-of-compliance with the contractual requirements in the MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(6). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
B.III.B-When the MHP determines that the beneficiary's diagnosis is not included as a SMHS, or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations. (CCR, tit.9, § 1810.415(d).).

FINDING

The MHP did not furnish evidence to demonstrate it complies with CCR, tit.9, § 1810.415(d). When the MHP determines that the beneficiary's diagnosis is not included as a SMHS, or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations. (CCR, tit.9, § 1810.415(d).).

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

- Policy and Procedure AC-404 Clinical Consultation and Training for Primary Care Providers.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP determines that the beneficiary's diagnosis is not included as a SMHS, or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations.

DHCS deems the MHP out-of-compliance with the contractual requirements in the CCR, tit.9, § 1810.415(d). The MHP must complete a POC addressing this finding of non-compliance.

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
D.II.GCb-The MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973: a) Prohibiting the expectation that family members provide interpreter services. **b) A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.** c) Minor children should not be used as interpreters. (Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973)

FINDING

The MHP did not furnish evidence to demonstrate it complies with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

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

- Policy and Procedure AC-160 Meeting Client Cultural and Linguistic needs and Interpreter Services; and
- Free Language Assistance Available poster

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973:

- A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

DHCS deems the MHP out-of-compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
D.VI.B-Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: 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. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

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 it complies with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1). Each MHP must provide:

- 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; and
- The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.

The seven (7) test calls are summarized below:

Test call #1 was placed on Tuesday, January 15, 2019, at 7:20 a.m. The call was answered after three (3) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator informed the caller that there is a lot of calls coming in right now and asked the caller if he/she had any suicidal thoughts or thoughts of hurting him/herself or others. The caller replied in the negative. The operator informed the caller to call back in 10-15 minutes. The caller said ok and thanked the operator and ceased the call. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDINGS

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call #2 was placed on Monday, January 28, 2019, at 5:42 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about refilling his/her medication and informed the operator that he/she is new to Alpine county. The operator informed the caller that Alpine offers a range of services. The operator instructed the caller to call in the morning. The operator repeatedly directed the caller to call between during business hours. The operator reported the caller could call the crisis line again, if they need someone to talk too. The operator informed the caller that if they need immediate help, to go to the nearest emergency room or your pharmacy. The operator offered to assist with finding the nearest emergency room. The caller declined. The operator inquired if the caller was having thoughts of suicide. The caller replied in the negative. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDINGS
DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call #3 was placed on Wednesday, January 30, 2019, at 8:29 a.m. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator provided information to the caller about services. The operator 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 an urgent condition.

FINDINGS
DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call #4 was placed on Thursday, February 7, 2019, at 9:27 a.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide some information. The caller provided the information. The operator asked the caller if he/she is in crisis. The caller replied in the negative. The operator provided detailed information about how to access SMHS, including information about services needed to treat a beneficiary's urgent condition. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and the caller was provided information about services needed to treat an urgent condition.

FINDINGS
DHCS deems the MHP in compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call #5 was placed on Thursday, January 17, 2019 at 7:45 a.m. The call was answered after one (1) ring via a live operator. The operator asked the caller to provide his/her name and contact information. The caller requested information about how to file a complaint regarding the therapist the caller is seeing. The operator provided detail information on how to file a grievance. The caller was provided information about the beneficiary problem resolution process and how to file the grievance.

FINDINGS
DHCS deems the MHP in compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call #6 was placed on Thursday, December 27, 2018 at 7:43 a.m. The call was answered after two (2) rings via a live operator. The operator asked for callers for his/her name and the caller provide his/her name. The operator then asked for additional information, which the caller did not provide. The caller requested information on how to file a complaint. After a few seconds on hold, the operator provided information on how to file a complaint. The caller thanked operator for information and ended the call. The caller was provided information about the beneficiary problem resolution process and how to file the grievance.

FINDINGS
DHCS deems the MHP in compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call #7 was placed on Tuesday, January 22, 2019 at 1:32 p.m. The call was answered after two (2) rings via a live operator. The caller requested information about how to file a complaint against a therapist. The operator provided three options on how to file a grievance. The operator provided the address and hours of operation for the office. The caller was provided information about how to use the beneficiary problem resolution and fair hearing processes.

FINDINGS
DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1).

Test call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
D.VI.B.1	IN	IN	IN	IN	N/A	N/A	N/A	100%
D.VI.B.2	OOC	OOC	IN	IN	N/A	N/A	N/A	50%
D.VI.B.3	IN	IN	OOC	IN	N/A	N/A	N/A	75%
D.VI.B.4	N/A	N/A	N/A	N/A	IN	IN	IN	100%

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- Policy and Procedure AC-180 Access Line and Log-Availability of 24/7 Services; and
- DHCS test calls.

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP's toll-free telephone number did not provide 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 and provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
D.VII.C-The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

FINDING

The MHP did not furnish evidence to demonstrate it complies with CCR title 9, section 1810.410. The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

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

- Policy and Procedure AC-3002 Cultural and Linguistic Competence Program; and
- Cultural Competence Plan.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the CCC completes its Annual Report of CCC activities as required in the CCPR.

DHCS deems the MHP out-of-compliance with the terms of CCR title 9, section 1810.410. The MHP must complete a POC addressing this finding of non-compliance.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
E.I.J-The MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225. The MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

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

- Policy and Procedure AC-120 Authorization Process for Outpatient Mental Health Services; and
- Policy and Procedure AC-172 Inpatient Treatment Authorization Request (TARs).

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.II.A2-The MHP requires providers to request payment authorization for day treatment intensive services at least every 3 months for continuation of Day Treatment. (CCR, title 9, § 1810.227; CCR, title 9, §1810.216 and 1810.253).

FINDING

The MHP did not furnish evidence to demonstrate it complies with CCR, title 9, § 1810.227; CCR, title 9, §1810.216 and 1810.253. The MHP requires providers to

request payment authorization for day treatment intensive services at least every 3 months for continuation of Day Treatment. (CCR, title 9, § 1810.227; CCR, title 9, §1810.216 and 1810.253).

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

- Policy and Procedure AC-660 Day Rehabilitation Services.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP requires providers to request payment authorization for day treatment intensive services at least every 3 months for continuation of Day Treatment.

DHCS deems the MHP out-of-compliance with the terms of CCR, title 9, § 1810.227; CCR, title 9, §1810.216 and 1810.253. The MHP must complete a POC addressing this finding of non-compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
F.I.N-The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a). The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).).

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

- Policy and Procedure AC-360 Client Problem Resolution Guide.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or

beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
F.I.O-The MHP shall provide the beneficiary and his or her representative the beneficiary's case file, including medical records, 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. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(5).).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(5). The MHP shall provide the beneficiary and his or her representative the beneficiary's case file, including medical records, 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. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(5).).

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

- Policy and Procedure AC-360 Client Problem Resolution Guide.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall provide the beneficiary and his or her representative the beneficiary's case file, including medical records, 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.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(5). The MHP must complete a POC addressing this finding of non-compliance.

OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

REQUIREMENT
H.A-The MHP must comply with the requirements of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

FINDING
The MHP did not furnish evidence to demonstrate it complies with W&I Code Sections 14705(c) and 14712(e). The MHP must comply with the requirements of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

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

- Policy and Procedure AC-4015 Cost Report Preparation;
- Email correspondence between DHCS and the MHP (Delinquency Notice); and
- Email correspondence between DHCS and the MHP (Reminder Notice).

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP complied with the requirements of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

DHCS deems the MHP out-of-compliance with the terms of W&I Code Sections 14705(c) and 14712(e). The MHP must complete a POC addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
A.III.F- 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 furnish evidence to demonstrate it complies with 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 provide Therapeutic Foster Care (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:

- Policy and Procedure AC-392 Intensive Services for Medi-Cal Youth/Pathways to Well-Being (Formerly Katie A.).

SUGGESTED ACTION
DHCS is not requiring no further action at this time.

REQUIREMENT
A.III.G- 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 furnish evidence to demonstrate it complies with 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 has 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:

- Policy and Procedure AC-392 Intensive Services for Medi-Cal Youth/Pathways to Well-Being (Formerly Katie A.).

SUGGESTED ACTION
DHCS is not requiring no further action at this time.

CARE COORDINATION AND CONTINUITY OF CARE

REQUIREMENT
B.III.C-The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.62(b)(1)-(2).).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.62(b)(1)-(2). The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.62(b)(1)-(2).).

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

- Develop policies and procedures to address the requirements.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
E.I.H2-The MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

FINDING
The MHP did furnish evidence to demonstrate it complies that the MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

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

- Authorization process for Outpatient Mental Health Services.

SUGGESTED ACTION
DHCS is not requiring no further action at this time.