CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

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

SYSTEM FINDINGS REPORT

Review Dates: January 10, 2023 to January 11, 2023

Humboldt County Mental Health Plan
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EXECUTIVE SUMMARY

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

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

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

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

In accordance with the California Code of Regulations, title 9, chapter 11, § 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 review of the Humboldt County MHP's Medi-Cal SMHS programs on January 10, 2023 to January 11, 2023. 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) 2022/2023 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 Humboldt County MHP. The report is organized according to the findings from each section of the FY 2022/2023 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, the 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 1.2.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with the BHIN No. 21-073 and 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 beneficiary access criteria for SMHS as medically necessary.

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

- 1001.402 Authorization and Referral Process for Therapeutic Foster Care
- FY21-22 through 22-23 Contracted Organizational Provider Scope Redwood Community Services Inc.
- ICC Training Revised Cway updated with Question Slide 6_24_22
- 1246 Therapeutic Foster Care (TFC) Assessment
- 1247 Therapeutic Foster Care (TFC) Authorization - Medical Necessity
- Authorization and Referral Process for Therapeutic Foster Care
- Statement regarding provision of TFC services and list of beneficiaries

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. Per the discussion during the review, the MHP has a contracted TFC provider; however, the contract provider has experienced challenges in recruiting and training TFC families and has been unable to provide this service.

DHCS deems the MHP out of compliance with the BHIN No. 21-073 and 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 BHIN No. 21-073 and 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 beneficiary access criteria for SMHS need TFC.

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

- 1001.402 Authorization and Referral Process for Therapeutic Foster Care
- FY21-22 through 22-23 Contracted Organizational Provider Scope Redwood Community Services Inc.
- ICC Training Revised Cway updated with Question Slide 6_24_22
- 1246 Therapeutic Foster Care (TFC) Assessment
- 1247 Therapeutic Foster Care (TFC) Authorization - Medical Necessity
- Authorization and Referral Process for Therapeutic Foster Care
- Statement regarding provision of TFC services and list of beneficiaries
- 1.2.8 Statement

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth to determine if they meet medical necessity criteria for TFC. Per the discussion during the review, the MHP stated it has developed a TFC assessment process; however, it has not screened for TFC as this service is currently unavailable.

DHCS deems the MHP out of compliance with the BHIN No. 21-073 and Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Repeat deficiency Yes

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.1.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 1(C); and Code of Federal Regulations, title 42, section 438, subdivision 330(a)(1), (e)(2). The MHP must have a written description of the Quality Assessment and Performance Improvement Program addressing the below listed requirements:

1. Clearly defines its structure and elements,
2. Assigns responsibility to appropriate individuals, and
3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement.

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

- 0100.106 Quality Improvement
- 0704.020 Scope of Responsibilities
- QI Work Plan FY 2021-2022

- QI Work Plan FY 2022-2023
- QI Work Plan FY 2020-2021 Evaluation
- QI Work Plan FY 2021-2022 Evaluation
- QI Work Plan FY 2021-2022 Evaluation with quantitative highlights
- QI Work Plan FY 2022-2023 with quantitative highlights
- QAPI Work Plan Statement

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a written Quality Assessment and Performance Improvement (QAPI) program that adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement. Per the discussion during the review, the MHP described its QAPI Work Plan as including the entirety of the quality improvement process. Post review, the MHP provided a written statement and a QAPI Work Plan with highlighted data; however, it was not evident that all goals had established quantitative measures to assess performance.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 1(C); and Code of Federal Regulations, title 42, section 438, subdivision 330(a)(1), (e)(2).

Question 3.2.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 2(a)(5). The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence.

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

- QI Work Plan FY 2020-2021 Evaluation
- QI Work Plan FY 2021-2022 Evaluation
- QI Work Plan FY 2021-2022
- QI Work Plan FY 2022-2023
- OP CQI Agenda Tracking
- Statement regarding 3.2.6
- Language Line Services Inc. Agreement FY2021-2025
- 0100.600 Request for Access to Mental Health Services 11-02-20
- 0704.271 Test Calls to the Toll-Free Access Number
- 0.100.305 Cultural Competence Committee
- 0100.150 Racial and Cultural Equity in Behavioral Health
- 0100.151 Racial and Cultural Equity Document Review in Behavioral Health (CR 090821)
- 0100.152 Racial and Cultural Equity Budget Review in Behavioral Health

- MH-20 BH Policy and Procedure Equity Review Tool
- Interpreter Utilization FY 21-22 Q4
- Interpreter Utilization FY 22-23 Q1
- Sample of BH CRC Learning Opportunities 2021-2022
- Sample of Cultural Competency & Awareness Training

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's QAPI Work Plan includes evidence of compliance with the requirements for linguistic competence. Per the discussion during the review, the MHP stated it had evidence of meeting this requirement and would provide additional evidence. Post review, the MHP provided a statement that it addresses this requirement through its Cultural Responsiveness Committee and trainings; however, the MHP acknowledged it had not included this requirement in the 2022-2023 QAPI Work Plan and would do so moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 2(a)(5).

Question 3.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 6(A); Code of Federal 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:

- DHHS 92 New Program Implementation Worksheet
- DHHS 94 EBP Consideration Checklist
- DHHS Programs and Services Guide 2023
- NEW PROGRAM IMPLEMENTATION GUIDE
- Practice Guidelines Evidence on Website
- QMS 680 Outcome Measurement Tools for Clients in Overlapping Programs
- The Hexagon Tool
- Access Training v4 2020
- Chart Review Training 1.7
- New Clients Forms Training v.2
- NOABD Training
- Outpatient Documentation Training RELIAS VER
- Statement regarding staff resources
- Organizational Provider Manual

- Implementation Plan 2022-04-20 update
- FFS Provider Manual
- BH Services and Programs 2020 (provides more in depth information about EBPs – treatment/reason)
- 0704.380 Documentation Training
- 0704.370 QM Chart Review
- 0704.690 Medical Necessity and Access Criteria for SMHS
- Organizational Provider Professional Services Agreement (boilerplate)
- Contractor Professional Services Agreement (boilerplate)
- MH-20 BH Policy and Procedure Equity Review Tool
- 0100.151 Racial and Cultural Equity Document Review in Behavioral Health (CR 090821)
- 0.100.305 Cultural Competence Committee

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established practice guidelines that meet the requirements of the MHP Contract. Per the discussion during the review, the MHP stated it has established and implemented practice guidelines and would provide evidence post review. Post review, the MHP submitted implementation guides, trainings, and evidence based programs that it has established; however, it was not evident practice guidelines are established.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 6(A); Code of Federal 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, section 6(c); Code of Federal Regulations, title 42, section 438, subdivision 236(c); 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:

- DHHS 92 New Program Implementation Worksheet
- DHHS 94 EBP Consideration Checklist
- DHHS Programs and Services Guide 2023
- NEW PROGRAM IMPLEMENTATION GUIDE
- Practice Guidelines Evidence on website
- QMS 680 Outcome Measurement Tools for Clients in Overlapping Programs
- The Hexagon Tool

- Access Training v4 2020
- Chart Review Training 1.7
- New Clients Forms Training v.2
- NOABD Training
- Outpatient Documentation Training RELIAS VER

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the guidelines to all affected providers, and upon request, beneficiaries and potential beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it would look to identify a policy that includes these requirements. Post review, no additional evidence was provided to demonstrate this practice is occurring.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 6(c); Code of Federal Regulations, title 42, section 438, subdivision 236(c); and California Code of Regulations, title 9, section 1810, subdivision 326.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.2.2

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 Friday, October 28, 2022, at 10:27 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 concerning his/her child's mental health and disruptive behavior in school. The operator provided the caller the number for child and family services and transferred the caller. Once the caller was transferred to the second operator, the caller repeated his/her request. The operator explained the services available through the county's system of care as well as the process required to schedule an appointment with a therapist.

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 #2

Test call was placed on Sunday, November 7, 2022, at 3:04 p.m. The call was answered immediately via a recorded message that stated the call would be answered by the next available operator. The call was disconnected after being placed on hold for approximately 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. 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, November 3, 2022, at 8:07 a.m. The call was answered after one (1) ring via a live operator. The caller explained he/she was the sole caregiver for his/her ill mother and had been feeling isolated and depressed. The caller was put on a brief hold as the operator was experiencing computer issues. After approximately 30 seconds on hold, a second operator answered the call. The caller again explained why he/she was calling. The operator requested personally identifying information, which the caller provided. The operator then explained that once a licensed clinician was able to complete the screening and assessment, the caller would receive a referral for treatment, which would include counseling and consultation with a psychologist. The operator provided the caller the phone number to the 24/7 crisis line should the caller experience an urgent condition.

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 #4
Test call was placed on Friday, December 16, 2022, at 9:45 a.m. The call was answered via a live operator after one (1) ring. The caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator requested personally identifying information, which the caller provided. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the intake process and informed the caller that the appointment wait time was currently two (2) months and offered to transfer the caller to an intake coordinator who would begin the assessment process. The caller declined and ended the call.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. 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 Friday, November 18, 2022, at 5:23 p.m. The call was answered after two (2) rings via recorded message that instructed the caller to wait for the next available operator. A live operator answered the call after approximately two (2) minutes. The caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The caller was then placed on a brief hold for approximately 30 seconds. The operator returned to the call and stated that the office was closed, but the caller could leave a message for a return call or call the clinic back during business hours to make an appointment. The operator provided the business hours and clinic's location.

The caller was not provided information on 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 *partial compliance* with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

TEST CALL #6
Test call was placed on Thursday, December 8, 2022, at 8:47 a.m. The call was answered after one (1) ring via a live operator. The caller asked how to file a complaint in the county. The operator advised the caller that the grievance forms are located in the clinic lobby. The operator also offered to mail a grievance form to the caller.

The caller was provided 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, October 28, 2022 at 5:25 p.m. The call rang nine (9) times before a recorded message informed the caller that the party was not answering. The call was then disconnected.

The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process.

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

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	OOC	IN	IN	IN	N/A	N/A	80%
3	N/A	OOC	IN	IN	OOC	N/A	N/A	50%
4	N/A	N/A	N/A	N/A	N/A	IN	OOC	50%

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 4.2.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, 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:

- 0100.600 Request for Access to Mental Health Services 11-02-20
- 0704.271 Test Calls to the Toll-Free Access Number
- 24-7 Access Line Call Log
- 4.2.4 Statement

While the MHP submitted evidence to demonstrate compliance with this requirement, four of the 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
1	10/28/2022	10:27 a.m.	OOC	IN	IN
2	11/6/2022	3:04 p.m.	OOC	OOC	OOC
3	11/3/2022	8:07 a.m.	OOC	OOC	OOC
4	12/16/2022	9:45 a.m.	OOC	OOC	OOC
5	11/18/2022	5:23 p.m.	OOC	OOC	OOC
Compliance Percentage			**0%**	**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 5.2.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Code of Federal Regulations, title 42, section 438, subdivision 210(b)(1); and California Code of Regulations, title 9, section 1810, subdivision 440(b)(2)(i-ii). The MHP must establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Authorization procedures and utilization management criteria shall:

a. Be based on medical necessity and consistent with current evidence- based clinical practice guidelines, principles, and processes;
b. Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice;
c. Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's beneficiaries and network providers.

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

- Blast fax to regularly used facilities
- Letter to Inform Hospitals of Concurrent Review Authorization Process Restpadd Redbluff
- Letter to Inform Hospitals of Concurrent Review Authorization Process Restpadd Redding
- Letter to Inform Hospitals of Concurrent Review Authorization Process StarView
- 0704.660 Inpatient Hospitalization Authorization
- 0704.625 Consistency in Inpatient Utilization Review and Authorization Practices -TAR-Invoice Accuracy Reviews
- 0704.620 Treatment Authorization Requests
- 0100.317 Out-Of-County Psychiatric Hospitalization Placement
- 5.2.2 Statement

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP engaged and collaborated with network and organizational providers, hospitals, and other licensed mental health stakeholders to develop its inpatient concurrent review authorization policies and procedures. Per the discussion during the review, the MHP stated it had evidence of meetings and email communications documenting this requirement. Post review, the MHP submitted announcement letters to county providers; however, it is not evident that its process was developed with involvement from network providers per the requirement.

DHCS deems the MHP out of compliance with BHIN 22-017; Code of Federal Regulations, title 42, section 438, subdivision 210(b)(1); California Code of Regulations, title 9, section 1810, subdivision 440(b)(2)(i-ii).

Question 5.3.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice No. 18-027 and Welfare and Institution Code 14717.1, subdivision (b)(2)(F), (g). The MHP must have a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction.

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

- 1001.105 Incoming Presumptive Transfer of Medi-Cal
- 1001.109 Outbound Presumptive Transfer of Medi-Cal
- Presumptive Transfer Dashboard
- Presumptive Transfer Tracking CY2022
- Presumptive Transfer (Dashboard)
- PT Authorization Database
- Presumptive Transfer Samples
- 5.3.1 & 5.3.2 Statement

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. Per the discussion during the review, the MHP acknowledged that its Presumptive Transfer policy is insufficient and out of date. Post review, the MHP submitted a statement explaining that while the scenario has not occurred during the review period, it acknowledged the need to update its policy moving forward.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice No. 18-027 and California Welfare and Institution Code 14717.1, subdivision (b)(2)(F), (g).

Question 5.3.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Welfare and Institution Code, section 14717, subdivision 1(d)(6). A waiver processed based on an exception to presumptive transfer shall be contingent upon the MHP in the county of original jurisdiction demonstrating an existing contract with a SMHS provider, or the ability to enter into a contract within 30 days of the waiver decision, and the ability to

deliver timely SMHS directly to the foster child. That information shall be documented in the child's case plan.

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

- 1001.105 Incoming Presumptive Transfer of Medi-Cal
- 1001.109 Outbound Presumptive Transfer of Medi-Cal
- Presumptive Transfer Dashboard
- Presumptive Transfer Tracking CY2022
- Presumptive Transfer (Dashboard)
- PT Authorization Database
- Presumptive Transfer Samples
- 5.3.1 & 5.3.2 Statement

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains an existing contract with a SMHS provider or has the ability to enter into a contract within 30 days of the waiver decision, and the ability to deliver timely SMHS directly to the foster child. Per the discussion during the review, the MHP confirmed that its Presumptive Transfer policy did not include the requirement for a waiver, but if presented with such a case, it would send a letter of intent to process and ensure payment. Post review, the MHP submitted a statement explaining that while the scenario has not occurred during the review period, it acknowledged the need to update its policy moving forward.

DHCS deems the MHP out of compliance with California Welfare and Institution Code, section 14717, subdivision 1(d)(6).

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.14

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5). The MHP shall provide information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance with:

a) The MHP and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

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

- 0704.460 Client Problem Resolution Process
- 0704.500 Notice of Adverse Benefit Determination
- Access Brochure-Info about HCBH (tan paper; English & Spanish)
- Beneficiary Handbook (English, Spanish, Large Print)
- BH Patients' Rights Poster (English & Spanish)
- Client Problem Resolution Guide (pink paper; English, Spanish, Large Print)
- Client Problem Resolution Guide poster (English & Spanish)
- Client Problem Resolution Request Form (pink paper; English, Spanish, Large Print)
- BH grievance acknowledgment letter TEMPLATE
- Appeal Acknowledgement letter
- QI-108 NAR Your Rights Attachment (English & Spanish)
- QI-112 NAR Your Rights Attachment (English & Spanish)
- QI-109 Non-discrimination (English & Spanish)
- QI-113 NAR Adverse Benefit Determination Overturned Notice
- QI-114 NAR Adverse Benefit Determination Upheld Notice
- QI-115 NAR Notice of Grievance Resolution
- Behavioral Health Grievance and Appeals Logs
- Grievance and Appeals Samples
- Training Materials Samples
- 0100.153 Admin Non-Discrimination (Effective 12/15/2022)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provided information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance. Per the discussion during the review, the MHP stated that it had not updated its grievance and appeals policy, but any Discrimination Grievances would be resolved through the standard problem resolution path. Post review, the MHP submitted a Non-Discrimination policy; however, it did not meet the contract requirements.

DHCS deems the MHP out of compliance with MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5).

Question 6.1.15

FINDING

The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1). The MHP must designate a Discrimination Grievance

Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

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

- 0100.153 Admin Non-Discrimination (Effective 12/15/2022)
- 0704.460 Client Problem Resolution Process
- Access Brochure-Info about HCBH (tan paper; English & Spanish)
- Beneficiary Handbook (English, Spanish, Large Print)
- BH Patients' Rights Poster (English & Spanish)
- Client Problem Resolution Guide (pink paper; English, Spanish, Large Print)
- Client Problem Resolution Guide poster (English & Spanish)
- Client Problem Resolution Request Form (pink paper; English, Spanish, Large Print)
- BH grievance acknowledgment letter TEMPLATE
- Appeal Acknowledgement letter
- QI-108 NAR Your Rights Attachment (English & Spanish)
- QI-112 NAR Your Rights Attachment (English & Spanish)
- QI-109 Non-discrimination (English & Spanish)
- QI-113 NAR Adverse Benefit Determination Overturned Notice
- QI-114 NAR Adverse Benefit Determination Upheld Notice
- QI-115 NAR Notice of Grievance Resolution

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has designated a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP designated the Quality Improvement Coordinator as the Discrimination Grievances Coordinator. Post review, the MHP submitted a Non-Discrimination policy; however, it was not evident this process is in place.

DHCS deems the MHP out of compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1).

Question 6.1.16

FINDING

The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2). The MHP shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. The MHP shall not require a beneficiary to file a Discrimination Grievance with the MHP before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

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

- 0100.153 Admin Non-Discrimination (Effective 12/15/2022)
- Beneficiary Handbook (English, Spanish, Large Print)
- 0704.460 Client Problem Resolution Process

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has adopted procedures to ensure the prompt and equitable resolution of discrimination-related complaints. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it had not updated its grievance and appeals policy, but any Discrimination Grievances would be resolved through the standard problem resolution path. Post review, the MHP submitted a Non-Discrimination policy; however, it did not meet the contract requirements.

DHCS deems the MHP out of compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2).

Question 6.1.17

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHP Contract, exhibit A, Attachment 12, section 4(A)(3) and California Medicaid State Plan, section 7, attachments 7.2-A and 7.2-B. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the MHP must submit the following information regarding the complaint to the DHCS Office of Civil Rights:

a) The original complaint.
b) The provider's or other accused party's response to the complaint.

c) Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the MHP.
d) Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
e) All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.
f) The results of the MHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

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

- 0100.153 Admin Non-Discrimination (Effective 12/15/2022)
- 0704.460 Client Problem Resolution Process
- 0704.500 Notice of Adverse Benefit Determination
- Beneficiary Handbook (English, Spanish, Large Print)
- Informing Materials and Forms
- Grievance and Appeals Samples
- Grievance and Appeals Logs
- Grievance and Appeals Training Samples

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits required information regarding a complaint to the DHCS Office of Civil Rights within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it had not identified or processed discrimination grievances during the review period. Post review, the MHP submitted a Non-Discrimination policy; however, the policy did not meet the contract requirements.

DHCS deems the MHP out of compliance with MHP Contract, exhibit A, Attachment 12, section 4(A)(3) and California Medicaid State Plan, section 7, attachments 7.2-A and 7.2-B.

Question 6.3.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-010E. The MHP must use a written Notice of Grievance Resolution to notify beneficiary of the results of a grievance resolution which shall contain a clear and concise explanation of the Plan's decision.

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

- Post Review Evidence: Sample of Grievances and Notice of Grievance Resolution Letters (NGRs)
- 0704.460 Client Problem Resolution Process
- 0704.500 Notice of Adverse Benefit Determination
- Beneficiary Handbook (English, Spanish, Large Print)
- Informing Materials and Forms
- Grievance and Appeals Samples
- Grievance and Appeals Logs
- Grievance and Appeals Training Samples

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides Notice of Grievance Resolutions (NGR) that includes a summary of the grievance, steps taken to resolve the grievance, explanation of how the grievance was resolved, and reason for the decision, as required in MHSUDS IN 18-010E. Of the grievances reviewed by DHCS, nine (9) of the ten grievance resolution letters did not have an NGR that met the requirements. Per the discussion during the review, the MHP stated that the expectation is that staff use the standard NGR letter template and that it would research this issue. Post review, the MHP provided additional grievance and resolution samples demonstrating the volume of correct NGRs it had issued; however, the grievances reviewed by DHCS remained out of compliance.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-010E.

Question 6.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 420(c)(1)-(3) and 408(d)(2), and MHP Contract Exhibit A, Attachment 12, section 9(C). At the beneficiary's request, the MHP must continue the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the below listed occurs:

a) The beneficiary withdraws the appeal or request for a State Hearing;
b) The beneficiary does not request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (e.g.), NAR);
c) 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:

- Beneficiary Handbook (English, Spanish, Large Print)
- 0704.460 Client Problem Resolution Process
- State Hearings Sample

- 19-P002 Notice of Adverse Benefit Determination
- Sample of Notice of Adverse Benefit Determination Notification Letter Templates
- Appeal Samples

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending. Per the discussion during the review, the MHP stated that this requirement was included in its informing materials but was not included in its policy. Post review, DHCS re-reviewed the MHP's beneficiary informing materials and confirmed that the required contract language is absent. No additional documentation was submitted by the MHP.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 420(c)(1)-(3) and 408(d)(2), and MHP Contract Exhibit A, Attachment 12, section 9(C).