CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE KERN COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: June 21, 2022 to June 23, 2022

Kern County Mental Health Plan
FY 2021/2022 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

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Kern 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 webinar review of the Kern County MHP's Medi-Cal SMHS programs on June 21, 2022 to June 23, 2022. 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) 2021/2022 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 Kern County MHP. The report is organized according to the findings from each section of the FY 2021/2022 Protocol deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS.

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

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

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

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

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Question 1.1.3

FINDING

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

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

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

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

- 7. Service Request Log 7.1.21 – 9.30.21
- Policy 10.1.9 Notice of Adverse Benefit Determination with Templates
- Service Request Log Associated NOABDs
- 5.4.1 Line 54 – Service Request Log NOABD_1of4
- 5.4.1 Line 55 – Service Request Log NOABD_2of4
- 5.4.1 Line 60 – Service Request Log NOABD_3of4
- 5.4.1 Line 61 – Service Request Log NOABD_4of4
- Service Request log 7.1.21 – 9.30.21 updated

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP meets the Department standards for timely access to care for physician and urgent care services. Of the 100 appointments reviewed by DHCS, seven (7) of the 50 physician appointments and four (4) of the 50 urgent appointments did not meet timeliness standards. Per the discussion during the review, the MHP stated that it began a new process for logging urgent and physician appointments in July 2021 and has faced challenges documenting these requests. The MHP was provided the opportunity to submit additional evidence to demonstrate compliance with this requirement, including Notice of Adverse Beneficiary Determinations (NOABD) for appointments that did not meet timeliness standards, however, no additional evidence was provided.

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

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.2.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals listed in the below requirements:

1. Responsiveness for the Contractor's 24-hour toll-free telephone number.
2. Timeliness for scheduling of routine appointments.
3. Timeliness of services for urgent conditions.
4. Access to after-hours care.

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

- 3.2.5 Test Call Process
- 4. 21-22 Kern County Work Plan.Final
- 4. QAPI Work Plan Evaluations FY1819 FY1920 FY2021
- 3.2.6 21-22 Kern County Work Plan.Final- Cultural Competence information highlighted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures the QAPI Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged these specific requirements were missing from its QAPI Work Plan. The MHP stated that these requirements are monitored in different committees throughout its service delivery system. The MHP was given the opportunity to provide additional evidence post review to demonstrate these elements are tracked as part of the QAPI work plan, however, no additional evidence was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5.

Question 3.2.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 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:

- 4. 21-22 Kern County Work Plan.Final
- 4. QAPI Work Plan Evaluations FY1819 FY1920 FY2021
- 2. Cultural Competence Annual Plan FY 21-22
- 3.2.6 21-22 Kern County Work Plan.Final- Cultural Competence information highlighted
- 3.2.6 CC Annual Plan FY 21-22 FINAL

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures the QAPI Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that cultural and linguistic competence is tracked in the cultural competence plan and in various Quality Improvement Committee subcommittees. The MHP was given the opportunity to provide additional evidence post review to demonstrate these elements are tracked as part of the QAPI Work Plan, however, no additional evidence was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.3.2

FINDING

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The toll-free telephone number provides information to beneficiaries to the below listed requirements:

1. The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2. The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3. The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4. The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

The seven (7) test calls are summarized below.

TEST CALL #1
Test call was placed on Friday, December 10, 2021, at 7:34 a.m. The caller received a busy signal. The caller attempted the call again five (5) additional times over a span of three (3) minutes and continued to receive a busy signal. The caller was unable to determine the reason for the technical difficulty and concluded the test call attempt.

The caller was not provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met.

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

TEST CALL #2
Test call was placed on Tuesday, December 22, 2021, at 11:12 a.m. The caller received a busy signal. The caller attempted the call again four (4) additional times over a span of two (2) hours and continued to receive a busy signal. The caller was unable to determine the reason for the technical difficulty and concluded the test call attempt.

The caller was not provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #3
Test call was placed on Thursday, March 24, 2022, at 7:28 a.m. The call was answered after four (4) rings via a live operator. The caller requested information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling overwhelmed, isolated, and hopeless. The operator verified the caller's county of residence and proceeded to provide the caller with information regarding the clinic location and hours of operation to receive walk-in services. The operator explained the screening and assessment process to determine medical necessity. The operator assessed the caller's need for urgent services, which the caller responded in the negative.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. 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 Thursday, March 24, 2022, at 2:31 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services and how to refill his/her medication. The operator explained the process for how to access mental health services including walk-in services for crisis and routine services, and provided clinic locations and hours of operation. The operator informed the caller the 24/7 crisis line is available if he/she needed to speak with staff for psychiatric assistance. The operator assessed the caller's need for urgent services, which the caller responded in the negative. The operator provided the office locations and hours of operation for clinics where he/she may be able to receive an immediate medication refill.

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, March 25, 2022, at 1:33 p.m. The call was answered after one (1) ring via a live operator. The caller requested assistance with what he/she described as feeling depressed, unable to sleep, and bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator requested personally identifying information, which the caller provided. The operator provided the clinic location and hours of operation where he/she could be assessed for services. The operator explained the assessment process and gave the caller several options for crisis services as well as reaffirming the 24/7 line is available for any urgent requests.

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 #6

Test call was placed on Monday, February 28, 2022, at 12:34 pm. The call was answered after one (1) ring via a live operator. The caller asked for assistance with filing a complaint about a county therapist that he/she had been seeing. The operator inquired about the type of complaint, which the caller declined to share. The operator provided the contact information for the Patients' Right's Office. No additional information was provided.

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).

TEST CALL #7

Test call was placed on Friday, March 25, 2022, at 5:18 p.m. The call was answered after six (6) rings via a live operator. The caller asked for assistance with filing a complaint about a county therapist that he/she had been seeing. The operator informed the caller that he/she reached the MHP's after-hours crisis line and stated that he/she would need to call the Patients' Right's Advocate regarding filing a complaint, a grievance, or to request a new provider. The operator provided the contact information for the Patients' Right's Office. No additional information was provided.

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	OOC	OOC	IN	IN	IN	N/A	N/A	60%
3	N/A	OOC	IN	IN	IN	N/A	N/A	75%
4	N/A	N/A	N/A	N/A	N/A	OOC	OOC	0%

Based on the test calls, DHCS deems the MHP *in partial compliance* with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

Repeat deficiency Yes

Question 4.3.4

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

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

- 4.3.4 First Quarter 2020-2021 MHP Test Call Analysis
- 4.3.4 First Quarter 2021-2022 MHP Test Call Analysis
- 4.4.3 Fourth Quarter 2020-2021 MHP Test Call Analysis
- 4.3.4 MHP 24-7 Hotline Call Logs – 03242022
- 4.3.4 MHP 24-7 Hotline Call Logs – 03252022
- 4.3.4 MHP 24-7 Hotline Call Logs – 12102021
- 4.3.4 MHP 24-7 Hotline Call Logs – 12222021
- 4.3.4 Policy 5.5.2 – Initial Request for Services Log
- 4.3.4 Policy 5.5.3 – 24-7 Toll-Free Telephone Access
- 4.3.4 Policy 5.5.3 – Attachment A – Call Script
- 4.3.4 SilentMonitoringDATA March 3. 2022
- 4.3.4 Third Quarter 24_7 Access Line Form Report FY 20_21
- 4.3.4 Hotline Call Log 12.10.21 1of3
- 4.3.4 Hotline Call Log 12.10.21 2of3
- 4.3.4 Hotline Call Log 12.10.21 3of3
- 4.3.4 Hotline Call Log 12.22.21

While the MHP submitted evidence to demonstrate compliance with this requirement, two (2) of the five (5) 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	12/10/2021	7:34 a.m.	OOC	OOC	OOC
2	12/22/2021	11:12 a.m.	OOC	OOC	OOC
3	3/24/2022	7:28 a.m.	IN	IN	IN
4	3/24/2022	2:31 p.m.	IN	IN	IN
5	3/25/2022	1:33 p.m.	IN	IN	IN
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).

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.2.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must comply with the following communication requirements:

1. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2. Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization.
3. A physician shall be available for consultation and for resolving disputed requests for authorizations;
4. Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting these online;
5. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
6. MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

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

- Policy 5.1.19 Treatment Authorization Requests
- 5.2.2 Blank Inpatient UR Concurrent Review Tool
- 5.2.2 Good Sam-Concurrent Review Notification Letter
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.2 Provider Notification

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensures that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services; or discloses to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP uses to authorize, modify, or deny SMHS. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. No additional evidence of practice was submitted for this requirement.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.2.5

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status for the below requirements:

1. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
2. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.
3. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

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

- Policy 5.1.19 Treatment Authorization Requests
- 5.2.5 Administrative Days Calculation Form
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.5 Admin Day TAR Allen, D – 6.25.21
- 5.2.5 Admin Day TAR Hernandez, V – 11.11.21
- 5.2.5 Admin Day TAR Johnson Jr., V – 7.22.21

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. Post review, the MHP provided Treatment Authorization Requests (TARs), however the TARs did not demonstrate the administrative day contact requirements.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.2.6

FINDING

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization for the below:

1. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.
2. The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

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

- Policy 5.1.19 Treatment Authorization Requests
- 5.2.6 Blank Authorization Request Form
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP utilizes referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. No additional evidence of practice was submitted for this requirement.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.2.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS:

a. MHPs may not require prior authorization for the following services/service activities:
    i. Crisis Intervention;
    ii. Crisis Stabilization;
    iii. Mental Health Services;
    iv. Targeted Case Management;
    v. Intensive Care Coordination; and,
    vi. Medication Support Services.
b. Prior authorization or MHP referral is required for the following services:
    i. Intensive Home-Based Services
    ii. Day Treatment Intensive
    iii. Day Rehabilitation
    iv. Therapeutic Behavioral Services
    v. Therapeutic Foster Care

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

- Policy 5.1.19 Treatment Authorization Requests
- Policy 5.1.26 Out of Plan OutPt Auth and Out of Network Access to Serv
- 5.2.7 2nd Bridge Request
- 5.2.7 Example TBS Assessment-Plan
- 5.2.7 IHBS Request
- 5.2.7 Non-Formulary Request
- 5.2.7 TBS Request
- 5.2.7 TFC Request
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established and implements policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS that may not require prior authorization. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.2.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.

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

- Policy 5.1.19 Treatment Authorization Requests
- SAR Packet_12of14
- SAR Packet_13of14
- SAR Packet_14of14
- 5.1.1 SARs Explanation
- 5.1.1 SARs Sample_1of14
- 5.1.1 SARs Sample_2of14
- 5.1.1 SARs Sample_3of14
- 5.1.1 SARs Sample_4of14
- 5.1.1 SARs Sample_5of14
- 5.1.1 SARs Sample_6of14
- 5.1.1 SARs Sample_7of14
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- 5.1.1 SARs Sample_10of14
- 5.1.1 SARs Sample_11of14
- 5.1.1 SARs Sample_12of14
- 5.1.1 SARs Sample_13of14
- 5.1.1 SARs Sample_14of14
- External Kern Additional Evidence
- DD SARs Receipt
- EW SARs Receipt 2.16.22

DHCS reviewed samples of authorizations to verify compliance with regulatory requirements. The service authorization sample verification findings are detailed below:

Requirement	# of Services Authorizations in compliance	# of Service Authorizations out of compliance	Compliance Percentage
Regular Authorization: The MHP makes a decision regarding a provider's request for prior authorization not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.	5	7	42%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information. Per the discussion during the review, the MHP stated that this is the practice of the MHP. Of the 12 service authorization requests (SARs), eight (8) exceeded the five (5) business day requirement. Post review, the MHP submitted additional evidence for this requirement; however, seven (7) SARs remained out of compliance.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.2.9

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2). The MHP must for cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.

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

- Policy 5.1.19 Treatment Authorization Requests
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. No additional evidence of practice was submitted for this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2).

Question 5.2.11

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,
4. Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

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

- Policy 5.1.19 Treatment Authorization Requests
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.11 Retro Auth CR
- 5.2.11 Retro Auth DP
- 5.2.11 Retro Auth PC
- 5.2.11 Retro Auth WT
- 5.2.11 Retro Auth AZ

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this

policy was implemented during the review period per email communications with the MHP and discussions during the review. The MHP submitted additional TARs post review; however, these TARs do not satisfy the requirement of having an established policy and procedure as outlined in the MHSUDS IN 19-026.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.2.12

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

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

- Policy 5.1.19 Treatment Authorization Requests
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.11 Retro Auth CR
- 5.2.11 Retro Auth DP
- 5.2.11 Retro Auth PC
- 5.2.11 Retro Auth WT
- 5.2.11 Retro Auth AZ

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's retrospective authorization decision is communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information and is communicated to the provider in a manner that is consistent with state requirements. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. The MHP submitted additional TARs post review; however, it was not evident the MHP's authorization decision was communicated to the individual, the individual's designee, or the provider as required in MHSUDS IN 19-026.

The evidence of practice submitted post review does not meet the requirement.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Question 5.3.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Welfare and Institution Code, section 14717, subdivision 1(f). The MHP must ensure if the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP in the county in which the foster child resides shall accept that assessment.

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

- Policy 5.4.5 Presumptive Transfer
- 5.3.3 Policy Presumptive Transfer – County of Jurisdiction Assessment
- 5.3.3 Policy 5.4.5 Presumptive Transfer

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures when the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP will accept that assessment. Per the discussion during the review, the MHP stated that its draft policy and procedure would be approved soon and includes this requirement. Post review, the MHP submitted a compliant policy that was dated prior to the review that it will implement moving forward, however it was not evident this policy was in place during the review period.

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

Question 5.3.8

FINDING

The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-027, and California Welfare and Institution Code, section 14717, subdivision 1(b). 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:

- Policy 5.4.5 Presumptive Transfer
- 5.3.5 Presumptive Transfer Timeliness Tracking Log
- 5.3.7 Expedited Presumptive Transfer Notices
- 5.3.8 Policy 5.4.5 Presumptive Transfer – Expedited Transfers
- 5.3.8 Policy 5.4.5 Presumptive Transfer

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 stated that its draft policy and procedure would be approved soon and includes this language. Post review, the MHP submitted a compliant policy that was dated prior to the review that it will implement moving forward, however it was not evident this policy was in place during the review period.

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, section 14717, subdivision 1(b).

Question 5.4.1

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 below:

1. 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.
2. The reduction, suspension or termination of a previously authorized service.
3. The denial, in whole or in part, of a payment for service.
4. The failure to provide services in a timely manner.
5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

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

- Policy 10.1.9 Notice of Adverse Benefit Determination with Templates
- Service Request Log Associated NOABDs
- TARs-SARs NOABD Tracking w NOABDs 2-1-21 to 3-31-22
- 5.4.1 Line 54 – Service Request Log NOABD_1of4
- 5.4.1 Line 55 – Service Request Log NOABD_2of4
- 5.4.1 Line 60 – Service Request Log NOABD_3of4
- 5.4.1 Line 61 – Service Request Log NOABD_4of4

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides NOABDs to beneficiaries for the failure to provide services in a timely manner. This requirement was not included in any evidence provided by the MHP. Of the 50 physician appointments reviewed by DHCS, seven (7) beneficiaries did not receive a NOABD. Of the 50 urgent appointments reviewed by

DHCS, four (4) beneficiaries did not receive a NOABD. Per the discussion during the review, the MHP stated that it has experienced challenges in providing the required NOABDs and hopes to improve this process moving forward. The MHP was given the opportunity to submit the NOABDs for these appointments requests, however, no additional evidence was submitted.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400.

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.13

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a). The MHP must 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.

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

- Policy 10.1.3 Grievance & Appeal System
- Policy 11.1.13 Beneficiary Informing Materials
- Beneficiary Handbook
- Policy 10.1.03 Grievance & Appeal System

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures that decision makers for 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. Per the discussion during the review, the MHP stated that it reviews all information submitted by beneficiaries and beneficiary's representative for grievances and appeals. The MHP was provided the opportunity to submit additional evidence to demonstrate this process was in place. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, it is not evident this policy was in place during the triennial review period.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a).

Question 6.4.13

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 410(b). The MHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

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

- Policy 10.1.3 Grievance & Appeal System
- Policy 11.1.13 Beneficiary Informing Materials
- Beneficiary Handbook
- Policy 10.1.03 Grievance & Appeal System

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. Per the discussion during the review, the MHP stated it would review its policy to see if this requirement was included. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, however, it is not evident this policy was in place during the triennial review period.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 410(b).

Question 6.4.14

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c). The MHP must inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal.

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

- Policy 10.1.3 Grievance & Appeal System
- 6.4.14 Beneficiary’s right template_English_YOUR RIGHTS UNDER MEDI-CAL
- Problem Resolution Informing posters
- Policy 10.1.03 Grievance & Appeal System

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP informs beneficiaries of the limited time available to present

evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. Per the discussion during the review, the MHP stated that the grievance and appeal posters it has posted throughout the MHP have general information about this requirement and that it would look for evidence to demonstrate this practice. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, it is not evident this policy was in place during the triennial review period.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c).

PROGRAM INTEGRITY

Questions 7.5.3

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

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

- Policy 3.1.15 Screen for Ineligible – Susp Employees & Entities
- Policy 3.1.15 AttB Exclusion Attestation
- 7.5.3 KernBHRS Letter regarding Exclusions 6.28.22
- 7.5.3 Policy 3.1.15 Screen Inelig and Susp Empl

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded. Per the discussion during the review, the MHP stated that it reviews exclusion lists monthly, however, it would have to review its policy to identify if the practice of notifying DHCS is in place. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, it was not in place during the triennial review period.

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