CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2019/2020

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE KINGS COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: February 25, 2020 to February 27, 2020

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY 2

FINDINGS 5

ATTESTATION 5

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES 6

CARE COORDINATION AND CONTINUITY OF CARE 14

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT 15

ACCESS AND INFORMATION REQUIREMENTS 21

COVERAGE AND AUTHORIZATION OF SERVICES 27

BENEFICIARY RIGHTS AND PROTECTIONS 28

PROGRAM INTEGRITY 34

OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS 42

SURVEY ONLY FINDINGS 44

EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted an onsite review of the Kings County MHP's Medi-Cal SMHS programs from February 25, 2020 to February 27, 2020. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2019/2020 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

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

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

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

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

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

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

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

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

Review Findings Overview

- During DHCS review, the Kings County MHP demonstrated numerous strengths, including but not limited to the following examples:
  - The Multiple Organization Shared Psychiatry (MOST) Innovation Project expanded access to tele-psychiatry services with emphasis to those who have urgent care needs and/or are in higher levels of care.

- The Oak Wellness Center (OWC) provided a peer-driven, non-treatment oriented social environment to promote recovery from mental health issues.

- The Assertive Community Treatment (ACT) program provided by the subcontractor added an evidence-based practice for adults with severe mental illness who are most at-risk of psychiatric crisis, hospitalization, and involvement in the criminal justice system

- A Cultural Competence Training Plan identified areas where training and development are limited, and where trainings and resources have not been covered in recent years.

- DHCS identified opportunities for improvement in various areas, including:
  - Continuous improvement in the twenty-four hours, seven days a week toll free access line monitoring and tracking mechanisms.
  - Development and implementation of a comprehensive Compliance Plan.
  - Enhancing the Service Verification Process to include all sites where beneficiaries receive services.
  - System-wide development of policies and procedures
  - Expanding performance monitoring for system and beneficiary outcomes.

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

FINDINGS

ATTESTATION

ATTESTATION REQUIREMENTS
The MHP must ensure that the Fee-for-Service/Medi-Cal contract hospital rates negotiated by the MHP are submitted annually. (Cal. Code Regs., tit. 9, chap. 11, § 1810.375(c), W&I Code, § 5613(b)(4))

FINDING
The MHP did not attest that it ensures that the Fee-for-Service/Medi-Cal contract hospitals rates negotiated by the MHP are submitted annually.

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

- County Mental Health Plan Attestation Fiscal Year 19/20

Specifically, the MHP submitted the Attestation and identified that the information needed to meet this requirement would be submitted as of June 2020 and annually thereafter. It did not occur during the triennial review period.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, chapter 11, section 1810.375(c), and Welfare and Institutions Code, section 5614 (b)(4). The MHP must complete CAP addressing this findings of non-compliance.

ATTESTATION REQUIREMENTS
The MHP must allocate (for services to persons under age 18) 50% of any new funding received for new or expanded mental health programs until the amount expended for mental health services to persons under age 18 equals not less than 25% of the county's gross budget for mental health or not less than the percentage of persons under age 18 in the total county population, whichever percentage is less. (W&I Code, § 5704.6)

FINDING
The MHP did not attest it allocates (for services to persons under age 18) 50% of any new funding received for new or expanded mental health programs until the amount expended for mental health services to persons under age 18 equals not less than 25% of the county's gross budget for mental health or not less than the percentage of persons under age 18 in the total county population, whichever percentage is less.

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

- County Mental Health Plan Attestation Fiscal Year 19/20

Specifically, the MHP submitted the Attestation, and identified that they do not have a monitoring mechanism available but will begin a review funding allocations to ensure compliance. It did not occur during the triennial review period.

DHCS deems the MHP out of compliance with Welfare and Institutions Code, Section 5704.6. The MHP must complete CAP addressing these findings of non-compliance.

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
The MHP shall offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county. (Fed. Code Regs., tit. 42, § 438, subd.207(b)(1).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 24, section 438, subdivision 207(b)(1). The MHP must offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county.

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

- Crisis Program Description
- MHP Service Map
- Policy & Procedure Network Adequacy
- Policy & Procedures SMHS Medi-Cal Services
- Tele health Services Agreement 2018-2019
- NACT Report
- MHSA Services Annual Update 2019-2020

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP offers an appropriate range of SMHS that is adequate for the number of beneficiaries in the county. In addition to the evidence submitted by the MHP, DHCS reviewed the most recent Network Adequacy Findings Report and the Remediation Tool. The MHP received a conditional pass on the Network Adequacy Findings Report for Outpatient Specialty Mental Health Services (SMHS) Provider Capacity for Children/Youth, and is required to complete a CAP.

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

REQUIREMENT
The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (Fed. Code Regs, tit. 42, § 438, subd. 206(c)(1)(i).)

FINDING

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

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

- Monitoring of Timely Access FY 19/20
- NACT Report
- P&P A-046 Network Adequacy
- P&P A-047 Timely access
- Timely Access Corrective Action Plan
- Timely Access Report EQRO 2018-2019
- Timely Access Report NACT 19/20 Quarter 2
- Service Request Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP meets this requirement. Based on the Network Adequacy CAP Remediation Tool, the MHP received a conditional pass in the area of reporting service requests meeting thresholds and is required to submit timely access standard reports with all the requested data elements.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section438, subdivision 206(c)(1)(i). The MHP must comply with CAP requirement per Network Adequacy Finding Report addressing this finding of non-compliance.

REQUIREMENT
The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements. (Fed. Code of Regs, tit. 42, § 438, subd. 206(c)(1)(iv)).
The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (Fed. Code of Regs, tit. 42, § 438, subd. 206(c)(1)(v)).
The MHP shall take corrective action if there is a failure to comply with timely access requirements. (Fed. Code of Regs, tit. 42, § 438, subd. 206(c)(1)(vi)).

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi). The MHP must comply with following;

- Establish mechanisms to ensure that network providers comply with the timely access requirements.
- Monitor network providers regularly to determine compliance with timely access requirements.
- Take corrective action if there is a failure to comply with timely access requirements.

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

- Quality Work Plan Evaluation FY 2018/19
- P&P A-046 Network Adequacy
- P&P A-047 Timely Access

The Quality Work Plan Evaluation FY 2018/19 identifies that the MHP is monitoring this requirement. However, the policies and procedures do not identify that the MHP will take corrective action if there is a failure to comply with timely access requirements. Additionally evidence was not submitted that would validate that a CAP was provided when the requirement was not met.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi). The MHP must complete a CAP addressing this finding of non-compliance.

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

FINDING

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

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

- Request for Proposal RFP due October 4, 2019

Specifically, the MHP is not currently able to provide TFC services to all children and youth who meet medical necessity criteria for TFC. They are currently in the process of identifying a provider.

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

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

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

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

- Request for Proposal RFP due October 4, 2019

The MHP did not provided evidence that it determines if children and youth who meet medical necessity criteria need TFC.

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

REQUIREMENT
The County uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS, IN., No. 18-008; Cal. W&I Code, § 5600, subd. (a), 4(f), 5(e), 6(e), and 7(e).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institution Code, section 5600, subdivision (a), 4(f), 5(e), 6(e) and 7(e). The MHP must use its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations.

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

- Program Brochure for Asprianet
- Billing for Services while Consumers are in IMDs
- Job Description for Outreach to Person who are homeless
- Evidence of Outreach at Community events
- Calendar of Outreach Events

The evidence provided did not provide information regarding how the MHP meets this requirement. The document “IMD Billing for Services while Consumers are in IMDs” briefly explains the allowable Medi-Cal billable service. The evidence did not validate that the county uses 1991 Realignment funding to provide acute psychiatric inpatient hospital services in Institutions for Mental Disease (IMD). Additional evidence was requested during the onsite but was not submitted by the MHP.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institution Code, section 5600, subdivision (a), 4(f), 5(e), 6(e) and 7(e). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Cal. W&I Code §14053, subd. (a) and (b)(3); Fed. Code of Regs, tit. 42, § 1396, subd. d(a)(29)(B), (a)(16) & (h)(1)(c); Fed. Code of Regs, tit. 42, § 441, subd.13 and §435, subd.1009)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institutions Code, section 14053, subdivision (a) and (b)(3), and Federal Code of Regulations, title 42, section 1396, subdivision d(a)(29)(B), (a)(16), (h)(1)(c), and Federal Code of Regulations, title 42, section 441.subdivision 13 and section 435, subdivision 1009. The MHP must cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older.

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

- Program Brochure for Asprianet
- Billing for Services while Consumers are in IMDs
- Job Description for Outreach to Person who are homeless
- Evidence of Outreach at Community events

- Calendar of Outreach Events

Specifically, the evidence provided did not identify that the MHP covers acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institutions Code, section 14053, subdivision (a) and (b)(3), and Federal Code of Regulations, title 42, section 1396, subdivision d(a)(29)(B), (a)(16), (h)(1)(c), and Federal Code of Regulations, title 42, section 441, subdivision 13, and section 435, subdivision 1009. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
All contracts or written agreements between the MHP and any network provider specify the following:
The activities and obligations, including services provided, and related reporting responsibilities. (Fed. Code Regs., tit. 42, § 438, subd. 230(c)(1)(i).)
The delegated activities and reporting responsibilities in compliance with the Contractor’s obligations in this Contract. (Fed. Code Regs, tit. 42, § 438, subd. 230(c)(1)(ii).)
Subcontractor's agreement to submit reports as required by the Contractor and/or the Department.
A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable available at any time for inspection, examination or copying by the Department, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (Fed. Code Regs., tit. 42, §438, subd. 3(h).) This audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (Fed. Code Regs., tit. 42, § 438, subd.230(c)(3)(iii).) The Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk, then. (Fed. Code Regs., tit. 42, § 438, subd. 230(c)(3)(iv).)

The Department's inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least ten years from the close of the state fiscal year in which the subcontract was in effect. Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the Contractor.
A requirement that the Contractor monitor the subcontractor's compliance with the provisions of the subcontract and this contract and a requirement that the subcontractor provide a CAP if deficiencies are identified. (MHP Contract, Ex. A, Att. 1; Fed. Code Regs., tit. 42, § 438, subd. 230)

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 230 and the MHP Contract, exhibit A, attachment 1. The MHP must ensure that all contracts or written agreements between the MHP and any network provider specify all aspects listed above.

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

- Contract Boilerplate
- 24/7 agreement

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP's current contracts or written agreements did not include the required elements listed above.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 230 and MHP Contract, exhibit A, attachment 1. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP shall certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435. (MHP contract, Ex. A, Att. 8)

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

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

- MHS site certification documents
- DHCS Overdue Provider Report
- Provider Site Certification by MHP –Aspiranet
- Provider Site Certification by MHP –Kings County ACT

While the MHP submitted evidence to demonstrate compliance with this requirement. DHCS also reviewed its internal Overdue Provider Report, which identified that two (2) providers were overdue for re-certification.

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 8. The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
The MHP shall comply with the provisions of the MHP's Implementation Plan as approved by the Department. (MHP contract, Ex. A, Att. 1; Cal. Code Regs., tit. 9, § 1810, subd..310) The Implementation Plan shall include:
Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.
A description of the process for: (A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services. (B) Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP. (C) Assuring continuity of care for beneficiaries receiving specialty mental health services. (D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.
A description of the processes for problem resolution.
A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435.
Documentation that demonstrates that the entity: (A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries that will be served by the MHP, and (B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served by the MHP.
A description of how the MHP will deliver age–appropriate services to beneficiaries.

The proposed Cultural Competence Plan.
A description of a process for planned admissions in non–contract hospitals if such an admission is determined to be necessary by the MHP.
A description of the MHP's Quality Improvement and Utilization Management Programs.
A description of policies and procedures that assure beneficiary confidentiality in compliance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.
Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to beneficiaries.

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 1, and California Code of Regulations, title 9, section 1810, subdivision 310. The MHP must comply with the provisions of the MHP's Implementation Plan as approved by the Department

MHP did not submit evidence to demonstrate compliance with this requirement.

Specifically, the MHP did not submit an Implementation Plan. The MHP has some policies and procedures that cover some of the components that would be part of an Implementation Plan, however this that does not substitute for the requirement to develop one. The MHP stated during the onsite that they are currently in the process of developing an Implementation Plan.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 1, and California Code of Regulations, title 9, section 1810, subdivision 310. The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in previous triennial review.

CARE COORDINATION AND CONTINUITY OF CARE

REQUIREMENT
The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (MHP contract, Ex. A, Att.10; Fed. Code Regs., tit. 42, § 438, subd. 62(b)(1)-(2).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, subdivision 62(b)(1)-(2). The MHP must implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy.

The MHP did not submit evidence of compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, subdivision 62(b)(1)-(2). The MHP must complete a CAP addressing this finding of non-compliance.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

REQUIREMENT
The Quality Assessment and Performance Improvement Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. (MHP contract, Ex. A, Att. 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 evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

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

- QAPI Work Plan FY 19/20
- QAPI Work Plan FY 17/18

The Work Plan for FY 19/20 had an objective that the MHP would provide a grievance and appeals system for consumers to include expedited appeal and state fair hearing. However, no data or any other evidence of implementation was provided. The Work Plan FY 17/18 provided a statement that grievances, appeals, expedited appeals, fair hearings, and expedited fair hearings, are continuously monitored, and analyzed for trends. However, there was no evidence of monitoring activities included as part of the plan.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The Quality Assessment and Performance Improvement Work Plan includes evidence that Quality Improvement activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service. (MHP contract, Ex. A, Att. 5)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the QAPI Improvement Work Plan includes evidence that Quality Improvement activities, including Performance Improvement Projects (PIPs), have contributed to meaningful improvement in clinical care and beneficiary service.

The MHP submitted the following documentation as evidence of compliance with this requirement:
- QAPI Work Plan FY 19/20
- QAPI Work Plan FY 17/18
- Clinical PIP starting FY 19/20
- Non Clinical PIP Starting FY 19/20

Specifically, the QAPI Work Plans submitted, did not include information regarding how the PIPs have contributed to meaningful improvement in clinical care and beneficiary services.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The Quality Assessment and Performance Improvement Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for: (MHP contract, Ex. A, Att. 5)
Responsiveness for the Contractor's 24-hour toll-free telephone number.
Timeliness for scheduling of routine appointments.
Timeliness of services for urgent conditions.
Access to after-hours care.

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 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 above.

The MHP submitted the following documentation as evidence of compliance with this requirement:
- QAPI Work Plan FY 19/20
- QAPI Work Plan FY 17/18

The MHP submitted a QAPI Work Plan for FY 17/18, which provides assessment data related to access to after-hours care, timeliness of services for urgent conditions, and timeliness for scheduling of routine appointments. However, it did not include assessment data related to the MHP's Responsiveness for the Contractor's 24-hour toll-free telephone number.

The QAPI Work Plan submitted for FY 19/20 included an objective for the 24-hour toll free telephone number but no additional information. However, it did not include objective or assessment data regarding access to after-hours care, timeliness for scheduling of routine appointments, or urgent appointments. The MHP did not submit a QAPI Work Plan for FY 18/19.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The Quality Assessment and Performance Improvement Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. (MHP contract, Ex. A, Att. 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 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:

- QAPI Work Plan FY 18/19
- QAPI Work Plan FY 19/20

The Work Plan Evaluation submitted for FY 18/19 states that Cultural Humility Training is to be completed by Kings County Behavioral Health (KCBH) with no objectives or assessment data. Therefore, DHCS was not be able to make determination for the MHP's compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP Quality Assessment and Performance Improvement program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the Quality Improvement program. (MHP contract, Ex. A, Att. 5)

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the MHP Quality Assessment and Performance Improvement program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the Quality Improvement program.

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

- QIC minutes for 2019
- Structure and subcommittees
- ASOC collaboration sign in sheets and minutes
- CSOC Agency collaborative meeting sign in sheets

While the MHP submitted the evidence of compliance with this requirement, the evidence did not indicate that the QAPI program includes active participation by beneficiaries. The MHP stated during the onsite that they are actively seeking beneficiary participation.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP obtains input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services. (MHP contract, Ex. A, Att. 5)

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must obtain input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services.

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

- QIC Minutes 2019
- QIC Structure and Subcommittees
- QIC Subcommittee Minutes Adult System
- QIC Subcommittee Minutes Children's System
- QIC Subcommittee Minutes Cultural Competency

Specifically, the evidence did not demonstrate that the MHP receives input from beneficiaries and family members in identifying barriers to delivery of clinical care and

administrative services. The MHP identified during the onsite that it is their goal to obtain input from beneficiaries, parent support specialist, and parent partners in the future.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP shall conduct a minimum of two PIPs per year, including any Performance Improvement Projects required by DHCS or CMS. (MHP contract, Ex. A, Att. 5; Fed. Code Regs., tit. 42, § 438, subd.330(b)(1) and (d)(1).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(1) and (d)(1). The MHP must conduct a minimum of two Performance Improvement Projects per year, including any PIPs required by DHCS or CMS.

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

- Clinical PIP starting FY 19/20
- Non-clinical PIP starting FY 19/20

Specifically, the MHP informed the DHCS team that their non-clinical PIP provided to the External Quality Review Organization (EQRO) was not approved. The MHP is currently exploring other areas of performance for their non-clinical PIP.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(1) and (d)(1). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP has practice guidelines, which meet the requirements of the MHP Contract.(MHP contract, Ex. A, Att. 5; Fed. Code Regs., tit. 42. § 438, subd.236(b); Cal. Code Regs., tit. 9, § 1810, subd.326.)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must have practice guidelines, which meet the requirements of the MHP Contract.

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

- Statement by the MHP stating that new provider manual is planned for 2021

Specifically, the MHP submitted a statement as an evidence, that a new provider manual has not been developed due to the transition of managed care oversight to the county from Kings View. The MHP stated that the update is planned for 2021 after oversight transition and conversion to new Electronic Health Record will be completed.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
The MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. (MHP contract, Ex. A, Att. 5; Fed. Code Regs., tit. 42,§ 438, subd.236(b); Cal. Code Regs., tit. 9, § 1810, subd.326.)

FINDING

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

The MHP did not submit evidence of compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
The MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. (MHP contract, Ex. A, Att. 5; Fed. Code Regs., tit. 42, § 438, subd.236(b); Cal. Code Regs., tit. 9, § 1810, subd. 326.)

FINDING

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

236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.

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

- Policy & Procedure Service Authorization and Utilization Management
- Policy & Procedure Utilization Review/Quality Assurance
- Utilization Review Committee Audit Tool
- Performance Outcomes System Report (children's/adults) March 13, 2018

Specifically, the evidence provided did not demonstrate that the MHP take steps to assure that decisions for beneficiary education and coverage of services are applied consistently with the guidelines adopted.

Specifically, the MHP reported that they are in the process of developing practice guidelines that would include beneficiary education and coverage of services and how they are applied. The evidence provided did not meet this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
Beneficiary information required in Federal Code of Regulations, title 42, section 438, subdivision 10 (e.g., information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if all of the following conditions are met: (Fed. Code Regs., tit. 42, §438, subd.10(c)(6).)
The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(c)(6). The MHP must ensure beneficiary information required in Federal Code of Regulations, title 42, section 438, subdivision 10 may only be provided electronically by the MHP if all of the above listed conditions are met.

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

- Beneficiary Handbook
- Provider Directory

Specifically, the documents submitted did not include information that the beneficiary is informed that the information is available in paper form without charge upon request within 5 business days.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(c)(6). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (Cal. Code Regs., tit. 9, chap. 11, § 1810, subd.405(d) and 410(e)(1).)
The 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.
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.
The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

FINDING

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). Each MHP must provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes. The seven (7) test calls are summarized below.

TEST CALL #1

Test call was placed on September 30, 2019, at 9:07 p.m. The call was answered after two (2) rings via a live operator. The caller requested information about how to file a grievance. The operator provided the caller with information regarding the grievance and appeal process including the name and phone number of the grievance coordinator. The

caller was also given the address and hours of operator of the clinic to obtain complaint forms. The caller was provided information about how to use the beneficiary 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 #2

Test call was placed on November 13, 2019 at 8:57 a.m. The call was answered after two (2) rings via a live operator. The caller requested information on how to file a complaint. The operator provided the process and location of the grievance forms. The caller was provided information about how to use the beneficiary problem resolution and fair hearing processes.

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

TEST CALL #3

Test call was placed on November 25, 2019, at 1:42 p.m. The call was answered after four (4) rings via a live operator. The caller requested information about accessing mental health services in the county. The caller was transferred to a crisis worker. The crisis worker asked the caller how long they were a resident in the county. The caller stated they were not a resident, but was staying with a friend. The crisis worker asked the caller if they wanted to hurt oneself or others. The caller replied in the negative. The crisis worker asked if the caller was on medication and what county of residency the caller was from. The caller informed the crisis worker that he/she was not on medication and was from Modesto. The Crisis worker informed the caller they would need to contact Modesto County for services and if they were in crisis to call 911 or the crisis line for assistance. No additional information about SMHS was provided to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, because the caller identified themselves as an out of county resident. 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 November 27, 2019, at 7:25 a.m. The call was answered after two (2) rings via a live operator. The operator asked the caller if he/she was in crisis. The

caller replied in the negative. The caller requested information about accessing mental health services in the county. The operator informed the caller that he/she reached the after hour line and that the caller should call back after 8:00 a.m. The operator did not provide any other information. The caller thanked the operator and ceased the call. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was asked about caller'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 #5

Test call was placed on November 27, 2019, 8:14 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, specifically to establish urgent care for anxiety medication refill. The operator advised the caller that it would take two to three weeks to be screened and processed and then an unknown wait time (dependent upon availability) for an appointment with a physician. No additional information about SMHS was provided to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL #6

Test call was placed on December 2, 2019, at 12 p.m. The call was answered after two (2) rings via a live operator named Pauline. The caller was then transferred to another operator named Valerie. The caller requested information about accessing mental health services in the county for her son. The caller received the information and the address to the location for walk in appointment. 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 #7

Test call was placed on December 12, 2019, at 7:50 a.m. The call was answered after one (1) ring by a live operator. The live operator asked if the caller was in crisis. The caller responded in negative. The caller explained that she was new to the county and almost running out of the medication. The caller requested information about accessing mental health services in the county, specifically how to establish service to receive a medication refill. The operator asked the caller to provide his/her name and the caller gave the name May. The operator advised the caller that the office is open from 8:00 a.m. to 5:00 p.m. on a walk-in basis. The operator also informed the caller that if the caller can call back within 7 minutes, the office will be open and they can assist the caller with setting up an appointment. The operator also stated that she is not sure of how the medication refill process works and suggested the caller to go to hospital if emergency medication is needed. The operator did not provide information on location of the office or the location of the hospital emergency room. No additional information about SMHS was provided to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING
The call is deemed not 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).

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	**N/A**	**N/A**	**IN**	**OCC**	**OCC**	**IN**	**OOC**	40%
3	**N/A**	**N/A**	**IN**	**NA**	**OCC**	**N/A**	**IN**	67%
4	**IN**	**IN**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	100%

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The MHP must complete a CAP addressing this finding of partial compliance.

REQUIREMENT
The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (Cal. Code Regs., tit. 9, chap. 11, §1810, subd.405(f)). The written log(s) contain the following required elements:
Name of the beneficiary.

Date of the request.
Initial disposition of the request.

FINDING

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

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

- Before business hours access log
- Call log during business hours
- During business hours access call log request
- MHP P& P A-050 24-7 Access Line
- Vendor-P&P AD MCB MHPs 24-7 toll free number
- Vendor-24-7 Access Line Script
- Vendor-24-7 Access Line Training
- 24-7Access Line contract language line services

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) 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**
3	11/25/2019	1:42 p.m.	OOC	OOC	OOC
4	11/27/2019	7:25 a.m.	OOC	OOC	OOC
5	11/27/2019	8:14 a.m.	OOC	OOC	OOC
6	12/2/2019	12:00 p.m.	IN	IN	IN
7	12/12/2019	7:50 a.m.	IN	IN	IN
Compliance Percentage			**40%**	**40%**	**40%**

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

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f). The MHP must complete a CAP addressing this finding of partial compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
Regarding the MHP's Cultural Competence Committee:
The MHP has evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee activities include the following: a) Provides reports to the Quality Assurance and/or the Quality Improvement Program. (Cal. Code Regs., tit.9, §1810, subd.410).

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410. The MHP must have a Cultural Competence Committee or other group that addresses cultural issues and has participation from cultural groups that is reflective of the community, and evidence of policies, procedures, and practices that demonstrate the Cultural Competence activities include above listed elements.

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

- Policy A-016 Cultural Competency Taskforce
- policy A-015 Cultural Competency Policy

Specifically, the evidence provided by the MHP did not demonstrate that the Cultural Competence Committee provided reports to the Quality Assurance and/or the Quality Improvement Program.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410. The MHP must complete a CAP addressing this finding of non-compliance.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
The MHP shall have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. (MHP contract, Ex. A, Att 6; Fed. Code Regs., tit. 42, § 438, subd. 210(b)(3).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(b)(3). The MHP must have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs.

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

- Sample of 24 Service Authorization Requests
- Sample of 50 Treatment Authorization Requests
- Policy & Procedure AD-062 Service Authorization & Utilization Management (DRAFT)
- Signature Page

In addition, DHCS inspected samples of seventy four (74) service authorizations to verify compliance with regulatory requirements. The service authorization samples review findings are detailed below:

Requirement	# of Services Authorizations in compliance	# of Service Authorizations out of compliance	Compliance Percentage
Service authorization approved or denied by licensed mental health or waivered/registered professionals	72	2	97%
Adverse decisions based on criteria for medical necessity or emergency admission approved by a physician (or psychologist, per regulations)	N/A	N/A	N/A

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(b)(3). The MHP must complete a CAP addressing this finding of partial compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP contract, Ex. A, Att. 12; Fed. Code. Regs., tit. 42, § 438, subd.406(b)(1).)
The acknowledgment letter shall include the following: a) Date of receipt b) Name of representative to contact c) Telephone number of contact representative d) Address of Contractor (MHSUDS., IN., No. 18-010E)
The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS., IN., 18-010E)

FINDING

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

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

- Policy A-023 Beneficiary Problem Resolution (Grievance and Appeals)
- Grievance and Appeal Process Brochure
- FY 2018-2019 Grievances Samples
- FY 2017-2018 Grievances Log
- FY 2018-2019 Grievances Log
- FY 2019-2020 Grievances Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP sample verification identified inconsistency in providing acknowledgement letters postmarked within five (5) calendar days of receipt of the grievance, appeals, and expedited appeals.

In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below;

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	50	15	31	38%
APPEALS	N/A	N/A	N/A	N/A
EXPEDITED APPEALS	N/A	N/A	N/A	N/A

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

REQUIREMENT
The MHP shall adhere to the following record keeping, monitoring, and review requirements:
Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (Fed. Code Regs., tit. 42, § 438, subd.416(a); Cal. Code Regs., tit. 9, § 1850, subd.205(d)(1).)
Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person for whom the appeal or grievance was filed. (Fed. Code Regs., tit. 42, § 438, subd.416(b)(1)-(6).)
Record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. (Cal. Code Regs., tit. 9, § 1850, subd.205(d)(2).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must adhere to the record keeping, monitoring, and review requirements as listed above.

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

- Policy A-023 Beneficiary Problem Resolution (Grievance and Appeals)
- FY 2017-2018 Grievances Log
- FY 2018-2019 Grievances Log
- FY 2019-2020 Grievances Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the FY 2017-2018 and FY 2018-2019 grievance logs did not have mechanisms to track compliance for recording grievances, appeals, and expedited appeals in the log within one (1) working day of the date of receipt of the grievance, appeal, or expedited appeal. All logs lacked the date of each review or review meeting, resolution information for each level of the appeal or grievance if applicable, and the final disposition or reason for not having final disposition.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 416(a), and California Code of Regulations, title 9, section 1850, subdivision 205(d)(1). However, the MHP demonstrated corrections made in the log for FY 2019-2020 and has hired a dedicated of grievance/appeal coordinator to monitor the process. Therefore, a CAP is not necessary for this deficiency. The MHP must complete a CAP addressing on going monitoring compliance with this requirement utilizing updated log and newly hired grievance/appeal coordinator.

REQUIREMENT
Resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (Fed. Code Regs., tit. 42, § 438, subd. 408(a)-(b)(1).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance

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

- Policy A-023 Beneficiary Problem Resolution (Grievance and Appeals)
- FY 2018-2019 Grievances Samples
- FY 2017-2018 Grievances Log
- FY 2018-2019 Grievances Log
- FY 2019-2020 Grievances Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the grievance sample verification indicated some grievance samples did not have information necessary to verify the compliance in this area.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below;

	RESOLVED WITHIN TIMEFRAMES			REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
	# OF SAMPLE REVIEWED	# IN COMPLIANCE	# OOC		
GRIEVANCES	50	13	37	0	26%
APPEALS	N/A	N/A	N/A	N/A	N/A
EXPEDITED APPEALS	N/A	N/A	N/A	N/A	N/A

DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must complete a CAP addressing this finding of partial compliance.

REQUIREMENT
Provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted. (Cal. Code Regs.,tit. 9, § 1850, subd.206(c).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c). The MHP must provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

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

- Policy A-023 Beneficiary Problem Resolution (Grievance and Appeals)
- FY 2018-2019 Grievances Samples
- FY 2017-2018 Grievances Log
- FY 2018-2019 Grievances Log
- FY 2019-2020 Grievances Log

While the MHP submitted evidence to demonstrate compliance with this requirement, the grievance sample verification indicated thirty four (34) missing written Notices of Grievance Resolutions.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below;

	# OF SAMPLE REVIEWED	RESOLUTION NOTICE		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	50	16	34	32%
APPEALS	N/A	N/A	N/A	N/A
EXPEDITED APPEALS	N/A	N/A	N/A	N/A

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c). The MHP must complete a CAP addressing this finding of partial compliance.

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

FINDING

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

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

- Policy & Procedure A-023 Beneficiary problem Resolution

While the MHP submitted evidence to demonstrate compliance with this requirement, the Policy & Procedure only states that the beneficiary has the right to request current aid or services continue until the resolution of an Appeal or State Fair Hearing. It does not include all the circumstances where the MHP must continue services.

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

PROGRAM INTEGRITY

REQUIREMENT
The MHP has a Compliance program designed to detect and prevent fraud, waste and abuse. (Fed. Code Regs., tit. 42, § 455, subd.1(a)(1) and 608).

FINDING
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 1(a)(1) and 608. The MHP must have a Compliance program designed to detect and prevent fraud, waste and abuse.

The MHP submitted the following documentation as evidence of compliance with this requirement:
- Comprehensive Health Insurance Portability and Accountability Act (HIPPA) policies
- Provider Overpayment Tracking Logs
- Example of Fraud Report and Correction
- Tulare County Compliance Plan

Specifically, the MHP is using the Tulare County Compliance Plan to guide them in their development of their own county plan. The MHP identified that they are currently meeting monthly and the compliance plan is in development.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 1(a)(1) and 608. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP Compliance program includes:
A Regulatory Compliance Committee (RCC) at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements of this contract. (MHP contract, Ex. A, Att. 13; Fed. Code Regs., tit. 42, §438, subd.608(a)(1).)

Effective lines of communication between the CO and the organization's employees. (MHP contract, Ex. A, Att. 13; Fed. Code Regs., tit. 42, §438, subd.608(a)(1).)
Enforcement of standards through well publicized disciplinary guidelines. (MHP contract, Ex. A, Att. 13; Fed. Code Regs., tit. 42, §438, subd.608(a)(1).)
The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract. (Fed. Code Regs., tit. 42, §438, subd.608(a)(1).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attached 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(1). The MHP Compliance program must include all requirements listed above.

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

- Board Resolution adopting Compliance Officer (CO) and Policies
- Completed Staff Training-HIPAA-Responding to HIPPA Breaches
- Competed Staff Training-What everyone needs to know
- Compliance Officer Certificate of Training
- County Compliance policies
- Kings View Compliance policies
- Provider Overpayment Tracking Logs
- Example of Fraud Report and Correction
- Conflict of Interest Codes

The MHP identified that the compliance meetings began in 2019 on a monthly basis. The MHP is currently in the process of developing a checklist, which will allow for better communication between the organizations employees and their CO. The policies and procedures developed by the MHP require annual audits, however, evidence of this practice was not provided. Additional policies were provided after the review however, they are specifically related only to the subcontracted provider Kings View but not for the MHP's compliance program entirely.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attached 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(1). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP shall implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP contract, Ex. A, Att. 13; Fed. Code Regs., tit. 42, § 438, subd.608(a)(6).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(6). The MHP must implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers.

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

- Comprehensive Health Insurance Portability and Accountability Act Polices
- Fraud with County Compliance Policies

Specifically, the MHP does not have written policies that provide detail information about the False Claims Act and other Federal and State Laws.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(6). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP shall implement and maintain arrangements or procedures that include provision for the Contractor's suspension of payments to a network provider for which there is a credible allegation of fraud. (MHP contract, Ex. A, Att. 13; Fed. Code Regs., tit.42, § 438, subd.608(a)(8).)

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(8). The MHP must implement and maintain arrangements or procedures that include provision for the Contractor's suspension of payments to a network provider for which there is a credible allegation of fraud.

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

- Comprehensive Health Insurance Portability and Accountability Act Polices

Specifically, the evidence does not include the MHP's ability to suspend payments to its network providers.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(8). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP implements and maintains procedures designed to detect fraud, waste and abuse that includes provisions to verify that services reimbursed by Medicaid were received by the beneficiary. (Fed. Code Regs., tit. 42, § 438, subd.608(a)(5).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subd. 608(a)(5). The MHP must implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary.

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

- Revised Verification Form
- Service Verification Report
- Memo Service Verification Forms

While the MHP submitted evidence for this requirement, the MHP did not provide evidence of beneficiary service verification being conducted of one of their subcontractors.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subd. 608(a)(5). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP ensures collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control. (Fed. Code Regs., tit. 42, § 455, subd.101 and 104).

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 101 and 104. The MHP must ensure collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control.

The MHP did not submit evidence of compliance with this requirement.

The MHP during the review stated that currently they do not have policies and procedures regarding disclosure requirements. The MHP reported that this is an area that they will be focusing on in the upcoming year.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 101 and 104. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. (Fed. Code Regs., tit. 42, § 455, sube.434(a).)

FINDING

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

The MHP did not submit evidence of compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a). The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
The MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. (Fed. Code Regs., tit. 42, § 455, subd.434(b)(1) and (2)).

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2). The MHP must require providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable.

The MHP did not submit evidence of compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2). The MHP must complete a CAP addressing this finding of non-compliance. This is a repeated deficiency identified in the previous triennial review.

REQUIREMENT
The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under Federal Code of Regulations, title 42, section 455, subd.104. (MHP contract, Ex. A, Att. 13)
Disclosures must include:
The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.
The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.
The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address.
Date of birth and Social Security Number (in the case of an individual).
Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest)
Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;
The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and

The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process under Federal Code of Regulations, title 42, section 455, subdivision 104.

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under Federal Code of Regulations, title 42, section 455, subd.104. Disclosure must include all aspects listed above.

The MHP did not submit evidence of compliance with this requirement.

DHCS deems the MHP out of compliance with MHP contract, exhibit A, attachment 13. The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. (MHP contract, Ex. A, Att. 13)
The ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
Any significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request.
The MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the

request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

The MHP did not submit evidence of compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13. The MHP must complete a CAP addressing this finding of non-compliance.

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

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

The MHP did not submit the evidence of compliance with this requirement.

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

EQUIREMENT
The MHP has a process to confirm monthly that no providers is on the: a) OIG List of Excluded Individuals/Entities (LEIE). b) System of Award Management (SAM) Excluded Parties List System (EPLS). c) DHCS Medi-Cal List of Suspended or Ineligible Providers (S&I List). (Fed. Code Regs., tit. 42, § 438, subd. 608(d) and §455, subd.436)

FINDING

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

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

- Policy & Procedure Credentialing/re-credentialing of Providers
- Kings View Network Provider Credentialing template
- Conflict of Interest Codes
- OIG HHS DHCS MediCal Suspended Ineligible database
- Provider Application

While the MHP submitted evidence to demonstrate compliance with this requirement, the report provided did not include the month of October 2019 and reviewer was unable to verify the MHP's compliance with this requirement for October 2019. The MHP stated that this was due to staffing issues.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608 and section 455, subdivision 436. The MHP must complete a CAP addressing this finding of non-compliance.

OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

REQUIREMENT
The MHP must comply with the requirements of California Welfare and Institution Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

FINDING

The MHP did not furnish evidence to demonstrate compliance with California Welfare and Institution Code, section 14705(c) and 14712(e). The MHP must comply with the requirements of California Welfare and Institution Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

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

- P&P Annual Mental Health Plan Cost Report
- Cost Report extension email from DHCS
- Cost Report submission extension request from MHP

In addition, DHCS reviewed internal compliance data on timely cost report submission. The Cost Reports for FY 16/17 and 17/18 were submitted on time. However, the Cost

Report for FY 18/19 was not submitted within the 30-day extension period that was approved by DHCS.

DHCS deems the MHP out of compliance with California Welfare and Institution Code, section 14705(c) and 14712(e). The MHP must complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. (MHP contract, Ex. E; Fed. Code Regs., tit. 42, § 438, subd. 3(h) and 230(c)(3)(i-iii).)
The MHP shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (MHP contract, Ex. E; Fed. Code Regs., tit. 42, § 438, subd. 3(h) and 230(c)(3)(i-iii).)

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit E, and Federal Code of Regulations title 42, section 438, subdivision 3(h) and 230(c)(3)(i-iii). The MHP, and subcontractors, must allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. Also the MHP must allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later

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

- Boilerplate contract
- 24/7 Agreement

While the MHP submitted evidence to demonstrate compliance with this requirement, the contract has a records and inspection section but does not include inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract.
In addition, the records and inspection section of the boilerplate contract does not include the inspection of and the premises, equipment, and facilities.

DHCS deems the MHP out of compliance with the MHP contract, exhibit E, and Federal Code of Regulations title 42, section 438, subdivision 3(h) and 230(c)(3)(i-iii).. The MHP must complete a CAP addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

AUTHORIZATION REQUIREMENTS FOR CONCURRENT REVIEW AND PRIOR AUTHORIZATION

REQUIREMENT
MHPs must comply with the following communication requirements: (MHSUDS., IN., No. 19-026)
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.
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.
A physician shall be available for consultation and for resolving disputed requests for authorizations.
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.
Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS.
MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

FINDING
The MHP did not furnish evidence to demonstrate compliance with this survey item requirement.

SUGGESTED ACTION

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

- Develop a policy/procedure and practices regarding the concurrent review process.

REQUIREMENT
Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision. 1) If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. 2) In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. (MHSUDS., IN., No. 19-026)

FINDING

The MHP did furnished evidence to demonstrate compliance with this survey item requirement.

- Service Authorization Utilization Management Policy

SUGGESTED ACTION

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

- Update language in the policy to include the 24-hour requirement.

REQUIREMENT
In order to conduct concurrent review and authorization for administrative day service claims, 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. 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. (MHSUDS., IN., No. 19-026)

FINDING

The MHP did not furnish evidence to demonstrate compliance with this survey item requirement.

SUGGESTED ACTION

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

- Develop a policy/procedure that includes all the requirements in MHSUDS. IN., No 19-026

REQUIREMENT
1) MHPs 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.
2) 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. (Fed. Code Regs., tit. 42, § 438, subd.210(d)(2)).

FINDING
The MHP did not furnish evidence to demonstrate compliance with this survey item requirement.

SUGGESTED ACTION

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

	# 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.	24	9	63%
Expedited Authorization: The MHP makes 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	N/A	N/A	N/A

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

- Develop a process to ensure that prior authorizations do not exceed five (5) business days from the MHP's receipt of the information

REQUIREMENT
The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized. (MHSUDS., IN., No. 19-026)

FINDING

The MHP did not furnish evidence to demonstrate compliance with this survey item requirement.

SUGGESTED ACTION

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

- Develop a policy/procedure to satisfy this requirement.

REQUIREMENT
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. (MHSUDS., IN., No. 19-026)

FINDING

The MHP did not furnish evidence to demonstrate compliance with this survey item requirement.

SUGGESTED ACTION

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

- Develop a policy/procedure to satisfy this requirement.