CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2018/2019
MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW OF THE LOS ANGELES COUNTY MENTAL HEALTH PLAN

FINDINGS REPORT

Review Dates: February 4, 2019 and February 6, 2019

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EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted an onsite review of the Los Angeles County MHPs Medi-Cal SMHS programs on February 4, 2019 through February 6, 2019. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2018/2019 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

The Medi-Cal system review evaluated the MHP's performance in the following categories:

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

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

The report is organized according to the findings from each section of the FY 2018/2019 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services, specifically Sections A-H and the Attestation. This report details the requirements deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS.

For informational purposes, this findings report also includes additional information that may be useful for the MHP, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone line and a section detailing information gathered for the "SURVEY ONLY" questions in the Protocol.

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

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

(1) Description of corrective actions, including milestones;
(2) Timeline for implementation and/or completion of corrective actions;
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS;
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should purpose an alternative corrective action plan to DHCS; and
(5) Description of corrective actions required of the MHP's contracted providers to address findings.

FINDINGS

SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

	REQUIREMENT
E	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. (42 C.F.R. § 438.206(c)(1)(i).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 CFR Section 438.206(c)(1)(i). The MHP must meet, and require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of SMHS. The MHP did not submit to DHCS its policies and procedures addressing the timely access standards and requirements.

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

- Policy and Procedure 302.07-Access to Care;
- Provider Contract Boilerplate;
- Current Implementation Plan 2017; and
- EQRO.

It was determined the documentations lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the evidence did not document psychiatry appointment within 15 days, non-urgent appointments with a non-physician mental health care provider within 10 business days from request to appointment, Urgent care appointments for services that do not require prior authorization within 48 hours of the request for an appointment, and Urgent care appointments for services that do require prior authorization within 96 hours of the request for an appointment.

DHCS deems the MHP out of compliance with 42 CFR Section 438.206(c)(1)(i). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
H	The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).) 1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.206(c)(1)(iv).), and (42 C.F.R. § 438.206(c)(1)(v).).

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

- Provider Contract.

It was determined the documentations lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not provide evidence of a mechanism to demonstrate how it monitor network providers regularly to determine compliance with timely access requirements and any evidence of corrective action plan policy or documents.

DHCS deems the MHP out of compliance per 42 C.F.R. § 438.206(c)(1)(iv).), and (42 C.F.R. § 438.206(c)(1)(v).). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
A	The County uses its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e).)
B	The MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); and 5600.7(e); Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§ 441.13 and 435.1009.

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

- Program Brochures.

The MHP did not provide evidence that the county uses its 1991 realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in an Institutions for Mental Disease (IMD) to target populations and to Medi-Cal beneficiaries under the age of 21 or 65 years or older.

DHCS deems the MHP out of compliance. The MHP must come into compliance with the provisions of (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 5600 (a); 5600.4(f); 5600.5(e); 5600.6(e); 5600.7(e).), (MHSUDS IN No. 18-008; Welf. & Insti. Code §§ 14053(a) and (b)(3); 42 U.S.C. § 1396d(a)(29)(B), (a)(16) & (h)(1)(c); 42 C.F.R. §§

441.13 and 435.1009). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
C	2) The MHP's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 C.F.R. §§ 438.12(a)(2), 438.214(c).)
	3) The MHP may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. (42 C.F.R. § 438.12(a)(1).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. §§ 438.12(a)(2), 438.214(c) and 42 C.F.R. § 438.12(a)(1). The MHP must not discriminate when selecting or retaining providers.

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

- Recruitment Announcement.

The recruitment announcement didn't address this requirement AND the MHP didn't submit a P&P or other documentation as evidence of compliance.

DHCS deems the MHP out of compliance with the provisions of (42 C.F.R. §§ 438.12(a)(2), 438.214(c).), (42 C.F.R. § 438.12(a)(1).). The MHP must complete a POC addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

	REQUIREMENT
F	**SURVEY ONLY** 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)

SURVEY

DHCS reviewed the following documentation provided by the MHP for this survey item:

- TFC Service Provision;
- List of Referrals (ITFC & MTFC);
- David & Margaret Home Inc.;
- Rosemary Children's Services;
- Ettie Lee Youth and Family Services; and

- ChildNet Youth and Family Services.

The MHP has implemented TFC in the County. DHCS will provide technical assistance, as appropriate.

SUGGESTED ACTION
No further action required at this time.

	REQUIREMENT
G	**SURVEY ONLY** 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)

SURVEY
DHCS reviewed the following documentation provided by the MHP for this survey item:

- TFC Service Provision;
- List of Referrals (ITFC & MTFC);
- David & Margaret Home Inc.;
- Rosemary Children's Services;
- Ettie Lee Youth and Family Services; and
- ChildNet Youth and Family Services.

The MHP has implemented TFC in the County. DHCS will provide technical assistance, as appropriate.

SUGGESTED ACTION
No further action required at this time.

SECTION B: CARE COORDINATION AND CONTINUITY OF CARE

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

SURVEY
The MHP did not furnish evidence to demonstrate it complies with the MHP Contract, Ex. A, Att.10 and 42 C.F.R. § 438.62(b)(1)-(2). On December 17, 2018, DHCS issued Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No. 18-059, which outlines requirements related to transition of care, including continuity of care guidelines.

The MHP did not submit any documentation(s) as evidence of compliance with this requirement.

SUGGESTED ACTION
There is no corrective action needed at this time; however, the MHP must implement MHSUDS Information Notice No. 18-059. DHCS will conduct additional monitoring related to these requirements.

SECTION C: QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENTS

	REQUIREMENT
E	The QAPI work plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for: 2. Timeliness for scheduling of routine appointments.

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 5.

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

- QAPI Work Plan;
- QIC agendas and/or minutes; and
- Contract Boilerplate.

The QI Work Plan did not address the timeliness for scheduling routine appointments.

DHCS deems the MHP out of compliance with MHP Contract, Ex. A, Att. 5. The MHP must complete a POC addressing this finding of non-compliance.

SECTION D: ACCESS AND INFORMATION REQUIREMENTS

	REQUIREMENT
B	Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1)) 1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.

	2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
	3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
	4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

The DHCS review team made seven (6) calls to test the MHP's 24/7 toll-free line. The six (6) test calls are summarized below:

Test Call #1 was placed on Monday, October 8, 2018, at 11:00 p.m. The call was initially answered after one (1) ring via a phone tree directing the test caller to dial 911 if life-threatening emergency then prompted caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was transferred to a live operator. The caller requested information about accessing SMHS in the county. The operator asked the caller if they required immediate services or were feeling suicidal. The caller replied in the negative. The operator advised caller of the mobile transport team, the assessment process and the walk-in process as well as calling the clinic for an appointment. The operator requested caller's zip code and provided them with a clinic location near their residence. The caller was provided a clinic's address, phone number and hours of operation. The MHP has a statewide, toll-free number 24/7 with language capability. The caller was provided information about how to access SMHS and provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #2 was placed on Wednesday, October 31, 2018, at 10:16 a.m. The call was initially answered after one (1) ring via a phone tree directing the test caller to dial 911 if life-threatening emergency then prompted caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was transferred to a live operator. The caller requested information about accessing SMHS in the county. The operator asked the caller if they required immediate services or were feeling suicidal and caller replied in the negative. The operator advised caller of the walk-in process as well as calling the clinic for appointment. The operator requested caller's zip code and provided two (2) clinic locations near the caller's residence. The caller was also provided with the clinic's address, phone number and hours of operation. The MHP has a statewide, toll-free number 24/7 with language capability. The caller was provided information about how to access SMHS and provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #3 was placed on Friday, December 7, 2018, at 3:48 p.m. The call was initially answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, other options included Mental Health, Emergency, or Gatekeeping, options were available too. The caller pressed the option for Patients' Rights. The operator asked the caller if this was a crisis and the caller replied in the negative. The caller informed the operator they wanted to file a complaint against a therapist. The operator explained that the Grievance Forms could be picked up at the mental health clinic or they could call the Patient's Rights' Office. The caller was also informed the forms could be mailed to them. The operator informed the caller that the Los Angeles County Department of Health's website contained a clinic finder by zip code. The operator located a mental health clinic in the caller's zip code. No additional information about SMHS was provided to the caller. The caller was provided information about how to use the beneficiary problem resolution process.

The call is deemed in compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #4 was placed on Tuesday, January 8, 2019, at 3:23 p.m. The call was initially answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the DHCS test caller then heard a recorded greeting and instructions to call 911 in an emergency. The caller was then placed on hold for about six (6) minutes while the call was transferred to a live operator. The caller requested information about accessing mental health services in the county. The operator asked the test caller if they were safe, felt like harming oneself or others. The test caller answered in the negative and then explained their situation. The operator then asked the caller to provide their name and contact information. The initial call was dropped, because of a poor connection; however, the operator called the caller back. The caller provided the operator with their general location. The operator located a clinic in the caller's area and gave her the name, address, phone number, and walk-in hours, as well as general hours of operation.

The call is deemed in compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #5 was placed on Thursday, December 13, 2018, at 7:47 a.m. The call was initially answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was then given more options based on information needed. The caller chose the option for the patient rights and heard a recording announced that for quality purposes, the call was being recorded and then a live operator answered. The operator asked the caller if they were in crisis and the caller stated negative. The caller requested information about filing a complaint about their therapist. The operator provided the 1-800-700-9996 number for the Patients' Rights Office and stated they would be in at 8:00 a.m. The caller asked the operator if they could provide information about the process. The operator was hesitant and stated they did not want to give out

misinformation. The operator advised the caller to fill out the forms, available in the office, and the grievance will be investigated. The operator did not provide an office location, where to obtain forms, or offer to mail the forms. The operator did not provide any specific procedures for grievances, problem resolution, or state fair hearings.

The call is deemed out of compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #6 was placed on Monday, December 31, 2018, at 7:25 a.m. The call was answered after one (1) ring via a phone tree directing the test caller to dial 911 if life-threating emergency then prompted the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was transferred to a live operator. The caller requested information about accessing SMHS in the county. The operator asked the caller to provide their son's name, DOB, insurance, and caller's name. The caller provided operator with the requested information and the stated her child had Medi-Cal, but could not locate the card. The operator requested the caller's phone number for a call back. The caller informed the operator they were using a friend's phone. The caller asked the operator if the MHP had walk-in services available. The operator stated no. The operator then provided the caller with the clinic address, phone number, hours of operation, and informed the caller to call ahead for an appointment. The caller was provided information about how to access SMHS and the caller was provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

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

FINDING

Test Call Results Summary

Protocol Question	Test Call Findings						Compliance Percentage
	#1	#2	#3	#4	#5	#6	
D.VI.B.1	IN	IN	IN	IN	IN	IN	100%
D.VI.B.2	IN	IN		IN		IN	100%
D.VI.B.3	IN	IN		IN		IN	100%
D.VI.B.4			IN		OUT		50%

In addition to conducting the seven (6) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- Annual Test Calls Report CY 2016;
- Policy 202.43 – Scheduling Initial Clinical Appointments and Associated Documentation;

- Quality Assurance Bulletin, Dated 11/7/2013 No. 13-06 – Service Request Log & Beneficiary Acknowledge of Receipt;
- ACCESS Center Training Plan - FY 2016 through FY 2019; and
- Cross Cultural Customer Service Phone Skills.

The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(d) and 1810.410(e)(1). Protocol requirement D.VI.B.4 is deemed OOC. The MHP must complete a POC addressing this finding of non-compliance.

The MHP must submit a POC addressing the OOC finding for these requirements.

REQUIREMENT	
C.	1) The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, title 9, chapter 11, section 1810.405(f)).
	2) The written log(s) contain the following required elements: CCR, title 9, chapter 11, section 1810.405(f) a) Name of the beneficiary.
	b) Date of the request.
	c) Initial disposition of the request.

In addition, the logs made available by the MHP did not include all required elements for calls. The table below details the findings:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	10/8/2018	11:00 p.m.	OUT	OUT	OUT
2	10/31/2018	10:16 a.m.	OUT	OUT	OUT
4	1/8/2019	3:23 p.m.	IN	IN	IN
7	12/31/2018	7:25 a.m.	IN	IN	IN
Compliance Percentage			50%	50%	50%

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

FINDING

The MHP did not furnish evidence of its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Los Angeles Call Log. However, the access log did not contain two (21) of the four (4) DHCS test calls. The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(f).

Protocol question(s) D.VI.C.2a, D.VI.C.2b, and D.VI.C.2c are deemed in partial compliance. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with all regulatory requirements. The MHP was deemed OOC during its previous triennial review. The MHP must complete a POC addressing this finding of non-compliance.

SECTION E: COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT	
H.	1) For standard authorization decisions, the MHP shall provide notice as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when: a) The beneficiary, or the provider, requests extension.

PROTOCOL REQUIREMENT		TREAMTMENT AUTHORIZATION DECISIONS IN COMPLIANCE	TREATMENT AUTHORIZATION DECISIONS OOC	COMPLIANCE PERCENTAGE
E.1.H.1	MHP makes authorization decisions and provides notice within 14 calendar days	199	1	99.5%

FINDING

The MHP did not furnish evidence to demonstrate it complies with the MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(d)(1). The MHP must make a decision to approve or deny a Treatment Authorization Request within 14 calendar days. The MHP submitted to DHCS a sample of 200 TARs for DHCS to review and out of the 200 DHCS found 1 that was out of compliance. DHCS reviewed one TAR that exceeded the 14 calendars days.

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

- 200 TAR's.

The evidence that was reviewed was insufficient to satisfy MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(d)(1), and is deemed in partial compliance. The MHP must complete a POC addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

	REQUIREMENT
H	**Survey Only:** 2. MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

SURVEY

DHCS reviewed the following documentation provided by the MHP for this survey item:

- FFS Network Provider Manual;
- Implementation Plan; and
- QAPI Work Plans.

SUGGESTED ACTION

The documents reviewed did not state what the timeline is for making decisions. There is no corrective action needed for this requirement, however the MHP needs to incorporate evidence of this requirement for meeting future requirements.

SECTION F: BENEFICIARY RIGHTS AND PROTECTIONS

	REQUIREMENT
E	2) The acknowledgment letter shall include the following: a. Date of receipt

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1). The MHP must send out an acknowledgment letter to the beneficiary when they receive a grievance. The letter must include the date the MHP received the grievance.

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

- Policy 200.04 - Beneficiary Problem Resolution Process;
- Sample of Acknowledgment Letters; and
- Grievance Log.

DHCS reviewed the evidence and the required date of receipt was not included in the sample of Acknowledgment Letters that were provided to DHCS. In the body of the letter, it states: "This is to inform you that we are in receipt of your grievance." It does not state the date of receipt.

DHCS deems the MHP out of compliance with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
E	3. 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 it complies with MHSUDS IN 18-010E. The MHP must send to the beneficiary an acknowledgment letter, postmarked within 5 calendar days of receipt of the grievance.

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

- Policy 200.04 - Beneficiary Problem Resolution Process;
- Acknowledgment Letter template; and
- Grievance Log.

The receipt date cannot be confirmed from the Acknowledgement Letters or the Grievance Log, therefore DHCS is unable to validate if the letters were sent out within fine (5) calendar days.

DHCS deems the MHP out of compliance with MHSUDS IN 18-010E. The MHP must complete a POC addressing this finding of non-compliance.

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

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a). When making decisions regarding adverse benefit determinations, the MHP must look at all information provided by the beneficiary, staff, or anyone who is involved with the grievance and/or appeal.

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

- Policy 200.04 - Beneficiary Problem Resolution Process.

The policy did not address, nor did the MHP submit any other evidence that the MHP shall ensure that the decision makers on the grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

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

	REQUIREMENT
P	The MHP shall provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.408(b)-(c).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.408(b)-(c). The MHP must inform the beneficiary that s/he can have their case file free of charge for standard and expedited appeal resolutions.

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

- Policy 200.04 - Beneficiary Problem Resolution Process.

The policy did not address, nor did the MHP submit any other evidence that the MHP shall provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

DHCS deems the MHP out of compliance with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.408(b)-(c). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
A	The MHP shall adhere to the following record keeping, monitoring, and review requirements: 1. 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. (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1). The MHP must log any grievance, appeal, or expedited appeal within one business day of receiving it. Receipt date and log date must be within one business day of each other.

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

- Grievance Log; and
- Policy 200.04 - Beneficiary Problem Resolution Process.

The Grievance log does not indicate when the grievance was received nor does it indicate when the grievance was logged.

DHCS deems the MHP out of compliance with 42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
A	2. 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 whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.416(b)(1)-(6). The MHP must provide 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 whom the appeal or grievance was filed for each and every entry.

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

- Grievance Log; and
- Policy 200.04 - Beneficiary Problem Resolution Process.

The Grievance log does not indicate when the grievance was received, the date of each review or review meeting, or the date of the resolution.

DHCS deems the MHP out of compliance with 42 C.F.R. § 438.416(b)(1)-(6). The MHP must complete a POC addressing this finding of non-compliance

	REQUIREMENT
A	3. 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, § 1850.205(d)(2).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with Cal. Code Regs., tit. 9, § 1850.205(d)(2). The MHP must note the date that the disposition was sent to the beneficiary.

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

- Grievance Log; and
- Policy 200.04 - Beneficiary Problem Resolution Process.

The Grievance log does not indicate the date that the disposition of the grievance, appeal, expedited appeal was sent to the beneficiary. The MHP did not provide any other evidence to comply with the requirement.

DHCS deems the MHP out of compliance with Cal. Code Regs., tit. 9, § 1850.205(d)(2). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
A	The MHP's grievance process shall, at a minimum: Allow beneficiaries to file a grievance either orally, or in writing at any time with the MHP. (42 C.F.R. § 438.402(c)(2)(i) and (c)(3)(i).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.402(c)(2)(i) and (c)(3)(i).

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

- Policy 200.04 - Beneficiary Problem Resolution Process

The MHP provided policy stating "A written statement by the beneficiary outlining his/her concerns must follow all oral grievances and appeals, with the exception of expedited appeals." An oral grievance does not need to be in writing.

DHCS deems the MHP out of compliance with 42 C.F.R. § 438.402(c)(2)(i) and (c)(3)(i). The MHP must complete a POC addressing this finding of non-compliance.

DHCS deems the MHP out of compliance with 42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(2). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
A	6. Provide the beneficiary and his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions.

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.408(b)-(c). The MHP must provide the beneficiary of the resolution of each grievance, appeal, or expedited appeal.

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

- Policy 200.04 - Beneficiary Problem Resolution Process.

The policy did not address, nor did the MHP provide any other evidence that the beneficiary and his or her representative would provide the beneficiary's case file free of charge.

DHCS deems the MHP out of compliance with 42 C.F.R. § 438.408(b)-(c). The MHP must complete a POC addressing this finding of non-compliance.

	REQUIREMENT
D	3. Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (42 C.F.R. § 438.410(b).)

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.410(b). There must not be any punitive action taken against a provider if one were to request for an expedited resolution or supports a beneficiary's expedited appeal.

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

- Policy 200.04 - Beneficiary Problem Resolution Process.

The policy did not address anything regarding not taking punitive action against a provider who requests for an expedited resolution.

DHCS deems the MHP out of compliance with 42 C.F.R. § 438.410(b). The MHP must complete a POC addressing this finding of non-compliance.

SECTION G: PROGRAM INTEGRITY

	REQUIREMENT
A	3. If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. §438.608(a)(2),(4).

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. §438.608(a)(2),(4). The MHP must inform DHCS if they come across a provider who is excluded.

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

- 106.03 Employee's ability to participate in federally funded health care programs;
- 106.04 Contractors eligibility to provide goods and services under federally; funded health care programs and to secure federally funded contracts;
- 106.09 Removing names of sanctioned individuals from the rendering provider list; and
- 106.14 National Provider Identifier (NPI) requirements.

The policies submitted by the MHP do not address this requirement. DHCS was unable to find any evidence that the MHP provides prompt notifications if they were to come across and excluded provider.

DHCS deems the MHP out of compliance per 42 C.F.R. §438.608(a)(2),(4). The MHP must complete a POC addressing this finding of non-compliance.

SECTION H: OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

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

FINDING

The MHP did not furnish evidence to demonstrate it complies with W&I Code Sections 14705(c) and 14712(e). MHP must submit their annual cost reports to DHCS. The Annual Cost Report will be due on September 15th for the fiscal year ending on the previous June 30th. The MHP did not submit its 2017/2018 cost report in accordance with the established reporting deadlines.

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