CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2019/2020

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE ORANGE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: December 10, 2019 to December 12, 2019

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

TABLE OF CONTENTS

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

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 Orange County MHP's Medi-Cal SMHS programs on 12/10/2019 to 12/12/2019. 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) 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 Orange 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 out of compliance. The MHP is required to submit a CAP to DHCS within 60-days of receipt of the findings report for all system and chart review items deemed out-of-compliance. 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 not to be effective, the MHP should propose an alternative CAP to DHCS; and
(5) Description of corrective actions required of the MHP's contracted providers to address findings.

Review Findings Overview

- During the DHCS review, the MHP demonstrated numerous strengths, including but not limited to the following examples:
    - The MHP's ability and commitment to collaboration across service areas
    - Collaborative working relationship with the Managed Care Plan as evidenced by successful treatment coordination through the linkage of

services. The collaboration between both agencies appears to provide a seamless system of mental and physical health care for beneficiaries.

  - The longevity and expertise of the staff. The wealth of experience of these individuals has allowed Orange County to make needed adjustments over time.

  - Continuum of Care Reform resulting in the MHP having nine (9) Short Team Residential Therapeutic Programs (STRTPs). The MHP is working to add thirteen (13) more STRTPs.

  - The MHP has expanded crisis services.

- DHCS identified opportunities for improvement in various areas, including:

  - The MHP has been under a hiring freeze and has faced challenges with the need to rapidly implement various DHCS Information Notices.

  - Lack of IT capacity to extract necessary data needed to track compliance and use statistical methods to draw conclusions.

  - Continuous deficiencies in the twenty-four hours seven days a week toll free access line.

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

FINDINGS

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 Regulation, 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:

- Network Adequacy Internal Compliance Data
- 2017-22 MHP Contract (Implementation Plan)
- Annual Report QI Workplan and Access Log
- BHS Service Utilization Rates Analyses
- CAT Call & Hospitalizations
- CYBH Outpatient Program Outcome Flowchart
- Engagement Rate Monitoring
- EQRO Foster Care Penetration Rates
- MHP Geographic Access Maps July 2019
- Network Adequacy Verification Tool July 2019
- P&P Mental Health Plan and Drug Medi-Cal Organized Delivery System Network Adequacy Monitoring
- Penetration Rate Analysis

While the MHP submitted evidence to demonstrate compliance with the 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 Corrective Action Plan Remediation Tool. The MHP received a conditional pass on the Corrective Action Plan Remediation Tool for Provider Capacity for Adult and Children/Youth.

DHCS deems the MHP out-of-compliance with Federal Code of Regulation, Title 24, Section 438, subdivision 207(b)(1). The MHP must comply with the CAP requirements per the Network Adequacy Findings 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:

- Network Adequacy Internal Compliance Data
- P&P Behavioral Health Services 24/7 Access Line Requirements
- P&P Medi-Cal Timely Access and Service Availability
- Service Request BHS Access Log Screenshot
- Service Request Log Access Training pages 21-24
- Service Request Timely Access Correction Log 8-1-2019 thru 8-31-2019

While the MHP submitted evidence to demonstrate compliance with the requirement, it is not evident that the MHP is meeting the standards for timely access to care and services taking into account the urgency of need for services. In addition to the evidence submitted by the MHP, DHCS reviewed the most recent Network Adequacy Findings Report and the Corrective Action Plan Remediation Tool. The MHP received a conditional pass on the Corrective action Plan Remediation Tool for reported service requests meeting threshold.

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 requirements per Network Adequacy Findings Report 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 the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January

2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

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

- TFC Memo 10/30/2019
- TFC Implementation Slides
- ISFC TFC webinar 053018 notification
- HCA TFC Discussion Meeting 1/23/2019
- HCA TFC Discussion Meeting 10/2/2019
- CCR Meeting Minutes from 2018
- CCR Regional Convening
- Policy & Procedures 01.02.06 Pathway to Well Being and Intensive Services

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP does not have a TFC provider at the time of this review, therefore it does not have capacity to provide TFC services to those children and youth who meet medical necessity criteria for 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 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 the 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:

- TFC Memo 10/30/2019
- TFC Implementation Slides
- ISFC TFC webinar 053018 notification
- HCA TFC Discussion Meeting 1/23/2019
- HCA TFC Discussion Meeting 10/2/2019

- CCR Meeting Minutes from 2018
- CCR Regional Convening
- Policy & Procedures (P&P) 01.02.06 Pathway to Well Being and Intensive Services

While the MHP submitted evidence to demonstrate compliance with this requirement, they did not submit evidence that they determine if children and youth meet medical necessity criteria need TFC. The MHP's P&P Pathway to Well Being and Intensive Services does not address the need for 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
All contracts or written agreements between the MHP and any network provider specify the following:
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).) <u>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</u>. (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).)

<u>FINDING</u>
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:

- SCCS –BHOP Provider Contract July 1,2018 through June 30 2021
- Provider Contract-South Coast Children's Society Wraparound
- CHOC FSP FY 17-20 Agreement May 1, 2018 through June 30, 2020
- TeleCare Corporation Agreement July 1, 2019 through June 30, 2020

While the MHP submitted evidence to demonstrate compliance with this requirement, the current contracts did not include that the 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. The MHP did not submit evidence of amendment of those contracts. The MHP submitted the new unsigned copy of the Telecare Corporation agreement, which now has this requirement in it. While the unsigned copy of the contract included this requirement, there was no evidence of compliance for currently executed contracts.

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.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

REQUIREMENT
The Quality Assessment and Performance Improvement (QAPI) 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 (QAPI) Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence.

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

- CQIC Meeting Minutes
- CQIC Meeting Presentation
- Cultural Competency Training
- Quality Assessment and Performance Improvement Plan Summary FY 17/18, 19/20

While the MHP submitted evidence to demonstrate compliance with this requirement, the QAPI Work Plans submitted did not include evidence of compliance with the requirement for cultural competence and linguistic competence.

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.

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
The MHP provider directory must contain the following required elements: (Fed. Code Regs., tit. 42, § 438, subd.10(h)(1)(v), Cal Code Regs., tit. 9, chap. 11, § 1810, subd. 410, MHSUDS, IN, No. 18-020).
California license number and type of license
An indication of whether the provider has completed cultural competence training.

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(h)(1)(v), California Code of Regulations, title 9, chapter 11, section 1810, subdivision 410, and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-020. The MHP provider directory must contain all the elements required above.

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

- Provider Directory PDF Version
- Provider Directory by clinician

The MHP submitted the Provider Directory including the license number and type of license for the contracted providers. However, while the MHP submitted evidence to demonstrate compliance with this requirement, the Provider Directory did not include the license number and type of license for the county owned and operated providers as required by Information Notice 18-020. In addition, the cultural competence training information was missing for all providers on the directory.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(h)(1)(v), California Code of Regulations, title 9, chapter 11, section 1810, subdivision 410, and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-020. 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 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 the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

FINDING

The 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 #1 was placed on Tuesday, September 17, 2019, at 12:26 a.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The DHCS test caller was directed to dial 911 in an emergency. After selecting the option for English, the call was transferred to a live operator. The caller requested information about obtaining information regarding the grievance process. The operator explained that the forms could be obtained in the lobby at the MHP and could be obtained online. The operator provided the caller with clinic hours of operation and a telephone number to obtain further assistance regarding filing a grievance. The caller was provided information about how to use the beneficiary resolution and fair hearing process.

FINDING

The call is 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 #2 was placed on Friday, September 27, 2019, at 8:47 a.m. The call was 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 directed to select from the following options: Press 1 for Alcohol and Drug Related, Press 2 for Other Mental Health Services or Press 3 if you are a Health Professional. The caller pressed option 2 and the caller was transferred to a live operator who answered the call as Beacon Health. The caller requested information about how to file a complaint against a therapist. The operator asked the caller to provide his/her name

and the caller responded. The therapist asked if the caller is now seeing another therapist with Orange County Mental Health. The caller replied in the negative. The operator provided the number to call about grievances which is 866-308-3074. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

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

TEST CALL #3

Test call #3 was placed on Thursday, September 26, 2019, at 10:06 am. The call was answered after one (1) ring via a phone tree directing the caller to select a language option. These options included the MHP's threshold languages. After selecting the option for English, the DHCS test caller heard a recorded greeting and instructions to call 911 in an emergency. The caller was routed immediately to a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide her name and identifying information. The caller provided her name but declined to provide other identifying information. The operator did not require the caller's Medi-CAL number or SSN and continued to provide information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The operator provided information about services needed to treat a beneficiary's urgent condition and other support and crisis resources. The operator asked if the caller was in a safe environment, was in danger of hurting herself, or was in danger of hurting others. The operator was professional, helpful, kind, caring, and courteous. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, the caller was provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #4

Test call #4 for was placed on Thursday, September 26, 2019, at 9:14 am. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide her name, contact information and advised the caller that she was not in the county system. The operator stated she could not authorize services without the caller's Medi-Cal information. The operator then proceeded to provide information about a walk in clinic and a confidential free support number to the caller. The caller was provided with the information about how to access SMHS, including SMHS required to assess whether

medical necessity criteria are met, the caller was provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #5

Test call #5 was placed on Tuesday, October 1, 2019, at 7:23 am. The call was answered after one (1) ring via a phone tree directing the caller to dial 911, select #1 or stay on the line if the caller is having a medical emergency. Another recording came on providing instructions in other languages and stated if the call is for routine business matter to call back during business hours and it provided the hours of operation or select #2 for mental health services. The caller selected #2 and the phone rang one (1) time and remained silent for approximately 10 seconds. After the 10 seconds, a recording stated that the call will be forwarded to an automated answering service #6572360121 and that it is not available, then the call disconnected on its own. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. However the caller was 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 #6 was placed on Tuesday, October 1, 2019, at 12:59 p.m. The call was 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 two (2) minutes and fifty-six (56) seconds 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 caller to provide their name and contact information, and advised the caller that she/he was not in the county system. The operator advised the caller that someone from the county would contact the caller later in the week to schedule an assessment. 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 #7

Test call #7 was placed on Wednesday, October 30, 2019, at 7:31 am. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The caller was then placed on hold for one (1) minute 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 caller to provide his/her name and contact information, and advised the caller that he/she needed to be located in the county system for appropriate service provision. The operator also requested the caller's contact number or any number where the caller could be reached, in the event the call was disconnected. The caller asked if the information requested was required before he could get information regarding how to access SMHS. The operator explained again, that the identifiers requested from the caller were to locate the caller with appropriate services. Further, the operator inquired if the caller was in crisis. The operator informed the caller that he should call the same number during business hours, after which he will be assessed over the phone and linked with appropriate services. Operator did not provide 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).

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	IN	IN	IN	IN	IN	100%
2	N/A	N/A	IN	IN	OOC	OOC	OOC	40%
3	N/A	N/A	IN	IN	IN	IN	IN	100%
4	IN	OOC	N/A	N/A	N/A	N/A	N/A	50%

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

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 the 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:

- OCMHP Access Call Logs with Specific Dates
- DHCS Test Call Summary
- 24/7 Test Call Quarterly Report
- ASO Access Line Script
- ASC Test Call Worksheet
- Sample of telephone log
- Beacon After Hours log
- P&P Access line Requirement
- P&P ASO test Call Procedure

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged in the MHP's written log of initial requests. 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	9/26/2019	10:06 a.m.	IN	IN	IN
4	9/26/2019	9:14 a.m.	IN	IN	IN
5	10/1/2019	7:20 & 7:23 a.m.	Out (Name was not requested by MHP)	Out	Out
6	10/1/2019	12:59 p.m.	Out	Out	Out
7	9/30/2019	7:31 a.m.	Out	Out	Out
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.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
The MHP must provide beneficiaries with a NOABD under the following circumstances:
The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. (Fed. Code Regs., tit.42, § 438, subd.400(b)(1))

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination under the circumstances listed above.

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

- P&P Notice of Adverse Benefit Determination
- NOABH NOABD Tracking log FY 18-19
- CYBH NOABD Tracking Log FY 18-19
- Sample of NOABD's

- FOUR (4) denied Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, four (4) denied TARS did not have the required NOABD. The MHP was provided the opportunity to submit the NOABD's after the review. The evidence was not provided.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must complete a CAP addressing this finding of non-compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

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).)

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:

- Grievance P&P Beneficiary Problem Resolution and Grievance Process
- Grievance log FY 17/18, 18/19 & 19/20
- Sample of grievances

While the MHP submitted evidence to demonstrate compliance with this requirement, The log reflected that seven (7) grievances were not logged within one (1) working day of the date of the receipt.

DHCS deems the MHP out-of-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 complete a CAP addressing this finding of non-compliance.

REQUIREMENT
The MHP includes in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. (Fed. Code Regs., tit. 42, § 438, subd.408(e)(1)).
The MHP includes in the NAR the beneficiary's right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. (Fed. Code Regs., tit.42, § 438, subd. 408(e)(2)(i)).
The MHP includes in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request. (Fed. Code Regs., tit.42, § 438, subd.408(e)(2)(ii)).

FINDING

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, subdivision 408(e)(2). The MHP must include in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. The MHP must include in the NAR the beneficiary's right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. Also, the MHP must include in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request

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

- Beneficiary Appeal of Actions Process
- PDF document titled Appeal all Elements SYBH
- Grievance and Appeal PowerPoint Staff Training
- Resolution of Appeal letters
- Appeal Form
- Your Rights Notice
- P&P Beneficiary Appeal of Actions Process
- P&P Continuation of Services

While the MHP submitted evidence to demonstrate compliance with this requirement, the written notice of the appeal resolution did not include the beneficiary's right to request a State fair hearing, and receive benefits while the State fair hearing is pending, and how the beneficiary makes those requests.

DHCS deems the MHP out-of-compliance with Federal Code of Regulations, title 42, subdivision 408(e)(2). The MHP must complete a CAP addressing this finding of non-compliance.

PROGRAM INTEGRITY

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:
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)

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

- Conflict of Interest Code Disclosure and Filing Policy
- MC Contract Application 9/11/2018
- P&P Gift Ban Ordinance & Conflict of Interest
- Sample MC Contract Application
- Form 700

While the MHP submitted evidence to demonstrate compliance with this requirement, the disclosure forms submitted do not include all of the required items, specifically missing date of birth, social security number, and other tax identification number.

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

- Conflict of Interest Code Disclosure and Filing Policy

While the MHP submitted a policy as evidence to demonstrate compliance with this requirement, evidence of practice and/or implementation of the policy to demonstrate compliance was not submitted. The policy did not include the details of 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.