CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2018/2019

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

SYSTEM FINDINGS REPORT-AMENDED

Review Dates: April 10, 2019 and April 11, 2019

Riverside County Mental Health Plan
FY 2018/2019 Medi-Cal SMHS Triennial Review
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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 Riverside County MHPs Medi-Cal SMHS programs on April 10, 2019 through April 11, 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.

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

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
A.VI.C6- The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (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)(1). The MHP's shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).).

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

- P&P Contracted Provider Selection and Retention (no policy number); and
- P&P Providers Credentialing and Re-Credentialing (no policy number).

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall give practitioners or group of practitioners who apply to be a MHP contract providers and whom the MHP decides not to contract with them provide a written notice of the reason for a decision not to contract.

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

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

REQUIREMENT
C.I.E3- The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5).

FINDING

The MHP did not furnish evidence to demonstrate it complies with the MHP Contract, Ex. A, Att. 5. The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5).

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

- Client Phone Satisfaction Survey Results;
- Consumer Perceptions Survey (CPS); and

- Survey results.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall inform providers of the beneficiary/family satisfaction activities.

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

ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
D.I.B5- Beneficiary information required in Title 42 of the Code of Federal Regulations part 438.10 (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: 1. The format is readily accessible; 2. The information is placed in a location on the MHP's website that is prominent and readily accessible; 3. The information is provided in an electronic form which can be electronically retained and printed; 4. The information is consistent with the content and language requirements of the MHP Contract; and **5. 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. (42 C.F.R. 438.10(c)(6).)**

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. 438.10(c)(6). Beneficiary information required in 42 CFR § 438.10 (e.g., information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if 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. (42 C.F.R. 438.10(c)(6).).

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

- Policy and Procedure: 290 Mental Health Consumer Brochures and Posters;
- Beneficiary Handbook; and
- MHP website.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the beneficiaries is informed that the information is

available in paper form without charge upon request and provides it upon request within 5 business days.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.10(c)(6). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
D.II.GCc-The MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973: a) Prohibiting the expectation that family members provide interpreter services b) A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services **c) Minor children should not be used as interpreters.** (Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973).

FINDING

The MHP did not furnish evidence to demonstrate it complies with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 that Minor children should not be used as interpreters.

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

- Poster of Interpreter Services are available free of charge;
- Interpreter Invoices; and
- Beneficiary Handbook.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP complies with requirement that minor children should not be used as interpreters.

DHCS deems the MHP out-of-compliance with the terms of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The MHP must complete a POC addressing this finding of non-compliance

REQUIREMENT
D.VI.B- Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: 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. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

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 it complies with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1). Each MHP must provide:

- 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 seven (7) test calls are summarized below:

Test call #1 was placed on Thursday, January 17, 2019, at 7:35 a.m. The call was answered after one (1) ring via a phone tree. The caller was directed to select option for English or Spanish. After selecting one of the options, it instructed the caller to dial 911 or go to the nearest emergency room if the caller was in a crisis or experiencing a psychiatric emergency. An operator then answered the call. The caller requested information on how to access services. The operator asked for the caller's information. Upon providing some information to the operator, the operator provided the phone number, address, and hours of operation to the mental health clinic in Blythe. The caller thanked the operator and ended the call. The caller was provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met, the caller provided was information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #2 was placed on Thursday, January 17, 2019, at 1:17 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. The caller selected one of the options and an automated message stated "if this an emergency, please hang up and dial 911" and if this for a non-emergency mental health services, select option to speak with a staff. The caller selected the option to speak to staff and after three (3) rings, a live operator answered the call. The caller requested information about filling a medication. The operator asked for the caller's information. The caller stated that he/she does not have that information. The operator informed the caller that the county has 3 urgent walk-in locations where he/she could fill their medication. The operator provided the hours of operation, phone number, and address to the urgent care clinic. The operator conducted a brief status of the caller's current mental health condition. The operator added that the caller is able to refill his/her medication at any emergency room. The caller thanked the operator and ended the call. The operator provided information about SMHS to the caller. The caller was provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met, the caller provided was information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #3 was placed on Tuesday, January 22, 2019, at 11:09 a.m. The call was answered via a phone tree. The caller was prompted to select the correct language option and was provided instructions for emergencies. The call was then answered via a live operator. The caller requested information about accessing mental health services in the county. The operator walked the caller through the process. The operator asked if the caller would like to begin the process. The caller responded in the negative and that he/she was seeking information only. The operator provided information on accessing SMHS, including SMHS required to assess whether medical necessity criteria are met, including information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #4 was placed on Tuesday, February 12, 2019, at 5:12 p.m. The call was answered via a phone tree. The caller was prompted to select a language option for English or Spanish. After selecting an option, a recording stated that if the caller was in crisis or experiencing an emergency to call 9-1-1 or go to the nearest emergency room. After the recording, there was another prompt asking the caller to select to talk to someone or for Mental Health Services to call back during business hours. After selecting the option to talk to someone, the call was answered by a live operator. The caller requesting information about how to access mental health services. The operator asked the caller a few questions, informed the caller to go to the mental health facility in Riverside, and informed the caller that they have therapists on staff that can provide urgent care mental crisis. The operator asked the caller for his/her insurance information, to which the caller stated Medi-Cal. The operator provided the clinic information, address, and phone number. The operator provided information on accessing SMHS, including

SMHS required to assess whether medical necessity criteria are met, including information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #5 was placed on Friday, March 1, 2019, at 12:54 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 caller then heard a recorded greeting and instructions to call 911 in an emergency. The caller then 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 Medi-Cal or Insurance number. The caller informed the operator that their information was packed. The operator informed the caller that for medication refills that Riverside Mental Health has a 24/7 walk-in clinic located at Mental Health Urgent Care, which the operator provided the address and telephone number. The caller was also informed that once they received services at the clinic they could set-up an appointment at the Department of Behavioral Health Department. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #6 was placed on Wednesday, December 26, 2018, at 9:24am. The call was answered immediately via a phone tree directing the caller to select a language option between English and Spanish. After selecting the option for English, the DHCS test caller received a recorded greeting and provided the caller several options to choose. The caller pressed three (3). After four rings, the line was answered by the voice message stating Riverside County Behavioral Health, Quality Improvement Department and to leave message and phone number and the staff will call back at later time. The same voice message was repeated in Spanish. The caller did not leave voice message and ended the call. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes. The call is deemed out of compliance with the regulatory requirements for protocol questions D.VI.B4.

Test call #7 was placed on Thursday, December 20, 2018, at 7:34 a.m. The call was answered after three (3) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The phone tree also instructed the caller to dial 911 or go to the emergency room if the call was a life threatening emergency or if the caller was in crisis. Another recording directed the caller that if he/she is requesting authorization for mental health services that they are open during business hours. The caller selected the option to talk to someone. A live operator answered the caller immediately. The caller requested information about how to file a complaint with the county. The operator asked where the caller had services, Indio or Palm Springs. The caller replied Indio. The operator instructed the caller to call another

telephone number. The caller paused for a bit to see if the operator would provide any additional information, however the operator did not. The caller thanked the operator and ceased the call. The caller was not provided information about how to use the problem resolution and fair hearing process. The call is deemed out of compliance with the regulatory requirements for protocol question D.VI.B4.

FINDINGS

Test call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
D.VI.B.1	IN	IN	IN	IN	IN	N/A	N/A	100%
D.VI.B.2	IN	IN	IN	IN	IN	N/A	N/A	100%
D.VI.B.3	IN	IN	IN	IN	IN	N/A	N/A	100%
D.VI.B.4	N/A	N/A	N/A	N/A	N/A	OOC	OOC	0%

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- DHCS Test call worksheet;
- Policy and Procedures: CARES line 24/7 Access Line; Authorization Process, and Contract Log and Communication Form;
- Test call scripts;
- MHP test call results;
- Staff training log regarding test calls; and
- CARES line staff meeting agendas and minutes.

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP's toll-free telephone number did not provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

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

REQUIREMENT
D.VI.C1-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)).

In addition, the logs made available by the MHP did not include all of the DHCS test 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	1/17/2019	7:35 a.m.	OOC	OOC	OOC
2	1/17/2019	1:17 p.m.	OOC	OOC	OOC
3	1/22/2019	11:09 a.m.	OOC	OOC	OOC
4	2/12/2019	5:12 p.m.	OOC	OOC	OOC
5	3/1/2019	12:54 p.m.	OOC	OOC	OOC
Compliance Percentage			**0%**	**0%**	**0%**

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:

- MH Contact Logs 4-1-18 to 3-18-19. However, the access log did not contain five (5) DHCS test calls.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP did not maintain a written log of initial requests for SMHS that includes requests made by phone, in person, or in writing.

The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(f). Protocol requirement D.VI.C1 is deemed OOC. The MHP must complete a POC addressing these finding of non-compliance.

REQUIREMENT
D.VII.C- The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

FINDING

The MHP did not furnish evidence to demonstrate it complies with CCR title 9, section 1810.410. The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

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

- PP #162 Cultural Competence; and

- Cultural Competence Plan.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the CCC completes its annual report of CCC activities as required in the CCPR.

DHCS deems the MHP out-of-compliance with the terms of CCR title 9, section 1810.410. The MHP must complete a POC addressing this finding of non-compliance

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
E.I.E-Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e). Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e).).

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

- No policy # CARES Line-TAR Processing Protocol;
- Policy 109 conflict of Interest and/or outside employment;
- Policy 101 Compliance Plan;
- Sample of TARs; and
- Inpatient Provider Manual.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.I.H3- 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. (42 C.F.R. § 438.210(d)(2)).

FINDINGS

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.210(d)(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. (42 C.F.R. § 438.210(d)(2)).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Sample of Authorization Requests;
- Service Authorization Instructions;
- Inpatient Provider Manual; and
- Incoming Documents Log Audit September 2018.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate 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.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.210(d)(2). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.I.H4-The MHP may extend the 72- hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary. (42 C.F.R. § 438.210(d)(2)).

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.210(d)(2). The MHP may extend the 72- hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary. (42 C.F.R. § 438.210(d)(2)).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Sample of Authorization Requests;
- Service Authorization Instructions;
- Inpatient Provider Manual; and
- Incoming Documents Log Audit September 2018

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.210(d)(2). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.I.I-The MHP shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility. (MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225. The MHP shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility. (MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Service Authorization Instructions; and

- Inpatient Provider Manual.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.I.J-The MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225. The MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Service Authorization Instructions; and
- Inpatient Provider Manual.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.III.G- In situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization. (MHSUDS IN No., 18-027).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN No., 18-027. In situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization. (MHSUDS IN No., 18-027).

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

- Policy #351 Presumptive Transfer.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that in situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization.

DHCS deems the MHP out-of-compliance with the terms of MHSUDS IN No., 18-027. The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.IV.B1- The MHP includes the following information in the NOABD: The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(1). The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1)).

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

- No policy #-NOABD Procedures.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP includes the adverse benefit determination of the MHP has made or intends to make in the NOABD.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(1). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.IV.B3- The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(2). The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2)).

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

- No policy #-NOABD Procedures

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(2). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.IV.B5- The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(5). The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)).
The MHP submitted the following documentation as evidence of compliance with this requirement:

- No policy #-NOABD Procedures

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the circumstances under which an appeal process can be expedited and how to request it.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(5). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.IV.B6- The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(6). The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6)).

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

- No policy #-NOABD Procedures

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(6). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.V.A- The MHP provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b). The MHP provides a second opinion from a network

provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

The MHP did not submit evidence of compliance that it provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
E.V.B- At the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e). At the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).

The MHP did not submit evidence of compliance that at the request of the beneficiary, when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse).

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e). The MHP must complete a POC addressing this finding of non-compliance.

BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
F.I.D-The MHP shall have only one level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 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. § 438.402(b); 42 C.F.R. § 438.228(a). The MHP shall have only one level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).).

The MHP did not submit evidence of compliance that it shall have only one level of appeal for beneficiaries.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
F.I.L-The MHP shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations have the appropriate clinical expertise as determined by DHCS in treating the beneficiary's condition or disease. If the decision involves an appeal based on a denial of medical necessity; a grievance regarding denial of a request for an expedited appeal; or if the grievance or appeal involves clinical issues. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 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)(ii)(A)-(C); 42 C.F.R. § 438.228(a). The MHP shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations have the appropriate clinical expertise as determined by DHCS, in treating the beneficiary's condition or disease. If the decision involves an appeal based on a denial of medical necessity; a grievance regarding denial of a request for an expedited appeal; or if the grievance or appeal involves clinical issues. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).).

The MHP did not submit evidence of compliance that it shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations have the appropriate clinical expertise as determined by DHCS in treating the beneficiary's condition or disease. If the decision involves an appeal based on a denial of medical necessity; a grievance regarding denial of a request for an expedited appeal; or if the grievance or appeal involves clinical issues.

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

REQUIREMENT

F.I.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).). 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).).

The MHP did not submit as evidence of compliance that it 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.

DHCS deems the MHP out-of-compliance with the terms of 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.

OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

REQUIREMENT
H.B2- 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; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) .

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. E; 42 C.F.R. §§ 438.3(h), 438.230(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; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).).

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

- Exhibit C-Reimbursement & Payment.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that 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.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. E; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii). The MHP must complete a POC addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
A.III.F- 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 furnished evidence to demonstrate it complies with Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide Therapeutic Foster Care (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 Service Criteria;
- ICC Coordinator Initiates TFC Flow Chart;
- Public Initiates TFC Flow Chart; and
- TFC Program Statement.

SUGGESTED ACTION
DHCS is not requiring no further action at this time.

REQUIREMENT
A.III.G- 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 furnished evidence to demonstrate it complies with Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP has 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 Service Criteria;
- ICC Coordinator Initiates TFC Flow Chart;
- Public Initiates TFC Flow Chart; and
- TFC Program Statement.

SUGGESTED ACTION
DHCS is not requiring no further action at this time.

CARE COORDINATION AND CONTINUTIY OF CARE

REQUIREMENT
B.III.C-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).).

FINDING
The MHP did not furnish evidence to demonstrate compliance that it shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care 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:

- Develop policies and procedures to address the requirements.

COVERAGE AND AUTHORIZATON OF SERVICES

REQUIREMENT
E.I.H2- The MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

FINDING

The MHP did not furnish evidence to demonstrate compliance that it must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

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 policies and procedures to address the requirements.