CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SANTA BARBARA COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: May 16, 2023 to May 18, 2023

Santa Barbara County Mental Health Plan
FY 2022/2023 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, § 1810.380, DHCS conducts monitoring and oversight activities such as the Medi-Cal SMHS Triennial System and Chart Reviews to determine if the county MHPs are in compliance with state and federal laws and regulations and/or the contract between DHCS and the MHP.

DHCS conducted a webinar review of the San Francisco County MHP's Medi-Cal SMHS programs on April 18, 2023 to April 20, 2023. 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) 2022/2023 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

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

- Category 1: Network Adequacy and Availability of Services
- Category 2: Care Coordination and Continuity of Care
- Category 3: Quality Assurance and Performance Improvement

- Category 4: Access and Information Requirements
- Category 5: Coverage and Authorization of Services
- Category 6: Beneficiary Rights and Protections
- Category 7: Program Integrity

This report details the findings from the Medi-Cal SMHS Triennial System Review of the San Francisco County MHP. The report is organized according to the findings from each section of the FY 2022/2023 Protocol deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS.

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

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

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

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

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Question 1.2.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with the BHIN No. 21-073 and 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 beneficiary access criteria for SMHS as medically necessary.

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

- 8.203 Intensive Mental Health Services
- CL 8.203 Intensive Mental Health Services
- Katie A Report
- Inter-Agency Placement Committee (IPC) minutes 04.13.23
- Inter-Agency Placement Committee (IPC) Minutes 04.20.23
- Inter-Agency Placement Committee (IPC) Minutes 04.27.23
- Inter-Agency Placement Committee (IPC) Minutes 05.04.23
- Inter-Agency Placement Committee (IPC) Minutes 05.11.23
- Inter-Agency Placement Committee (IPC) Minutes 05.18.23 - Limited IPC
- Therapeutic Foster Care (TFC) Request for Proposals (RFP) Draft
- Therapeutic Foster Care (TFC) Request for Proposals (RFP) Exhibit A Proposal Content Draft
- Therapeutic Foster Care (TFC) Request for Proposals (RFP) Exhibit E Evaluation and Scoring Criteria Draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not currently have a TFC provider but is working to develop a contract for this service.

DHCS deems the MHP out of compliance with the BHIN No. 21-073 and Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Repeat deficiency Yes

Question 1.4.4

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

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

- 2021 Medi-Cal Recertification Assignment List
- 2022 Nov - Fire Inspection
- Medi-Cal Certification and Transmittal - (DHCS 1735) - Provider Name: Merced Ranch Signed by DHCS
- Medi-Cal Certification and Transmittal - (DHCS 1735) - Provider Name: Merced Ranch
- Merced Ranch 11-30-21 Fire Inspection
- PIMS Snapshot Merced Ranch - Merced County
- Medi-Cal Certification and Transmittal - (DHCS 1735) Provider Name: Casa Pacifica Centers for Children and Families
- Re - Certification Casa Pacifica
- External Question (Email)
- Certifications Due (Email)
- Contracts for Stanislaus and Merced County (1) (Email)
- Contracts for Stanislaus and Merced County (Email)

Internal Documents Reviewed:

- Santa Barbara County Provider Monitoring Report

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certifies, or uses other MHP's certification documents to certify, the organizational providers that contract with the MHP to provide SMHS. Of the MHP's 62 providers, one (1) certification was overdue. Per the discussion during the review, the MHP stated it would provide evidence of submitted transmittals and actions taken to resolve the overdue certification. Post review, additional evidence was provided; however, it was not evident the provider was recertified prior to the review.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 435 and MHP contract, exhibit A, attachment 8, section 8(D).

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 6(A); Code of Federal Regulations, title 42, section 438, subdivision 236(b); and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must have practice guidelines, which meet the requirements of the MHP Contract.

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

- MHP Outpatient Practice Guidelines
- Documentation Manual final 2020
- 2021 - 2022 Guide for Documentation of Youth Services
- 2021 - 2022 Guide for Engagement and Access Templates
- 2021 - 2022 Guide to Chart Requirements
- 2021 - 2022 Guide to Documentation of Client and Non - Bill Activities
- 2022 - 2023 Assessment and Treatment Plan Training
- 2022 - 2023 CalAIM Progress Notes Training
- Special Population Youth Requirements
- Behavioral Wellness Director if Programs - Jan 2022

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established practice guidelines that meet requirements of the MHP contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not have practice guidelines that meet MHP contract requirements; instead, it has an outpatient operational manual, which identifies services available for beneficiaries. Post review, the MHP submitted additional evidence including a program directory; however, practice guidelines were not submitted.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 6(A); Code of Federal Regulations, title 42, section 438, subdivision 236(b); and California Code of Regulations, title 9, section 1810, subdivision 326.

Question 3.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 6(c); Code of Federal Regulations, title 42, section 438, subdivision 236(c); and California Code of Regulations, title 9, section 1810, subdivision

326. The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

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

- MHP Outpatient Practice Guidelines
- Documentation Manual final 2020
- 2021 - 2022 Guide for Documentation of Youth Services
- 2021 - 2022 Guide for Engagement and Access Templates
- 2021 - 2022 Guide to Chart Requirements
- 2021 - 2022 Guide to Documentation of Client and Non - Bill Activities
- 2022 - 2023 Assessment and Treatment Plan Training
- 2022 - 2023 CalAIM Progress Notes Training
- Special Population Youth Requirements
- Behavioral Wellness Director if Programs - Jan 2022

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates practice guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged it did not develop or disseminate practice guidelines during the review period. Post review, the MHP submitted additional evidence including a program directory; however, this contract requirement was not included.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 6(c); Code of Federal Regulations, title 42, section 438, subdivision 236(c); and California Code of Regulations, title 9, section 1810, subdivision 326.

Question 3.5.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 6(D); Code of Federal Regulations, title 42, section 438, subdivision 236(d); and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.

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

- MHP Outpatient Practice Guidelines
- Documentation Manual final 2020
- 2021 - 2022 Guide for Documentation of Youth Services
- 2021 - 2022 Guide for Engagement and Access Templates

- 2021 - 2022 Guide to Chart Requirements
- 2021 - 2022 Guide to Documentation of Client and Non - Bill Activities
- 2022 - 2023 Assessment and Treatment Plan Training
- 2022 - 2023 CalAIM Progress Notes Training
- Special Population Youth Requirements
- Behavioral Wellness Director if Programs - Jan 2022

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP takes steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. Per the discussion during the review, the MHP acknowledged it does not have practice guidelines that meet the contract requirements and it does not have an established process to ensure consistent application of the guidelines. Post review, the MHP submitted additional evidence including a program directory; however, this contract requirement was not identified.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 6(D); Code of Federal Regulations, title 42, section 438, subdivision 236(d); and California Code of Regulations, title 9, section 1810, subdivision 326.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.2.2

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

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

The seven (7) test calls are summarized below.

TEST CALL #1

Test call was placed on Thursday, April 6, 2023, at 5:10 p.m. The call was answered after one (1) ring via a phone tree directing the caller to select the option for mental health services. Once the caller was transferred to a live operator, he/she requested information about accessing mental health services in the county concerning his/her son's mental health and his disruptive behavior in school. The operator asked for the child's personally identifying information, which the caller provided. The operator explained that the office was closed, but someone would call back during regular business hours.

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

FINDING

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

TEST CALL #2

Test call was placed on Monday, April 24, 2023, at 12:15 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 language. After selecting the option for English, a recorded greeting provided instructions to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller asked for assistance with what he/she described as feeling depressed, bouts of crying, the inability to sleep, and a loss of appetite. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained that the caller would need to complete a screening so that he/she could be scheduled for an appointment for services. The operator asked for the caller's phone number so that someone could call him/her back to conduct a screening, which the caller declined.

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 #3

Test call was placed on Thursday, April 13, 2023, at 6:05 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 language. After selecting the option for English, a recorded greeting provided instructions to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller asked for information about accessing mental health services in the county and explained he/she had been providing care for an

elderly parent and had been feeling isolated, sad, and unable to sleep. The operator asked for the caller's phone number so that someone could call him/her back or to call back during business hours.

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

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

TEST CALL #4
Test call was placed on Thursday, April 13, 2023, at 10:00 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 language. After selecting the option for English, a recorded greeting provided instructions to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller requested information about accessing mental health services and how to refill his/her anxiety medication. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the process for accessing mental health services including walk-in services for crisis and regular services. The operator provided clinic locations, hours of operation, and informed the caller that 24/7 crisis services are available for same day medication refills. The operator offered to transfer the caller to the crisis clinic for an urgent same day appointment, which the caller declined.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #5
The test call was placed on Thursday April 20, 2023, at 7:05 a.m. The call was answered after three (3) rings via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller requested information about accessing mental health services in the county concerning his/her child's mental health and his disruptive behavior in school. The operator asked for the child's personally identifying information, which the caller provided. The operator explained the assessment process and provided the caller with the location and hours of operation for the walk-in clinic.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

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

TEST CALL #6
Test call was placed on Tuesday, February 21, 2023, at 3:41 p.m. The call was answered after three (3) rings via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller requested information for how to file a complaint about a therapist he/she was seeing through the county. The operator placed the caller on hold for approximately three (3) minutes. Upon return, the operator provided the caller with information on where to find grievance forms on the county's website. The operator stated the caller could call back if he/she had any additional questions.

The caller was provided information about how to use the beneficiary problem resolution and fair hearing process.

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

TEST CALL #7
Test call was placed on Sunday, March 5, 2023, at 10:15 p.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller requested information for how to file a complaint about a therapist he/she was seeing through the county. The operator stated that caller could be transferred to a staff member for assistance with filing a grievance over the phone or go to a clinic to pick up a grievance form. The caller stated he/she would prefer to pick up the grievance form at a clinic. The operator provided the clinic locations and hours of operation.

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).

The caller was provided information about how to use the beneficiary problem resolution and fair hearing process.

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	IN	IN	IN	IN	N/A	N/A	100%
2	OOC	IN	OOC	IN	IN	N/A	N/A	60%
3	IN	IN	IN	IN	N/A	NA	NA	100%
4	N/A	N/A	N/A	N/A	N/A	IN	IN	100%

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

Repeat deficiency Yes

Question 4.2.4

FINDING

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

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

- Access Line Test Call Log Quarter 3
- Access Test Call Scenarios
- AQS - 2.010 - 24-7 Toll - Free Access Line
- August 2020 Access PowerPoint Crisis Staff
- August 2022 Access Line Presentation for CenCal
- 24 - 7 Access Line Form Report FY 19 - 20 (January - March)
- 24 - 7 Access Line Form Report FY 20-21 (January - March 2021)
- 24 - 7 Access Line Form Report FY 21-22 Quarter 4 (April - June 2022)
- Interpreter Vendors
- Language Line Payments
- Access Call Logs

While the MHP submitted evidence to demonstrate compliance with this requirement, four (4) of the five (5) required DHCS test calls were not logged on the MHP's written log of initial request. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	4/6/2023	5:10 p.m.	OOC	OOC	OOC
2	4/24/2023	12:15 p.m.	OOC	OOC	OOC
3	4/13/2023	6:05 p.m.	OOC	OOC	OOC
4	4/13/2023	10:00 a.m.	IN	IN	IN
5	4/20/2023	7:05 a.m.	OOC	OOC	OOC
Compliance Percentage			**20%**	**20%**	**20%**

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 partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.1.5

FINDING

The MHP did not furnish evidence to demonstrate compliance with BHIN No 22-016; Welfare & Institution Code, section 14197.1; Health and Safety Code, section 1367.01(h)(4); Code of Federal Regulations, title 42, section 438, subdivision 210(c). A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.

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

- 8.203 - Intensive Mental Health Services
- 4.010 - Notices of Adverse Benefit Determination (NOABD)
- C.S. Notices of Adverse Benefit Determination (NOABD)
- J.S. Notices of Adverse Benefit Determination (NOABD)
- M.J. Notices of Adverse Benefit Determination (NOABD) Modification
- Notices of Adverse Benefit Determination (NOABD) Modification- L.B (2)

- Notices of Adverse Benefit Determination (NOABD) Report Santa Barbara County
- Notices of Adverse Benefit Determination (NOABD) SBC
- D.A. 2.26.21
- Att. J - NOABD Your Rights
- Att. K - Language Assistance
- Att. L - Beneficiary Non - Discrimination
- Att. B - NOABD Payment Denial
- Report PREST Std 828364 Redacted
- Written approval determination letter

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP includes the name and direct telephone number of the professional who made the authorization decision and offers the treating provider the opportunity to consult with the professional who made the authorization decision. Per the discussion during the review, the MHP stated it would provide evidence that demonstrates this requirement. Post review, the MHP submitted additional evidence including NOABD and beneficiary rights samples; however, the evidence did not demonstrate compliance to the requirement.

DHCS deems the MHP out of compliance with BHIN No 22-016; Welfare & Institution Code, section 14197.1; Health and Safety Code, section 1367.01(h)(4); Code of Federal Regulations, title 42, section 438, subdivision 210(c).

Question 5.2.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017. The MHP must decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in I.a. of BHIN 22-017. The MHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services.

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

- 4.019 - Auth and Utilization Management of Psychiatric Inpatient Services
- 8.203 - Intensive Mental Health Services
- Kepro Concurrent Review Policy and Procedures - 22-017
- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services

- Out of County Utilization Review Procedures (Psychiatric Inpatient Hospitalization)
- Psychiatric Health Facility (PHF) utilization Review procedures

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services. Per the discussion during the review, the MHP stated it completes the concurrent review authorizations for its county inpatient facility and a contractor completes concurrent review authorization for all other facilities. The MHP acknowledged its policy for the county facility did not outline the expedited authorization process. Post review, the MHP re-submitted its authorization policy and its utilization procedure documents; however, the policy remains out of compliance.

DHCS deems the MHP out of compliance with BHIN 22-017.

Question 5.2.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; Health and Safety Code, section 1367.01(h)(2). When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay- authorization request for a specified number of days to the responsible county MHP. The responsible county MHP *shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.*

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

- Kepro Concurrent Review Policy and Procedures - 22-017
- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services
- Staff Signatures for TARs (SBC)
- TARs
- SARs
- Attachment A and B

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP issues a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination. Per the discussion during the review, the MHP stated it completes the concurrent review authorizations for its county inpatient facility and a contractor completes concurrent review authorization for all other facilities. The MHP stated it would submit its internal policy that demonstrate this requirement is

in place. Post review, the MHP submitted an attachment to its authorization policy; however, it did not include the required language.

DHCS deems the MHP out of compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; and Health and Safety Code, section 1367.01(h)(2).

Question 5.2.10

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; California Code of Regulations, title 9, section 1820, subdivision 230; and Welfare and Institution Code 14184.402, 14184.102 and 14184.400. Authorizing Administrative Days:

1. In order to conduct concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status.
2. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
3. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.
4. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.
5. MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact. (If an MHP has been granted an exemption to 9 CCR § 1820.220, then the review of the MHP will be based upon the alternate procedure agreed to in the MHP contract.)

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

- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services
- Kepro Concurrent Review Policy and Procedures - 22-017
- Administrative Day snap shot

- Administrative Day Questionnaire 8343002 CA. BH. HUM. LOP 002 Concurrent Review
- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services
- Out of County Utilization Review Procedures (Psychiatric Inpatient Hospitalization)
- Psychiatric Health Facility (PHF) Utilization Review procedures
- Attachment A and B

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP and a hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Per the discussion during the review, the MHP stated it completes the concurrent review authorizations for its county inpatient facility and a contractor completes concurrent review authorization for all other facilities and stated it will provide its policy for the county facility. Post review, MHP re-submitted it authorization policy including attachments and additional documentation; however, the county's policy was deficient in demonstrating compliance to the requirement.

DHCS deems the MHP out of compliance with BHIN 22-017; California Code of Regulations, title 9, section 1820, subdivision 230; and Welfare and Institution Code 14184.402, 14184.102 and 14184.400.

Question 5.2.14

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.

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

- SAR samples
- Copy of all authorizer licenses
- SB - SAR 2 MJB

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

Authorization	# of Service Authorization In Compliance	# of Service Authorization Out of Compliance	Compliance Percentage
Regular Authorization: The MHP makes a decision regarding a provider's request for prior authorization, not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.	7	1	86%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health conditions requires, not to exceed five (5) business days from the MHP's receipt of the information. Of the five (5) Service Authorization Requests (SARs) reviewed by DHCS, one (1) was not authorized within the timeframe. Per the discussion during the review, the MHP stated it would provide additional evidence to demonstrate the timeframe was met. Post review, the MHP submitted additional documentation; however, the one (1) SAR remained out of compliance.

DHCS deems the MHP partial compliance with BHIN 22-016.

Question 5.2.16

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHP referral or prior authorization shall specify the amount, scope, and duration of treatment that the MHP has authorized.

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

- 4.000 - Authorization of Outpatient Specialty Mental Health Services
- 8.203 - Intensive Mental Health Services
- IHBS Request Form
- Prior auth request form
- CRT Smartsheet
- Payment/authorization tracking
- Authorization log - IHBS-TBS

- A.G. – CRT
- ART Authorization CM
- ART authorization VB
- B.S. –CRT
- H.M.H –CRT
- L.M. –CRT
- N.M.J –CRT
- Initial 30 approved
- SIGNATURE - CRT-ART
- SIGNATURE -TBS-IHBS
- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services
- Out of County Utilization Review Procedures (Psychiatric Inpatient Hospitalization)
- Psychiatric Health Facility (PHF) Utilization Review procedures
- Attachment A and B

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's referral or prior authorization process specifies the amount, scope, and duration of treatment that the MHP has authorized. Per the discussion during the review, the MHP stated it completes the concurrent review authorizations for its county inpatient facility and a contractor completes concurrent review authorization for all other facilities. The MHP indicated it would provide its internal policy and procedures demonstrating compliance for this requirement for the county facility. Post review, the MHP re-submitted its authorization policy along with its utilization review procedure documents; however, it is not evident that the county has this process established as required in the contract.

DHCS deems the MHP out of compliance with BHIN 22-016.

Question 5.2.18

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

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

- 4.000 - Authorization of Outpatient Specialty Mental Health Services

- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services
- Kepro Concurrent Review Policy and Procedures - 22-017
- 4.019 - Authorization and Utilization Management of Psychiatric Inpatient Services
- Out of County Utilization Review Procedures (Psychiatric Inpatient Hospitalization)
- Psychiatric Health Facility (PHF) Utilization Review procedures
- Attachment A and B

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that where the review is retrospective, the MHP's authorization decision is communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information and is communicated to the provider in a manner that is consistent with state requirements. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP indicated it would provide its authorization policy that shows compliance with the requirement. Post review, the MHP re-submitted its authorization policy along with its utilization review procedure documents; however, it is not evident that the MHP's policy or process meets the requirement.

DHCS deems the MHP out of compliance with BHIN 22-016.

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.14

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5). The MHP shall provide information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance with:

a) The MHP and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

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

- 4.020 - Beneficiary Problem Resolution Process
- Problem Resolution Poster (English)

- Problem Resolution Poster (Spanish)
- Website links
- Notice of Appeal Resolution (NAR) upheld
- Notice of Appeal Resolution (NAR) Adverse Benefit Determination Overturned
- Appeal Form
- Grievance Form English
- Appeals Documentation (folder)
- Nondiscrimination Notice

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged it does not have a Discrimination Grievance process or procedure in place.

DHCS deems the MHP out of compliance with MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5).

Question 6.1.15

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1). The MHP must designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

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

- 4.020 - Beneficiary Problem Resolution Process
- Problem Resolution Poster (English)
- Problem Resolution Poster (Spanish)
- Website links
- Notice of Appeal Resolution (NAR) upheld
- Notice of Appeal Resolution (NAR) Adverse Benefit Determination Overturned
- Appeal Form
- Grievance Form English
- Appeals Documentation (folder)

- Nondiscrimination Notice

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has designated a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged it is currently working on developing a process for Discrimination Grievances, which will include designating a Discrimination Grievance Coordinator.

DHCS deems the MHP out of compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1).

Question 6.1.16

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2). The MHP shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. The MHP shall not require a beneficiary to file a Discrimination Grievance with the MHP before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

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

- 4.020 - Beneficiary Problem Resolution Process
- Problem Resolution Poster (English)
- Problem Resolution Poster (Spanish)
- Website links
- Notice of Appeal Resolution (NAR) upheld
- Notice of Appeal Resolution (NAR) Adverse Benefit Determination Overturned
- Appeal Form
- Grievance Form English
- Appeals Documentation (folder)

- Nondiscrimination Notice

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has adopted procedures to ensure the prompt and equitable resolution of discrimination-related complaints. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged it does not currently have Discrimination Grievances procedures in place.

DHCS deems the MHP out of compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2).

Question 6.1.17

FINDING
The MHP did not furnish evidence to demonstrate compliance with MHP Contract, exhibit A, Attachment 12, section 4(A)(3) and California Medicaid State Plan, section 7, attachments 7.2-A and 7.2-B. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the MHP must submit the following information regarding the complaint to the DHCS Office of Civil Rights:

a) The original complaint.
b) The provider's or other accused party's response to the complaint.
c) Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the MHP.
d) Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
e) All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.
f) The results of the MHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

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

- 4.020 - Beneficiary Problem Resolution Process
- Problem Resolution Poster (English)
- Problem Resolution Poster (Spanish)
- Website links
- Notice of Appeal Resolution (NAR) upheld
- Notice of Appeal Resolution (NAR) Adverse Benefit Determination Overturned
- Appeal Form

- Grievance Form English
- Appeals Documentation (folder)
- Nondiscrimination Notice

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits the required information regarding a complaint to the DHCS Office of Civil Rights within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP the acknowledged it is working on developing a process for Discrimination Grievances.

DHCS deems the MHP out of compliance with MHP Contract, exhibit A, Attachment 12, section 4(A)(3) and California Medicaid State Plan, section 7, attachments 7.2-A and 7.2-B.