CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SONOMA COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT-AMENDED

Review Dates: June 20, 2023 to June 22, 2023

Sonoma County Mental Health Plan
FY 2022/2023 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

TABLE OF CONTENTS

Sonoma County Mental Health Plan
FY 2022/2023 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

EXECUTIVE SUMMARY

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

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

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

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

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

DHCS conducted a webinar review of the Sonoma County MHP's Medi-Cal SMHS programs on June 20, 2023 to June 22, 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 Sonoma 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:

- DRAFT MHP-07 Continuum of Care-Intensive Services for Children and Youth 10.06.21 V2 (8.05.22)
- MHP-07-Katie-A-Services-rem
- TFC screening tool
- TFC Contract Status
- TFC criteria
- 2023-6-21 Email from NH to KS Re TFC Eligibility Extract
- TFC Eligibility extract
- TFC Eligibility Extract email #2
- TFC Eligibility Extract email

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides Therapeutic Foster Care (TFC) 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 that it is not providing TFC services at this time and is talking with a provider and that provider will submit a Request for Proposal

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:

- MHP-15 Short-Doyle Medi-Cal Site Certification for County Owned and Operated and MHP Contract Providers
- Completed Certifications, evidence listed under folder
- Site Certification Sample & Track, evidence listed under folder
- Site Certification Protocol, evidence listed under folder
- 23.06.22 DHCS Final TERMINATE Provider 4971 Petaluma People Services
- 23.06.22 DHCS RE TERMINATE All Services - All Services Provider 4968 CSN E St.
- 23.06.22 DHCS RE TERMINATE All Services - Provider 49CS Victor Treatment Redding
- 23.06.22 DHCS RE TERMINATE Provider 4971 Petaluma People Services
- 23.06.22 DHCS TERMINATE All Services Provider 4968 CSN E St.
- 45AD Termination Transmittal-45AD FEX
- 49CS Victor Redding TERM 1-20-2020 DHCS 1735 6-22-2023- signed
- 49CS Victor Redding TERM 6-30-2023 DHCS 1735 6-21-2023 signed
- 4968 CSN E St. TERM 9-30-2021 DHCS 1735 6-20-2023 email
- 4968 CSN E St. TERM 9-30-2021 DHCS 1735 6-20-2023 signed
- 4971 Petaluma People Services TERM 6-30-2021 DHCS 1735 6-20-2023 signed
- DHCS 1735 4971 TERM PROV 6.22.23
- RE External RE TERMINATE All Services - Provider 49CS Victor Treatment Redding
- RE External TERMINATE All Services Provider 4968 CSN E St
- RE External TERMINATE Provider 4971 Petaluma People Services
- RE TERMINATE All Services - Provider 49CS Victor Treatment Redding
- TERMINATE All Services - Provider 49CS Victor Treatment Redding
- TERMINATE All Services Provider 4968 CSN E St
- TERMINATE Provider 4971 Petaluma People Services email
- TERMINATE Provider 4971 Petaluma People Services

INTERNAL DOCUMENTS REVIEWED.

- DHCS overdue provider report

While the MHP submitted evidence to demonstrate compliance with this requirement it is not evident that the MHP certifies, or uses another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS. Of the MHP's 51 providers, three (3) certifications were overdue. Per the discussion during the review, the MHP stated the overdue sites are discontinued. Post review, the MHP submitted additional evidence to show termination of the providers; however, the terminations occurred the triennial 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:

- BH-03 Practice Guidelines
- Contract Samples
- BH Doc Trainings
- Final DHS-Mental Health Provider Manual (9.28.21)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has practice guidelines that meet the requirements of the MHP contract. Per the discussion during the review, the MHP stated it is currently developing its practice guidelines.

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:

- BH-03 Practice Guidelines, page 3
- BH Documentation Trainings
- Contract Samples
- Provider Manual
- General Contract Template v20220608-1 (with MHP STC v20220608-1)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the 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 stated it will develop a policy and training on dissemination of its practice guidelines once the practice guidelines have been established.

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.

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 Monday, March 27, 2023, at 4:10 p.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The phone tree provided instructions to dial 911 if experiencing an urgent condition. After selecting the option for English, the call was transferred to 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 asked for the child's personally identifying information, which the call provided. The operator transferred the caller to the Youth Access Team where an operator explained the assessment process for receiving services.

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 #2
Test call was placed on Thursday, April 13, 2023, at 12:43 p.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold languages and to dial 911 if experiencing an urgent condition. After reaching a live operator, the caller requested information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling overwhelmed, isolated, and hopeless. The operator stated the caller could go to the walk-in clinic for an assessment for services and provided the clinic location. The operator stated the caller could also provider his/her information receive a call back within 24 hours for an assessment for services.

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 Wednesday, May 10, 2023, at 2:20 p.m. The call was answered via a phone tree and instructed the caller to dial 911 if experiencing an urgent condition. The phone tree directed the caller to select a language option, which included the MHP's threshold languages. The caller was then transferred to an operator. The caller requested information about accessing mental health services and how to refill his/her medication. The operator explained the process for accessing mental health services

including walk-in services for crisis services, outpatient services, and provided the address and hours of operation for the clinic. The operator informed the caller that the 24/7 crisis line is available if he/she needed to speak with staff for a medication refill.

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

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

TEST CALL #4
Test call was placed on Thursday, May 11, 2023, at 5:14 p.m. The call was answered after three (3) rings via a phone tree directing the caller to dial 911 if an urgent condition or to stay on the line to speak to a counselor. The phone tree directed the caller to select a language option, which included the MHP's threshold languages Once the caller was connected to a live operator, he/she requested assistance with what he/she described as feeling depressed and unable to sleep with bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the screening and assessment process. The operator informed the caller that walk-ins services are available and provided the MHP's office hours and address. The operator explained that someone will be available 24 hours a day via the after-hours line.

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
Test call was placed on Wednesday, May 31, 2023, at 6:37 p.m. The call was answered after one (1) ring via a phone tree directing the caller to dial 911 if an urgent condition. The phone tree directed the caller to select a language option, which included the MHP's threshold languages. Once transferred to a live operator the caller requested assistance with what he/she described as feeling depressed, unable to sleep, and bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the screening and assessment process. The operator requested the caller's contact information for a call back by staff during regular business hours. The caller declined to provide information and stated he/she would call back during business hours. The operator explained that someone will be available 24 hours a day via the after-hours line.

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 #6
Test call was placed on Tuesday, May 23, 2023 at 7:11 a.m. The call was answered after two (2) rings via a phone tree that provided information to dial 911 if experiencing an urgent condition. The call was then transferred to a live operator. The caller asked how to file a complaint in the county. The operator advised the caller that the grievance forms are in each clinic lobby and provided the grievance coordinators contact information. The operator asked the caller if he/she has any thoughts of suicide. The caller replied in the negative.

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 Wednesday, May 24, 2023 at 8:19 a.m. The call was answered immediately by a phone tree that provided information to dial 911 if experiencing an urgent condition. The information was repeated in Spanish. The caller remained on the line and was then transferred to a live operator. The caller asked how to file a complaint in the county. The operator told the caller that the grievance forms are located in the clinic lobby and gave the caller the address. The operator also gave the caller the grievance coordinators phone number to call. The operator also gave the caller the option of mailing the form to the caller.

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).

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	IN	IN	IN	N/A	IN	N/A	IN	100%
2	N/A	IN	IN	IN	IN	N/A	N/A	100%
3	IN	IN	IN	IN	IN	IN	IN	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 compliance* with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

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 Call Log ALL FY
- Afterhours Calls - 05.12.23
- Afterhours Calls - 06.01.23

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of 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	3/27/2023	4:10 p.m.	OOC	OOC	OOC
2	4/13/2023	12:43 p.m.	OOC	OOC	OOC
3	5/10/2023	2:20 p.m.	OOC	OOC	OOC
4	5/11/2023	5:10 p.m.	IN	IN	IN
5	5/31/2023	6:37 p.m.	IN	IN	IN
Compliance Percentage			**40%**	**40%**	**40%**

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

DHCS deems the MHP *in partial compliance* with California Code of Regulations, title 9, section 1810, subdivision 405(f).

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:

- Inpatient Census 7.1.20-2.2.23
- CA.BH.HUM.LOP.002 Concurrent Review
- CA.BH.HUM.LOP.003 Denials and Appeals
- Kepro Concurrent Review P&P 22-017
- MHP-05 Notice of Adverse Benefit Determination SIGNED.doc
- 7.2.1 Authorization Standards for Outpatient SMHS signed
- SAR & PT Tracking
- SARs tr
- TARS tr
- Modification exchange dialogue
- NOABD
- RE PT Policy and Triennial Evidence

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that when the MHP decides to modify the authorization request that the MHP provides 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 requirement was not documented in the policy or submitted any evidence of practice. This requirement was not included in any evidence provided by the MHP. Per the discussion during the

review, the MHP stated it had one occasion that it happened, and it communicated via email, however, the email communication sample was not provided.

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 5.2.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. Concurrent Review: In the absence of an MHP referral, MHPs shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. MHPs may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.

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

- Utilization Management (UM), Audit, Oversight and Recoupment Standards for Specialty Mental Health Services (SMHS) signed
- Authorization Standards for Outpatient SMHS signed
- CA.BH.HUM.LOP.002 Concurrent Review
- CA.BH.HUM.LOP.003 Denials and Appeals
- Kepro Concurrent Review P&P 22-017

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP conducts concurrent review of treatment authorizations following the first day of admission to a facility through discharge. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it had not conducted any concurrent review of treatment authorizations within this triennial period. The requirement is missing on its Authorization Standards for Outpatient SMHS policy.

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

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:

- Req Submitted w Admin Days 7.1.22-3.31.23
- CA.BH.HUM.LOP.002 Concurrent Review
- CA.BH.HUM.LOP.003 Denials and Appeals
- Kepro Concurrent Review P&P 22-017

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP authorizes administrative days through its concurrent review process as required in contract. This requirement was included in the policy however, per the discussion during the review, the MHP stated it had authorized administrative days services during the review period and would provide two (2) samples. Post review, the MHP did not submit the samples.

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 5.2.11

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHP must utilize referral and/or concurrent review and authorization for all Crisis

Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization.

1. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.
2. The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services.

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

- Draft Authorization for CRT & ART Services 5.12.22
- DRAFT Direct Referrals to Crisis Residential from Hospitals

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP utilizes referral and/or concurrent review and authorization for all CRTS and ARTS and does not require prior authorization for these services. Per the discussion during the review, the MHP stated the policy is in draft form, however, did not state when it will go into effect.

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:

- MHP-06 Beneficiary Grievance and Appeal Process (rev 10.24.2019)
- MHS 406 (07-20) Client Grievance Appeal Process and Form
- Grievance Logs
- Appeals & Logs
- Forms & Templates

- Grievances
- Beneficiary Handbook with Taglines rem (1)

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 policy and that it would update its grievance policy to include these requirements moving forward.

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:
- MHP-06 Beneficiary Grievance and Appeal Process (rev 10.24.2019)
- MHS 406 (07-20) Client Grievance Appeal Process and Form
- Grievance Logs
- Appeals & Logs
- Forms & Templates
- Grievances
- Beneficiary Handbook with Taglines rem (1)

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 does not have a discrimination grievance policy and that it would update its grievance policy to include these

requirements moving forward.

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:

- MHP-06 Beneficiary Grievance and Appeal Process (rev 10.24.2019)
- MHS 406 (07-20) Client Grievance Appeal Process and Form
- Grievance Logs
- Appeals & Logs
- Forms & Templates
- Grievances
- Beneficiary Handbook with Taglines-rem (1)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a current policy documenting 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 have a discrimination grievance policy and that it would update its grievance policy to include these requirements moving forward.

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:

- MHP-06 Beneficiary Grievance and Appeal Process (rev 10.24.2019)
- MHS 406 (07-20) Client Grievance Appeal Process and Form
- Grievance Logs
- Appeals & Logs
- Forms & Templates
- Grievances
- Beneficiary Handbook with Taglines-rem (1)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits 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. Per the discussion during the review, the MHP acknowledged it does not have a discrimination grievance policy and that it would update its grievance policy to include these requirements moving forward.

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.

Question 6.5.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 420(c)(1)-(3) and 408(d)(2), and MHP

Contract Exhibit A, Attachment 12, section 9(C). At the beneficiary's request, the MHP must continue the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the below listed occurs:

a) The beneficiary withdraws the appeal or request for a State Hearing;
b) The beneficiary does not request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (e.g.), NAR);
c) A State Hearing office issues a hearing decision adverse to the beneficiary.

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

- MHP-06 Beneficiary Grievance and Appeal Process (rev 10.24.2019)
- MHP-05 Notice of Adverse Benefit Determination_SIGNED.doc
- MHP-21 Required Informing Materials and Translation of Written Documents (revised. 5-20-19)
- Beneficiary Handbook with Taglines-rem (1)

While the MHP submitted evidence to demonstrate compliance with this requirement it is not evident that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated this requirement is documented in its grievance and appeals policy; however, upon review by DHCS determined the required language was absent from the policy.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 420(c)(1)-(3) and 408(d)(2), and MHP Contract Exhibit A, Attachment 12, section 9(C).