CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE NEVADA COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: March 7, 2023 to March 8, 2023

Nevada 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 Nevada County MHP's Medi-Cal SMHS programs on March 7, 2023 to March 8, 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 Nevada 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:

- 219.1-Medi-Cal Array of MH Services and Service Provision Standards
- 297-Therapeutic Foster Care
- CWS Budget Narrative 23-24 Draft
- P&P 297-Therapeutic Foster Care
- TFC Email Communication
- 219.1-Medi-Cal Array of MH Services TFC

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. Per the discussion during the review, the MHP acknowledged that it does not have TFC services available and that it is in the process of collaborating with child welfare services to recruit TFC foster families.

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 1.2.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with the BHIN No. 21-073 and Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC.

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

- 219.1-Medi-Cal Array of MH Services and Service Provision Standards
- 297-Therapeutic Foster Care
- P&P 297-Therapeutic Foster Care
- 5.1.5-Delivery of Medi-Cal SMHS for Children in a Foster Care

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth to determine if they meet medical necessity criteria for TFC Services. Per the discussion during the review, the MHP stated it does not have a contract for TFC services and relies on Child Welfare Services to complete these assessments; however, the MHP did not have evidence for this process.

DHCS deems the MHP out of compliance with the BHIN No. 21-073 and Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services 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:

- 704 Individual and Organizational Provider Selection and Credentialing
- 191.1 SD-MC Provider Certification and Re-Certification Attachment A
- 191 Re-Certification of County Owned Sites (Self-Cert) for Medi-Cal Reimbursement
- 191.2 County Site Self-Recertification-Attachment B
- 706-Medi-Cal Certification and Recertification of Org Providers
- Medi-Cal Recertification Tracking Log
- Provider Reports JM Edits

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 27 MHP provider sites, one (1) had an overdue certification. Per the discussion during the review, the MHP stated that it has experienced technical difficulties while processing the applicable documentation. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

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).

Repeat deficiency Yes

Question 1.4.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8, section 8(M). The MHP must monitor the performance of its contractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the contractors' performance to periodic formal review.

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

- Admission assessment-new monitoring corrective action example
- Example Feedback to Provider about QA QIC report outs
- FW Admission Assessment-Example of Provider monitoring and change
- Non-reimbursable Dec Charis notes
- RE TBS Codes and Billing Feedback to Provider Example
- Victor Audit List recertification provider monitoring example

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors the performance of its contractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the contractors' performance to periodic formal review. Per the discussion during the review, the MHP stated it uses a variety of mechanisms to monitor performance of its contractors including the monthly Quality Improvement Committee, chart auditing, and site visits and that it would submit evidence of this post review. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8, section 8(M).

Question 1.4.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8, section 8(M). The MHP and the contractor shall take corrective action if the MHP identifies deficiencies or areas of improvement.

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

- Re-check in CAP follow-up and resolution
- SMWG Training CAP
- Training CAP

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP and its contractors take corrective action if the MHP identifies deficiencies or areas of improvement. Per the discussion during the review, the MHP acknowledged it does not have a formal process to take corrective action regarding identified performance deficiencies.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8, section 8(M).

Repeat deficiency Yes

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.2.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 2(a)(4). The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals listed in the below requirements:

1. Responsiveness for the Contractor's 24-hour toll-free telephone number.
2. Timeliness for scheduling of routine appointments.
3. Timeliness of services for urgent conditions.
4. Access to after-hours care.

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

- 5bi Adult & Urgent Timeliness QIC Data FY21-22
- 7 Monthly Psych Timeliness
- CY 21 Nevada County QI Work Plan Evaluation
- 23 Nevada County QI Work Plan

- Example of Server Caseload and Appointment Types Dashboard
- Nevada County BH 2021 QI Work Plan Final
- Example of Timeliness of Entry Dashboard

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's QAPI Work Plan includes a description of mechanisms the MHP has implemented to assess responsiveness of the 24-hour toll-free telephone number. Per the discussion during the review, the MHP stated it provides after-hours care; however, the MHP acknowledged the QAPI work plan did not include specific goals for Access to after-hours care.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 2(a)(4).

Repeat deficiency Yes

Question 3.3.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section (3)(E) and California Code of Regulations title 9, section 1810, subdivision 440(a)(2)(A)-(C). The MHP must ensure the MHP Quality Assessment and Performance Improvement program includes active involvement in the planning, design and execution of the QI Program by the Contractor's practitioners and providers, beneficiaries who have accessed SMHS through the Contractor, family members, legal representatives, or other persons similarly involved with beneficiaries.

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

- 192 Quality Assessment and Performance Improvement
- Job QIC Description
- QIC Contacts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP includes active participation from beneficiaries and family members in the planning, design, and execution of the Quality Improvement program. Per the discussion during the review, the MHP stated that gaining beneficiary and family member involvement in the Quality Improvement Committee has been a priority and that it would submit documentation to demonstrate its outreach efforts. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section (3)(E) and California Code of Regulations title 9, section 1810, subdivision 440(a)(2)(A)-(C).

Repeat deficiency Yes

ACCESS AND INFORMATION REQUIREMENTS

Question 4.1.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 10(d)(6)(ii) and MHP Contract, exhibit A, attachment 11, section 3(A). The MHP shall provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point.

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

- 222-Meeting Consumer Cultural and Linguistic Needs
- 228-Information for Visually and/or Hearing Impaired Clients
- 514-Informing Materials
- 516-Availability of Written Materials in English & Spanish
- 630-Beneficiary Rights
- Advance Directive Brochure-English & Spanish
- Advance Directive Brochure - English FINAL 04-27-17
- Advance Health Care Directive Instructions 6-A 09-09
- Advance Health Care Directive.5 –A FORM 09-09
- Client Problem Resolution Guide - English & Spanish
- MH Handouts –to take home -08.17.2022
- MH Regis Forms –to be signed – for JM
- NCBH – Appeal Form Letter
- NCBH –Grievance Form Letter
- NCBH Services Brochure - English & Spanish
- Nevada County MHP Beneficiary Handbook English
- Nevada Guide to County Behavioral Health Services English -FINAL 10-15-20
- Taglines

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides all written materials for potential beneficiaries and beneficiaries in a font size no smaller than12-point. Per the discussion during the review, the MHP stated it would update informing materials to reflect requirements moving forward. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 10(d)(6)(ii) and MHP Contract, exhibit A, attachment 11, section 3(A).

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, January 26, 2023, at 11:10 a.m. The call was answered after one (1) ring via a live operator. The caller 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 assessed the caller's need for urgent care services, which the caller responded in the negative. The operator requested personally identifying information, which the caller provided. The operator explained the assessment process to receive services with the county and offered to start the process over the phone. The caller declined and ended the call.

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 Friday, February 3, 2023, at 5:54 p.m. The call was answered after one (1) ring via 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 explained that walk-ins are available and provided the hours of operation and address for the clinic. The operator explained that someone would be available 24 hours a day at the Crisis Support Unit.

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 Friday, February 3, 2023, at 2:04 p.m. The call was answered after one (1) ring via a live operator. The caller asked the operator for 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 requested personally identifying information, which the caller provided. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator provided information regarding crisis support services and clinic information. The operator explained the availability of counseling and psychiatry options, and explained the screening and assessment process. The operator offered to start the screening process over the phone. The caller declined and ended the call.

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

The call was placed on Friday, February 3, 2023, at 6:17 a.m. The call was answered after two (2) rings via 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 routine services. The operator provided clinic

hours and location and informed the caller that the 24/7 crisis line is available if he/she needed to speak with staff for an immediate 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 #5
Test call was placed on Tuesday, December 20, 2022, at 4:43 p.m. The call was answered after one (1) ring via 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 treatment options including counseling and psychiatry services. The operator explained the screening and assessment process.

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 Thursday, December 22, 2022, at 7:30 a.m. The call was answered after one (1) ring via a live operator. The caller asked how to file a complaint in the county. The operator advised the caller that the grievance forms are located in the clinic lobby. The operator also provided instructions on accessing grievance forms on the website and how to contact a grievance advocate to file a grievance.

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 Tuesday, December 27, 2022, at 10:43 a.m. The call was answered after one (1) ring via a live operator. The caller asked how to file a complaint in the county. The operator advised the caller that he/she could call the Patients' Right's

Advocate and provided the phone number. The operator also advised the caller that the grievance forms are located in the clinic lobby and offered to mail a grievance 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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	IN	IN	IN	IN	N/A	N/A	100%
3	N/A	IN	IN	IN	IN	N/A	N/A	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:

- 24-7 Access Line Test Call Report Q2 FY22.23 Nevada County Code 29 MHP Only
- 24-7 Access Line Test Call Report Q2 FY22.23 Nevada County Code 29 MHP SUD
- 501.1-Access Line and Contact Log
- Nevada County Test Call January 10, 2023
- Sharepoint Pull 24.7 Access Line Log Request Dates
- Call Log Spreadsheet MHP SUD

- Call Log Spreadsheets MHP

While the MHP submitted evidence to demonstrate compliance with this requirement, five (5) of five (5) required DHCS test calls were logged on the MHP's written log of initial request; however, three (3) calls were missing the initial disposition of the 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	1/26/2023	11:10 a.m.	IN	IN	OOC
2	2/3/2023	5:54 p.m.	IN	IN	IN
3	2/3/2023	2:04 p.m.	IN	IN	OOC
4	2/3/2023	6:17 a.m.	IN	IN	IN
5	12/20/2022	4:43 p.m.	IN	IN	OOC
Compliance Percentage			**100%**	**100%**	**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

Question 4.3.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4). The MHP must plan for annual cultural competence training necessary to ensure the provision of culturally competent services:

1. There is a plan for cultural competency training for the administrative and management staff of the MHP.
2. There is a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP.
3. There is a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing).

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

- 222 Meeting Consumer Cultural and Linguistic Needs
- 223.1-Cultural Competence Program

- 514 Informing Materials
- 516 Availability of Written Materials in English and Spanish
- 630 Beneficiary Rights
- Annual Cultural Competency Plan Review 2022
- CCC Organizational Tree with contract information
- NCBH FY2020-2021 Cultural and Linguistic Proficiency Plan Final 121721
- Nevada County Test Call November 14, 2022
- Training Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP plans for annual cultural competence training necessary to ensure the provision of culturally competent services for persons providing SMHS employed by or contracting with the MHP. Per the discussion during the review, the MHP stated it performs trainings for both internal and external providers; however, it does not have a formal training log and requires providers to track and submit trainings to the MHP. DHCS requested evidence of training tracking material post review; however, none was provided.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4).

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.2.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Code of Federal Regulations, title 42, section 438, subdivision 210(b)(1); and California Code of Regulations, title 9, section 1810, subdivision 440(b)(2)(i-ii). The MHP must establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate. Authorization procedures and utilization management criteria shall:

a. Be based on medical necessity and consistent with current evidence- based clinical practice guidelines, principles, and processes;
b. Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice ;
c. Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's beneficiaries and network providers.

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

- Adult TARs

- Concurrent Review Logs
- Concurrent Review Worksheet
- Concurrent Review, TAR, and Authorization Signers
- Discharge Planning evidence
- TAR Log
- 510.1 Authorization Process for Outpatient MH Services
- 519-2022 Revision Inpatient Concurrent Review Authorization
- Nevada additional evidence of recurring management Crisis NCBH SNMH Monthly Management for P&P
- Evidence of ongoing collaboration with LE, Placer county, and TFH for MCT Dispatch Workflow 8.26.21
- Evidence of ongoing collaboration with Tahoe Forrest hospital to develop P&P related to MH
- Evidence of recurring hospital meeting for P&P
- Nevada on recurring meeting to develop P&P specific to MH crisis and hospitalization
- Meeting minutes with SNMH and SMWG regarding P&P development
- Example of correspondence with Network Provider as part of referral and authorization process
- Network Provider Authorization Tracking
- Sample Network Provider Authorization and Treatment Plan

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP engaged and collaborated with network and organizational providers, hospitals, and other licensed mental health stakeholders to develop its inpatient concurrent review authorization policies and procedures. Per the discussion during the review, the MHP stated it has meetings to create policies and procedures that include contract providers and hospital leadership. Post review, the MHP submitted additional evidence, including meeting minutes and agendas; however, it did not demonstrate collaboration or discussion as required in the contract.

DHCS deems the MHP out of compliance with BHIN 22-017; Code of Federal Regulations, title 42, section 438, subdivision 210(b)(1); California Code of Regulations, title 9, section 1810, subdivision 440(b)(2)(i-ii).

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:

- Adult TARs
- TAR Log
- Concurrent Review Logs
- Concurrent Review Worksheet
- Concurrent Review, TAR, and Authorization Signers
- Discharge Planning Evidence
- 510.1-Authorization Process for Outpatient MH Services
- 519-2022 Revision Inpatient Concurrent Review Authorization
- Sample Concurrent Review Process with hospital notes
- Evidence of concurrent review documents from an Adult TAR sample submitted

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. Per the discussion during the review, the MHP stated it does not have a CRTS or ARTS facility or program within the county and would refer the beneficiary out of county if there was a need. Post review, the MHP submitted documentation of out of county inpatient services; however, no evidence was provided to demonstrate outpatient concurrent review as required in the contract.

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

Question 5.2.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; and Health and Safety Code, section 1367.01(i), 1371.4(a). The MHPs must maintain telephone access to receive Psychiatric Inpatient Hospital or Psychiatric Health Facility (PHF) admission notifications and initial authorization requests 24-hours a day and 7 days a week.

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

- 510.1-Auth Process for Outpatient MH Services
- 519 -2022 Revision Inpatient Concurrent Review Authorization
- Concurrent Review Logs
- Evidence of Telephone tracking mechanism
- Sample of Telephone Access to receive admission notifications
- Telephone Access for Admission Notifications and Initial Authorizations

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains telephone access to receive Psychiatric Inpatient Hospital or PHF admission notifications and initial authorization requests 24-hours a day and 7 days a week. Per the discussion during the review, the MHP stated it receives notifications of inpatient admissions via a fax machine and it has trained the after-hours staff how to handle inpatient authorization request phone calls. DHCS requested after-hours training materials; however, no additional evidence was provided to demonstrate compliance with this requirement.

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(i), 1371.4(a).

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:

- 510.1-Auth Process for Outpatient MH Services
- 519-2022 Revision Inpatient Concurrent Review Authorization

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP utilizes referrals and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Per the discussion during the review, the MHP stated it does not have a CRTS or ARTS facility or program within the county and would refer the beneficiary out of county if there was a need. Post review, no additional evidence was provided to demonstrate a process was in place for concurrent review of CRTS and ARTS.

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

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:

- 510.1-Auth Process for Outpatient MH Services
- 519-2022 Revision Inpatient Concurrent Review Authorization
- SAR Timeliness Tracking
- SAR Email & Authorization Evidence Feb23
- SAR Email & Authorization Evidence Nov22

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.	0	2	0%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that 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 two (2) Service Authorization Requests reviewed by DHCS, zero (0) were completed within the required timeframe. Per the discussion during the review, the MHP stated it would submit supporting documentation post review to demonstrate compliance with this requirement. Post review, no additional evidence was provided.

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

Repeat deficiency Yes

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.5

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(5); Code of Federal Regulations, title 42, section 438, subdivision 406(b)(1) and 228(a), California Code of Regulation, title 9, section 1850, subdivision 205(d)(4); and MHSUDS IN 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements:

1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.
2. The acknowledgment letter shall include the following:
    a. Date of receipt
    b. Name of representative to contact
    c. Telephone number of contact representative
    d. Address of Contractor
3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

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

- 620 Grievance Compliant Definitions
- 630 Beneficiary Rights
- 632 Beneficiary Problem Resolution Process
- 640 Notices of Adverse Benefit Determination
- 661 Investigation of Beneficiary Complaint
- Grievance closure Template
- Grievance closure BS, DF, SF, CS, LD
- Grievance letter CS
- Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- Grievance Log 3-29-22
- Grievance Log 7-1-22 to 6-30-22 – 8-10-22
- Grievance Log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance Log 7-1-22 to 6-31-23 Updated 12-28-2022
- Grievance Log Template part 2 starting NOV2020 Current Year
- MH Log July2021-June 2022 Current Year
- Provider Receipt of complaint – CS
- Provider Receipt of complaint-Template

- Receipt of Grievance C. Schaffer
- Receipt of Grievance Kyle Estes
- Receipt of Grievance Letter LD; NB & DF
- Receipt of Grievance -Template

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP acknowledges the receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. Of the 10 grievances reviewed, four (4) acknowledgement letters were sent beyond the five-calendar day timeline. The MHP stated it would research the four (4) acknowledgement letters that do not meet timeliness requirements and submit supporting documentation. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below;

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**10**	**6**	**4**	**60%**

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(5); Code of Federal Regulations, title 42, section 438, subdivision 406(b)(1), 228(a); California Code of Regulation, title 9, section 1850, subdivision 205(d)(4); and MHSUDS IN 18-010E

Repeat deficiency Yes

Question 6.1.12

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(13) and Code of Federal Regulations, title 42, section 438, subdivision 406(b)(2)(ii)(A)-(C) and 228(a). The MHP must ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations, have the appropriate clinical expertise, as determined by DHCS, in treating the beneficiary's condition or disease, if the decision involves an appeal based on a denial of medical necessity, a grievance regarding denial of a request for an expedited appeal, or if the grievance or appeal involves clinical issues.

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

- 620-Grievance Complaint Definitions
- 630-Beneficiary Rights
- 632-Beneficiary Problem Resolution Process
- 640-Notice of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaints
- Reviewers Signers NOAS & Other Decision with Clinical Expertise Needed

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that individuals making decisions on the grievances and appeals of adverse benefit determinations, have the appropriate clinical expertise, as determined by DHCS, in treating the beneficiary's condition or disease. Per the discussion during the review, the MHP stated that it has a process wherein staff are assigned according to staff availability and expertise, and that it would update its policy to meet this requirement. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(13) and Code of Federal Regulations, title 42, section 438, subdivision 406(b)(2)(ii)(A)-(C) and 228(a).

Repeat deficiency Yes

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:

- 620-Grievance Complaint Definitions
- 630-Beneficiary Rights
- 632-Beneficiary Problem Resolution Process

- 640-Notice of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaints
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH-Appeal Form letter
- NCBH-Grievance Form letter
- Pre-Review: Grievance closure Template
- Pre-Review: Grievance closure BS, DF, SF, CS, LD
- Pre-Review: Grievance letter CS
- Pre-Review: Grievance logs

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. Per the discussion during the review, the MHP stated that it would update its policy to meet the contract requirements. Post review, no additional evidence was provided.

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:

- 620-Grievance Complaint Definitions
- 630-Beneficiary Rights
- 632-Beneficiary Problem Resolution Process
- 640-Notice of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaints
- Grievance closure NB
- Receipt of Grievance NB

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. Per the discussion during the review, the MHP stated that it would update its policy to meet this requirement. Post review, no additional evidence was provided.

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:

- 620-Grievance Complaint Definitions
- 630-Beneficiary Rights
- 632-Beneficiary Problem Resolution Process
- 640-Notice of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaints

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. Per the discussion during the review, the MHP stated it would update its policy to include this requirement. Post review, no additional evidence was provided.

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:

- 620-Grievance Complaint Definitions
- 630-Beneficiary Rights
- 632-Beneficiary Problem Resolution Process
- 640-Notice of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaints
- Grievance log Fiscal Year 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-21 to 6-30-22-8-10-22
- Grievance Call Log July 2020-June 2021 Current Year

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 stated it would update its policy to include this requirement. Post review, no additional evidence was provided.

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 6.2.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 416(a); California Code of Regulations, title 9, section 1850, subdivision 205(d)(1); and MHP Contract, exhibit A, attachment 12, section 2(A). The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

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

- P&P 632 Beneficiary Problem Resolution Process
- P&P 620 – Grievance Compliant Definitions
- P&P 630 Beneficiary Rights
- P&P 640 – Notices of Adverse Benefit Determination
- P&P 661 – Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance logs 3-29-22
- Grievance log Fiscal Year 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-21 to 6-30-22-8-10-22
- Grievance Call Log July 2020-June 2021 Current Year
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- Grievance Log Template part 2 starting Nov2020 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- MH Log July2021-June 2022 Current Year
- Posted signs 2 & 3
- PRA Call Log July 2020-June2021Current Year

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains a grievance and appeal log and records grievances within one (1) working day of the date of receipt of the grievance. Of the 10 grievances reviewed by DHCS, three (3) were not logged within the required timeframe. Per the discussion during the review, the MHP stated it would research the three (3) grievances in question and submit supporting documentation demonstrating compliance. Post review, no additional evidence was provided.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 416(a), California Code of Regulations, title 9, section 1850, subdivision 205(d)(1), and MHP Contract, exhibit A, attachment 12, section 2(A).

Repeat deficiency Yes

Question 6.2.6

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1850, subdivision 205(d)(6) and MHP Contract, exhibit A, attachment 12, section 2(E). The MHP must provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

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

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance closure NB
- Grievance letter LT
- Grievance logs 3-29-22
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides written notification to a provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. Of the 10 grievances reviewed by DHCS, three (3) did not demonstrate notification to the identified provider. Per the discussion during the review, the MHP stated it would research the three (3) grievances that were missing provider notification. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1850, subdivision 205(d)(6) and MHP Contract, exhibit A, attachment 12, section 2(E).

Question 6.3.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c) and MHP Contract, exhibit A, attachment 12, section 3(E). The MHP must provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

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

- 632-Beneficiary Problem Resolution Process
- 620–Grievance Compliant Definitions
- 630 Beneficiary Rights
- 640 – Notices of Adverse Benefit Determination
- 661 – Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance logs 3-29-22
- Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3
- PRA Call Log July 2020-June 2021 Current Year

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides a written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted. Of the 10 grievances reviewed by DHCS, four (4) did not include Notice Grievance Resolution to the beneficiary. Per the discussion during the review, the MHP stated it would research the four (4) grievances that were not provided written notification of grievance resolution. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below;

	# OF SAMPLE REVIEWED	RESOLUTION NOTICE		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**10**	**6**	**4**	**60%**

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c) and MHP Contract, exhibit A, attachment 12, section 3(E).

Repeat deficiency Yes

Question 6.4.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 408(a) and 408(b)(2); and MHP Contract, exhibit A, attachment 12, section 5(A)(3). The MHP must resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.

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

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance Log Template part 2 starting NOV2020 Current Year
- Grievance logs 3-29-22
- Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3

- PRA Call Log July 2020-June 2021 Current Year
- Provider receipt of complaint Template
- Receipt of grievance-Template

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each appeal and provides notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal. Per the discussion during the review, the MHP stated that it would update its policy to meet this requirement. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 408(a); 408(b)(2); and MHP Contract, exhibit A, attachment 12, section 5(A)(3).

Question 6.4.7

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 406(b)(6) and MHP Contract Exhibit A, Attachment 12, section 5(A)(7). The MHP must allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

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

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance Log Template part 2 starting NOV2020 Current Year
- Grievance logs 3-29-22
- Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3
- PRA Call Log July 2020-June 2021 Current Year

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP allows the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal. Per the discussion during the review, the MHP stated that it would update its policy to meet this requirement. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 406(b)(6) and MHP Contract Exhibit A, Attachment 12, section 5(A)(7).

Question 6.4.13

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 410(b) and MHP Contract Exhibit A, Attachment 12, section 6(B)(3). The MHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

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

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance Log Template part 2 starting NOV2020 Current Year
- Grievance logs 3-29-22
- Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3
- PRA Call Log July 2020-June 2021 Current Year

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

Per the discussion during the review, the MHP stated that it would update its policy to meet this requirement. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 410(b) and MHP Contract Exhibit A, Attachment 12, section 6(B)(3).

Question 6.4.14

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c) and MHP Contract Exhibit A, Attachment 12, section 6(B)(4). The MHP must inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal.

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

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- NCBH Services Brochure (English and Spanish)
- NCBH – Appeal Form letter, Grievance Form letter
- Grievance Log Template part 2 starting NOV2020 Current Year
- Grievance logs 3-29-22
- Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3
- PRA Call Log July 2020-June 2021 Current Year

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP informs beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. Per the discussion during the review, the MHP stated that it

would update its policy to meet this requirement. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c) and MHP Contract Exhibit A, Attachment 12, section 6(B)(4).

Question 6.4.17

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 410(c)(1) and MHP Contract Exhibit A, Attachment 12, section 6(B)(7)(a)-(b). If the MHP denies a request for an expedited appeal resolution, The MHP shall:

a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.410(c)(1).)
b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal.

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

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint
- Client problem resolution guide (English and Spanish)
- 6.4.17 NCBH Services Brochure (English and Spanish)
- 6.4.17 NCBH – Appeal Form letter, Grievance Form letter
- 6.4.17 Grievance Log Template part 2 starting NOV2020 Current Year
- 6.4.17 Grievance logs 3-29-22
- 6.4.17 Grievance Log FY 7-1-21 to 6-30-22-8-10-22
- 6.4.17 Grievance log 7-1-22 to 6-31-23 Updated 2-1-2023
- 6.4.17 Grievance log 7-1-22 to 6-31-23 Updated 12-28-2022
- 6.4.17 MH Log July2021-June2022 Current Year
- Link to Public Website with Problem Resolution Materials and CBO website
- Posted signs 2-3
- PRA Call Log July 2020-June 2021 Current Year

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP transfers the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal when the request for expedition is denied. Per the discussion during

the review, the MHP stated that it would update its policy to meet this requirement. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 410(c)(1) and MHP Contract Exhibit A, Attachment 12, section 6(B)(7)(a)-(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:

- 632-Beneficiary Problem Resolution Process
- 620-Grievance Compliant Definitions
- 630-Beneficiary Rights
- 640-Notices of Adverse Benefit Determination
- 661-Investigation of Beneficiary Complaint

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 until one of the required conditions is met. Per the discussion during the review, the MHP stated that it would update its policy to meet the contract requirements. Post review, no additional evidence was provided to demonstrate compliance with this requirement.

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).

PROGRAM INTEGRITY

Question 7.4.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 455, subdivision 104(b) and MHP Contract Exhibit A, Attachment 13, section 6(A)(2)-(3). The MHP must ensures disclosures include:

a) The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.
b) The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
c) Date of birth and Social Security Number (in the case of an individual);
d) Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);
e) Whether the person (individual or corporation) with an ownership or control interest in the MHP's network provider is related to another person with ownership or control interest in the same or any other network provider of the MHP as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;
f) The name of any other disclosing entity in which the MHP or subcontracting network provider has an ownership or control interest; and
g) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.
h) The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.

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

- 134-Conflict of Interest
- 139-Ethics and Conduct Policy
- 193-Ownership Interest Disclosure of Managing Staff and Contract Providers
- 703-Contract Development and Monitoring
- 704-Individual and Organizational Provider Selection and Credentialing
- BH-PSK Template FY 23-24
- NCBH Provider Disclosure Statement
- Nevada County Contractor Disclosure Log

- SMWG 2019 N.C corporate letter

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures disclosures include the name, address, date of birth, and Social Security Number of any managing employee of the managed care entity. Per the discussion during the review, the MHP stated it has a disclosure tracking form but the process is not currently being utilized and it is working to reestablish this process.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 455, subdivision, 106(a)(1),(2), and MHP Contract Exhibit A, Attachment 13, section 6(C)(1)(a)-(b).

Repeat deficiency Yes