CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SHASTA COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: June 6, 2023 to June 7, 2023

Shasta 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 Shasta County MHP's Medi-Cal SMHS programs on June 6, 2023, to June 7, 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 Shasta 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:

- TFC Contract Children First TFC 2223 DRAFT
- TFC P&P Assessment and Approval DRAFT
- TFC P&P Placement and Ongoing Management DRAFT
- Narrative

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it was in the process of finalizing a contract with a TFC provider and drafting necessary policies. The MHP anticipates this service will be available in fiscal year 2023-2024.

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 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:

- TFC Contract Children First TFC 2223 DRAFT
- TFC P&P Assessment and Approval DRAFT
- TFC P&P Placement and Ongoing Management DRAFT
- Wrap CFT meeting template, August 2022
- Engagement Phase for Hi Fi Wrap
- Initial Plan Development Phase for Hi Fi Wrap
- Implementation
- Transition Phase for Hi Fi Wrap
- ISFC - Eligibility Requirements, December 7, 2016
- ISFC- Assessing for ISFC Appropriateness, December 7, 2016
- ISFC - Approval & Coordination, December 7, 2016
- ISFC - Placement & Ongoing Case Management, December 7, 2016
- ISFC - Transition to Lower Level of Care Wrap Policy, December 7, 2016
- Interagency Placement Committee (IPC) DRAFT
- Plan of Care TEMPLATE
- IPC Samples

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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it assesses children and youth for an array of intensive services it provides in lieu of TFC. Post review, the MHP submitted additional evidence, including Intensive Services Foster Care (ISFC) criteria and policies; however, it is not evident that the MHP assesses for TFC as required in the contract.

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 1.4.3

FINDING

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 12(a) (1) and MHP Contract, exhibit A, attachment 8, section 7(F). The MHP must comply with following;

- The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

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

- Children's Services Contract Cancellation Template
- Contract Termination Letter Template
- Contract Termination SAMPLE
- Memorandum

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP gives practitioners, or groups of practitioners it decides not to contract with, a written notice of the reason for its decision not to contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it has not refused to contract with a provider during the review period and it does not have a template notification. The MHP acknowledged this requirement will be addressed via corrective action.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 12(a)(1) and MHP Contract, exhibit A, attachment 8, section 7(F).

CARE COORDINATION AND CONTINUITY OF CARE

Question 2.2.1

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHSUDS IN No. 18-059; MHP contract, exhibit A, attachment 10, section 1(F); and Code of Federal Regulations, title 42, section 438, subdivision 62(b)(2). The MHP Continuity of Care written notifications to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

- The MHP's denial of the beneficiary's continuity of care request;
- A clear explanation of the reasons for the denial;
- The availability of in-network SMHS;
- How and where to access SMHS from the MHP;
- The beneficiary's right to file an appeal based on the adverse benefit determination; and,
- The MHP's beneficiary handbook and provider directory.

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

- Continuity of Care Request - Acknowledgment Letter
- Continuity of Care Request - Approval Notice
- Continuity of Care Request - Notice of Adverse Benefit Determination
- Continuity of Care Request Form
- Continuity of Care Tracker

- Policy and Procedure Continuity of Care DRAFT

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's written notifications included the required information. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it was unaware that it was required to comply with continuity of care requirements. Post review, the MHP submitted additional evidence demonstrating its efforts to re-implement this process moving forward.

DHCS deems the MHP out of compliance with the MHSUDS IN No. 18-059; MHP contract, exhibit A, attachment 10, section 1(F); and Code of Federal Regulations, title 42, section 438, subdivision 62(b)(2).

Question 2.2.2

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHSUDS IN No. 18-059; MHP contract, exhibit A, attachment 10, section 1(F); and Code of Federal Regulations, title 42, section 438, subdivision 62(b)(2). The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30 calendar days before the end of the continuity of care period about the process that will occur to transition a beneficiary's care at the end of the continuity of care period.

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

- Continuity of Care Request - Acknowledgment Letter
- Continuity of Care Request - Approval Notice
- Continuity of Care Request - Notice of Adverse Benefit Determination
- Continuity of Care Request Form
- Continuity of Care Tracker
- P&P Continuity of Care (DRAFT)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies the beneficiary, and/or the beneficiary's authorized representative, 30 calendar days before the end of the continuity of care period about the process that will occur to transition a beneficiary's care at the end of the continuity of care period. Per the discussion during the review, the MHP stated it was unaware that it was required to comply with continuity of care requirements. Post review, the MHP submitted additional evidence demonstrating its efforts to re-implement this process moving forward.

DHCS deems the MHP out of compliance with the MHSUDS IN No. 18-059; MHP contract, exhibit A, attachment 10, section 1(F); and Code of Federal Regulations, title 42, section 438, subdivision 62(b)(2).

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.1.8

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 1(H). The MHP must implement mechanisms to monitor the safety and effectiveness of medication practices meeting the below listed requirements:

1. Under the supervision of a person licensed to prescribe or dispense medication.
2. Performed at least annually.
3. Inclusive of medications prescribed to adults and youth.

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

- Adult med monitoring screening tool
- Children's med monitoring screening tool
- Med Monitoring Feedback loop form
- Med Monitoring Log
- Quarter 4 of 2022 Medication Monitoring Results
- Re_ Quarter 4 of 2022 Medication Monitoring Results
- P&P Medication Monitoring- Adult and Children's, May 14, 2019
- Example Medication Consent
- Med Staff Doc Training Youth, May 2022
- Sign-In Sheet 1-31-20
- Sign-In Sheet 2-3-20 FEX
- Sign-In Sheet 2-4-20 FEX
- 2021 Med Mon Statement
- Medication Practices Training Materials

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implements mechanisms to monitor the safety and effectiveness of medication practices. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it is working on developing standards, training, and tools for monitoring its providers for medication practices. Post review, the MHP submitted additional evidence including a statement that it did not conduct any medication monitoring activities during 2021.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 1(H).

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 (QAPI) 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:

- QIC Meeting Minutes
- QI Goal Reports
- FY22-23 Q3 Quarterly No-Show Report
- MHADAB 2-1-23 Minutes
- MHADAB 3-1-23 Minutes
- MHADAB 4-5-23 Minutes
- MHADAB Grievance Presentation
- QIC Data Meeting Minutes 2023.05.17
- QIC Meeting Minutes 2023.03.14
- QIC Meeting Minutes 2023.04.20
- QIC Meeting Minutes TEMPLATE

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's QAPI program includes active participation from beneficiaries and beneficiary family members, in the planning, design and execution of the Quality Improvement program. Per the discussion during the review, the MHP stated that it would submit additional meeting minutes to demonstrate compliance with this requirement. Post review, the MHP submitted additional Quality Improvement Committee meeting minutes that documented increased contracted provider involvement; however, the evidence failed to show involvement of beneficiaries, family members, or legal representatives as required by the contract.

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).

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:

- Contract Boilerplate Adult
- Contract Boilerplate Children
- Contract Boilerplate MHP Exhibits
- Contract Boilerplate STRTP In-County
- Contract Boilerplate STRTP OOC
- Mental Health Provider Resources Provider Guideline Webpage with documents attached
- Policy and Procedure Practice Guidelines Development and Implementation DRAFT
- System of Care for Children and Youth MOU
- Child and Adolescent Needs and Strengths (CANS) Reference Guide
- Early Childhood Mental Health Treatment Overview
- Integrated Family Wellness Program (IFWP) handbook
- Neurosequential Model of Therapeutics (NMT): Clinical Practice Tools
- Shasta County PEI Program
- STAR Team PowerPoint
- Triple P PASS Manual 2013

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has practice guidelines, which meet the requirements of the MHP Contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not have formal practice guidelines. Post review, the MHP submitted additional evidence including a Child and Adolescent Needs and Strengths (CANS) reference guide and Integrated Family Wellness Program (IFWP) handbook; however, the evidence did not demonstrate compliance to the requirement.

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:

- Contract Boilerplate Adult
- Contract Boilerplate Childrens
- Contract Boilerplate MHP Exhibits
- Contract Boilerplate STRTP In-County
- Contract Boilerplate STRTP OOC
- Mental Health Provider Resources Provider Guideline Webpage with documents attached
- Policy and Procedure Practice Guidelines Development and Implementation DRAFT
- Child and Adolescent Needs and Strengths (CANS) Reference Guide
- Early Childhood Mental Health Treatment Overview
- Integrated Family Wellness Program (IFWP) handbook
- Neurosequential Model of Therapeutics (NMT): Clinical Practice Tools
- Shasta County PEI Program
- STAR Team PowerPoint
- Triple P PASS Manual 2013

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates practice guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. Per the discussion during the review, the MHP acknowledged that it does not have developed practice guidelines that can be disseminated as required in the contract. Post review, the MHP submitted additional evidence including a CANS reference guide and IFWP handbook; however, the evidence did not demonstrate compliance to the requirement.

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

Question 3.5.3

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

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

- Contract Boilerplate Adult
- Contract Boilerplate Childrens
- Contract Boilerplate MHP Exhibits
- Contract Boilerplate STRTP In-County
- Contract Boilerplate STRTP OOC
- Mental Health Provider Resources Provider Guideline Webpage with documents attached
- Policy and Procedure Practice Guidelines Development and Implementation DRAFT
- Child and Adolescent Needs and Strengths (CANS) Reference Guide
- Early Childhood Mental Health Treatment Overview
- Integrated Family Wellness Program (IFWP) handbook
- Neurosequential Model of Therapeutics (NMT): Clinical Practice Tools
- Shasta County PEI Program
- STAR Team PowerPoint
- Triple P PASS Manual 2013

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP takes steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. Per the discussion during the review, the MHP stated it provides wraparound services but acknowledged it does not have practice guidelines established. Post review, the MHP submitted additional evidence including a CANS reference guide and IFWP Handbook; however, the evidence did not demonstrate compliance to the requirement.

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

ACCESS AND INFORMATION REQUIREMENTS

Question 4.2.2

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

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

The seven (7) test calls are summarized below.

TEST CALL #1
Test call was placed on Wednesday, April 5, 2023, at 7:32 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 provided the clinic location and hours of operation for children services and informed the caller that walk-in assessment services are available. The operator stated the caller could also call back during business hours to schedule an appointment for an assessment.

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 Tuesday, April 11, 2012, at 1:51 p.m. The call was answered after two (2) rings via live operator. The caller requested assistance with what he/she described as feeling depressed, unable to sleep, and bouts of crying. The operator explained the screening and assessment process. The operator informed the caller that

walk-in services are available and provided the clinic location and hours of operation. The operator explained that someone is available 24/7 via the after-hours line. The operator informed the caller that crisis and urgent care services are available through the emergency room if needed.

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 Monday, May 1, 2023, at 1:43 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 informed the caller about the availability of walk-in appointments to receive mental health services and provided clinic location and hours of operation. The operator informed the caller that he/she could go to the emergency room if he/she were to experience an urgent condition or were in need of crisis care.

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 Tuesday, May 16, 2023, at 7:37 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 to get a refill of his/her anxiety medication. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator provided the clinic location and hours of operation for walk-in services for assistance with obtaining the medication. The operator stated the caller could also call back during business hours to schedule 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 #5
Test call was placed on Wednesday, May 3, 2023, at 11:44 a.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 informed the caller that he/she could walk in for services and provided the caller with the address and hours of operation for the county clinic. The operator informed the caller that a clinician would provide a screening, assessment, and referral to services. The operator also informed the caller that urgent and crisis services are available through the emergency room.

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, April 25, 2023, at 5:03 p.m. The call was answered after four (4) rings via a live operator. The caller was placed on hold for approximately 30 seconds. When the operator returned, the caller asked how to file a complaint in the county. The operator informed the caller of his/her right to file a complaint orally or in writing. The operator provided clinic locations and hours of operation where the caller could pick up grievance forms; provided the option to file the grievance online; and offered to send the grievance forms directly 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).

TEST CALL #7
Test call was placed on Tuesday, May 2, 2023, at 2:49 p.m. The call was answered after one (1) ring via a live operator. The caller told the operator he/she wanted to file a complaint against a therapist. The operator explained that the caller could either speak to quality management or file a complaint in writing. The caller stated he/she would like

to file the complaint in writing. The operator informed the caller that he/she can pick up the grievance form in the clinic or it can be mailed 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:

- Access to Services Journal for requested dates
- Memorandum

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

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	4/5/2023	7:32 a.m.	IN	IN	IN
2	4/11/2023	1:51 p.m.	IN	IN	IN
3	5/1/2023	11:50 a.m.	IN	IN	IN
4	5/16/2023	7:37 a.m.	IN	IN	IN
5	5/3/2023	11:44 a.m.	OOC	OOC	OOC
Compliance Percentage			**80%**	**80%**	**80%**

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

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

Repeat deficiency Yes

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:

- Interpreter Training Cultural Competency
- 4.3.5-6 CCC Meeting Minutes 2023.02.01
- 4.3.5-6 CCC Meeting Minutes 2023.03.01
- 4.3.5-6 CCC Meeting Minutes 2023.04.05
- Narrative dated 5/22/23 stating MHP is drafting policy

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 interpreters are trained and monitored for language competence (e.g., formal

testing). This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it is working on a process to ensure interpreters are trained and monitored for language competence. The MHP did not submit any additional evidence post review.

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 5.2.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN No. 22-017; California Code of Regulations, title 9, section 1810, subdivision 440(b); and Code of Federal Regulations, title 42, section 438, subdivision 210(a)(4), (b)(1),(2). The MHPs are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization review procedures.

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

- NOABD - Denials - Appeals - log
- Org Provider Document Submission Tracking Sheet
- Out of the County Group Home Tracking
- Inpatient Stays
- I - P Hospital Chart Tracking Sheet
- SARS
- TARS
- Hospital Concurrent Authorization Process 2-2021, February 25, 2021
- Remote Concurrent PHF Review Procedure, February 21, 2023
- Authorization of Outpatient SMHS policy No 2022 - 04, March 20, 2023
- Hospital Concurrent Authorization Process, February 2021
- Outpatient Auth P&P Statement
- Psynergy Adult Outpatient SMHS review PROCEDURE
- Sequoia ARTS CRAR with Instructions
- Concurrent review PP statement
- Value Options of California policies

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP operates a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. Per the discussion during the

review, the MHP stated it did not have an inpatient concurrent review policy implemented prior to March 20, 2023. Post review the MHP submitted a narrative stating that hospitals were notified of the concurrent review process and it has procedures that adhere to these requirements; however, the policies and procedures provided by the MHP do not demonstrate compliance to this requirement.

DHCS deems the MHP out of compliance with BHIN No. 22-017; California Code of Regulations, title 9, section 1810, subdivision 440(b); and Code of Federal Regulations, title 42, section 438, subdivision 210(a)(4), (b)(1),(2).

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:

- NOABD - Denials - Appeals - log
- Org Provider Document Submission Tracking Sheet
- Out of the County Group Home Tracking
- Inpatient Stays
- I - P Hospital Chart Tracking Sheet
- Hospital Concurrent Authorization Process 2-2021, February 25, 2021
- Remote Concurrent PHF Review Procedure, February 21, 2023
- Psychiatric Inpatient Hospital and Psychiatric Health Facility Services (No. 2022), No issue date
- BOC CUR 100.2 Medical Necessity Request Determination Timeframes
- Concurrent Review Policy and Procedure Statement
- Value Options of California policies
- Auth of OP services P&P and initial services ext form

- Authorization of initial services_ including extension requests (IN 19-026)
- TARs

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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it sent its providers a letter regarding the date concurrent review would begin. Post review, the MHP submitted additional evidence including policies developed by its contracted administrative entity; however, it is not evident that the policies and procedures were developed with involvement from network providers or are specific to concurrent review 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 5.2.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017 and Code of Federal Regulations, title 42, section 438, subdivision 10(g)(2)(iv). The MHP must comply with the following communication requirements:

1. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2. Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;
3. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
4. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

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

- Remote Denial Procedures for TARs
- Non-Acute Short - Doyle Days
- MD Invoice - HCIF Denial and NOABD Procedure
- Hospital Concurrent Authorization Process, February 25, 2021

- Remote Concurrent PHF Review Procedure, February 21, 2023
- SARs
- TARs
- Out of the County Group Home Tracking
- Inpatient Stays
- I - P Hospital Chart Tracking Sheet
- Psychiatric Inpatient Hospital and Psychiatric Health Facility Services (No. 2022), No issue date
- BOC CUR 100.2 Medical Necessity Request Determination Timeframes
- Concurrent Review Policy and Procedure Statement
- Value Options of California Policies
- 5.2.4 Statement
- Adventist Health Concurrent Review and Authorization
- Adventist Health RE_ Concurrent Review and Authorization
- County Administrators signed letters
- Heritage Oaks Concurrent Review and Authorization
- mhp_beneficiary_handbook_2023final
- NVBH Re Concurrent Review and Authorization
- Concurrent Review-SRMC
- Calling for authorization - more info
- Minutes Shasta County Daily Go-Live Check In 03082019
- Minutes Shasta County Daily Go-Live Check In 03082019
- Restpadd Redding Concurrent Review and Authorization
- Restpadd Redding RE_ calling for authorization - more info
- Sierra Vista Concurrent Review and Authorization
- Sutter Ctr for Psychiatry Concurrent Review and Authorization
- Sutter-Yuba Concurrent Review and Authorization
- TARS

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP complies with notification requirements to DHCS regarding concurrent review procedures and relevant timeframes. Per the discussion during the review, the MHP stated that it did not have a consistent notification and communication process for concurrent review implementation. Post review, the MHP submitted additional evidence including a statement acknowledging that it has not notified DHCS of all services that require prior and concurrent review authorization.

DHCS deems the MHP out of compliance with BHIN 22-017 and Code of Federal Regulations, title 42, section 438, subdivision 10(g)(2)(iv).

Question 5.2.9

FINDING

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Welfare and Institution Code 14197.1; Health and Safety Code 1367.01(e) & (h)(3-4); Code of Federal Regulations, title 42, section 431, subdivision 213(c); section 438, subdivision 404, section 438, subdivision 210(b)(3) & (c), section 431, subdivision 213(c), and MHSUDS IN 18-010E.

1. While LMHPs/LPHAs may review authorization requests and issue approvals within their scope of practice, all MHP decisions to modify or deny a treatment request shall be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs. A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent with the psychologist's scope of practice.
2. 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.
3. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider
4. the opportunity to consult with the professional who made the authorization decision.
5. If a MHP modifies or denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.
6. If a MHP denies a hospital's authorization request, the MHP must work with the treating provider to develop a plan of care. Services shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary.
7. If the MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

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

- TARs
- Second - Level Appeal Provider Care Cover Sheet
- Hospital Appeals new
- Appeal response template
- Hospital Concurrent Authorization Process 2.2021

- NOABD - Denials - Appeals - log
- Authorization delay
- NOABD Authorization Delay
- Modification Notice
- NOABD Delivery System Log
- Psychiatric Inpatient Hospital and Psychiatric Health Facility Services (No. 2022), No issue date
- SHA Audit Request Modified Authorization Sample 01
- Beacon Of California CUR 100.2 Medical Necessity Request Determination Timeframes
- Concurrent Review Policy and Procedure Statement
- Value Options of California policies

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP will work with a hospital treating provider to develop a treatment plan for a beneficiary if there is a disagreement with a modification or denial of an authorization as required per the regulation. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it sends an appropriate NOABD that includes the required information to the provider and beneficiary. Post review, the MHP submitted additional information, including a sample modified authorization; however, the modified authorization and accompanying documentation did not demonstrate the communication or resolution process outlined in the requirement.

DHCS deems the MHP out of compliance with BHIN 22-017; Welfare and Institution Code 14197.1; Health and Safety Code 1367.01(e) & (h)(3-4); Code of Federal Regulations, title 42, section 431, subdivision 213(c); section 438, subdivision 404, section 438, subdivision 210(b)(3) & (c), section 431, subdivision 213(c); and MHSUDS IN 18-010E.

Question 5.2.17

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016 and BHIN 22-017. The MHP must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payer.

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

- Remote IP Retro Hospital Review Processing Procedure (Updated 10/21/2022)
- SARs
- TARs
- Authorization of Outpatient SMHS Policy, March 20, 2023
- Concurrent Review and Authorization of Psychiatric Impatient Hospital Services for Shasta County Medi-Cal Beneficiaries, February 25, 2021
- Outpatient Auth P&P Statement
- Psynergy Adult Outpatient SMHS Review Procedure, April 28, 2017
- Sequoia ARTS CRAR with Instructions

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established written policies and procedures regarding retrospective authorization. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit the outpatient authorization policy that was active during the review period. Post review, the MHP submitted additional documentation, including a statement acknowledging that it did not have an active outpatient authorization policy prior to March 10, 2023.

DHCS deems the MHP out of compliance with BHIN 22-016 and BHIN 22-017.

Question 6.1.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(2) and Code of Federal Regulations, title 42, section 438, subdivision 402(b) and 228(a). The MHP must have only one level of appeal for beneficiaries.

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

- NOABDs, Appeals, and State Hearings Policy and Procedure, April 19, 2023
- P&P Beneficiary Problem Resolution February 7, 2017
- Grievance Form
- Appeal form
- Beneficiary Informing Materials Webpage
- MHADAB Grievance Presentation
- BHSS Branch Briefing Meeting Notes March 2023
- Memorandum

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has only one level of appeal for beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would update its policy with the required language.

Post review, the MHP submitted a memorandum, stating it is updating its policies and procedures to meet the requirements moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(2) and Code of Federal Regulations, title 42, section 438, subdivision 402(b) and 228(a).

Question 6.1.13

FINDING
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(15) and Code of Federal Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a). The MHP must ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

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

- NOABDs, Appeals, and State Hearings Policy and Procedure, April 19, 2023
- P&P Beneficiary Problem Resolution February 7, 2017
- Grievance Form
- Appeal form
- Beneficiary Informing Materials Webpage
- Grievances Logs and Samples
- Memorandum

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would update its policy with the required language. Post review, the MHP submitted a memorandum, stating it is updating its policies and procedures to meet the requirements moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(15) and Code of Federal Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a).

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:

- NOABDs, Appeals, and State Hearings Policy and Procedure, April 19, 2023
- P&P Beneficiary Problem Resolution February 7, 2017
- Grievance Form
- Appeal form
- Beneficiary Informing Materials Webpage
- Grievances Logs and Samples
- Discrimination Grievances Policy DRAFT
- Memorandum

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 stated it would update its policy with the required language. Post review, the MHP submitted a memorandum, stating it is updating its policies and procedures to meet the 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 6.1.16

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:
Pre-Review

- NOABDs, Appeals, and State Hearings Policy and Procedure, April 19, 2023
- P&P Beneficiary Problem Resolution February 7, 2017
- Grievance Form
- Appeal form
- Beneficiary Informing Materials Webpage
- Grievances Logs and Samples
- Discrimination Grievances Policy DRAFT
- Memorandum

While the MHP submitted evidence to demonstrate compliance with this requirement it is not evident that the MHP does 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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would update its policy with the required language. Post review, the MHP submitted a memorandum, stating it is updating its policies and procedures to meet the 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:

- NOABDs, Appeals, and State Hearings Policy and Procedure, April 19, 2023
- P&P Beneficiary Problem Resolution February 7, 2017
- Grievance Form
- Appeal form
- Beneficiary Informing Materials Webpage
- Grievances Logs and Samples
- Discrimination Grievances Policy DRAFT
- Memorandum

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits the required information regarding the 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 will update its policy with the required language. Post review, the MHP submitted a memorandum, stating it is updating its policies and procedures to meet the 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 6.5.1

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 420(a)-(b) and MHP Contract Exhibit A, Attachment 12, section 9(B)(1)-(5). The MHP must continue the beneficiary's benefits if all of the following occur:

a) The beneficiary files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice;
b) The appeal involves the termination, suspension, or reduction of a previously authorized service;
c) The services were ordered by an authorized provider;

d) The period covered by the original authorization has not expired; and,
e) The beneficiary timely files for continuation of benefits.

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

- NOABDs, Appeals, and State Hearings Policy and Procedure, April 19, 2023
- P&P Beneficiary Problem Resolution February 7, 2017
- P&P Grievances, April 19, 2023
- Grievance Form
- Appeal form
- Beneficiary Informing Materials Webpage
- Appeal Log FY20-21
- Appeal Log FY21-22
- Expedited Appeal Log FY20-21
- Expedited Appeal Log FY21-22
- Termination Notice-D1
- Notice Templates

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP continues the beneficiary's benefits under the required circumstances. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it was aware that its policy needed to be updated. Post review, the MHP submitted additional evidence, including notification templates; however, the templates do not include the required information for the continuation of benefits.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 420(a)-(b) and MHP Contract Exhibit A, Attachment 12, section 9(B)(1)-(5).

PROGRAM INTEGRITY

Question 7.2.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. If the MHP identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste, or abuse, in addition to notifying DHCS, the MHP must conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

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

- Compliance Work Plan FY21-22 FY 22-23
- Compliance Auditing and Monitoring policy, April 10, 2017
- Automatic reply External Shasta County MHP Identification of fraud
- Contract Boilerplate MHP Exhibits
- Fraud Report Securemail Shasta County MC 609
- Compliance Work Plan FY21-22 FY 22-23
- P&P Compliance Reporting and Investigating, April 10, 2017
- FY21-22 Compliance Training Tracker
- P&P False Health Care Claims, April 10, 2017

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies DHCS when it identifies an issue or receives notification of a compliant concerning an incident of potential fraud, waste, or abuse. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it is working on a policy that outlines reporting to DHCS. Post review, the MHP submitted additional evidence, including its reporting and investigating and false claims policies; however, the policies do not include this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Question 7.4.2

FINDING
The MHP did not furnish evidence to demonstrate 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). The MHP must submit the following disclosures to DHCS regarding the MHP's management:

1. The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs.
2. The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part 455.101.

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

- Contract Boilerplate Childrens
- Contract Sample Mountain Valley
- Contract Sample NVCSS
- MVCFS Provider Disclosure Statement
- Utilization Management Audit Oversight Recoupment Standards
- P&P Compliance Reporting and Investigating, April 10, 2017

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits the required disclosures to DHCS. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit its policy as additional evidence. Post review, the MHP submitted additional evidence, including its compliance reporting and investigating policy; however, the policy does not include the required language.

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).