CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE STANISLAUS COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT-AMENDED

Review Dates: June 20, 2023 to June 23, 2023

Stanislaus 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 Stanislaus County MHP's Medi-Cal SMHS programs on June 20, 2023 to June 23, 2023. The review consisted of an examination of the MHP's program and system operations, including chart documentation, to verify that medically necessary services are provided to Medi-Cal beneficiaries. DHCS utilized Fiscal Year (FY) 2022/2023 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

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

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

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

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

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

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

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

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

FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Question 1.1.5

FINDING

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi); and the MHP Contract, exhibit A, attachment 8, section (4)(A)(5)-(7). The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements.

1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements.
2. The MHP shall take corrective action if a network provider fails to comply with timely access requirements.

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

- After hours reports
- ASOC QIC QI work plan FY 21-22
- ASOC QIC QI work plan FY 22-23
- Aspiranet provider agreement document pages 16-19
- Assessment of timely access table 2.1 PMSR Report First non-urgent psychiatric services FY20-21 updated appointment only
- Assessment of timely access MH FY 2021-22 v2.1 07.12.21 Revised Table 4.1 10.16.21
- Assessment of timely access tracking reports
- CSOC QIC QAPI Plans
- MH MKI Q5 FY20-21
- MH MKI Q5 FY21-22
- Urgent Referral FY20-21
- Urgent Referral FY 21-22
- Urgent Referral FYTD 22-23
- MHSUD Provider Directory English Large
- Contact Log Data 070122-123122
- Medi-Cal key indicator report FY 20-21
- Medi-Cal key indicator report FY 21-22
- Provider Agreement pages 20 & 33
- Completed initial screening tool samples
- Contact Log Data 07.1.22 (resubmission post audit)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established mechanisms to ensure that network providers

comply with the timely access requirements. Per the discussion during the review, the MHP stated that it has set an internal goal to have 80% of beneficiaries receive an initial assessment within 28 days of the request for services. Post review, the MHP submitted evidence of monitoring its providers and service data; however, it is not evident that corrective action occurs when a network provider fails to comply with timely access requirements.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 206(c)(1)(iv), 206(c)(1)(v), 206(c)(1)(vi) and the MHP Contract, exhibit A, attachment 8, section (4)(A)(5)-(7).

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:

- Children's Services 02.24.2023 Enhanced ISFC Meeting Agenda
- Children's Services 02.24.2023 Enhanced ISFC Meeting Minutes
- Children's Services 03.24.2023 Enhanced ISFC Meeting Agenda
- Children's Services 03.24.2023 Enhanced ISFC Meeting Minutes
- Children's Services 04.28.2023 Enhanced ISFC Meeting Agenda
- Children's Services draft TFC SOW
- Children's Services STAN Co TFC screening and referral 4.28.23
- Stanislaus_1.2.8_TFC Criteria Screening and Referral Form 4.28.23

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 stated that despite its efforts, which include a request for proposal for this service during the review period, it has been unable to establish a TFC provider.

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:

- Children's Services 02.24.2023 Enhanced ISFC Meeting Agenda
- Children's Services 02.24.2023 Enhanced ISFC Meeting Minutes
- Children's Services 03.24.2023 Enhanced ISFC Meeting Agenda
- Children's Services 03.24.2023 Enhanced ISFC Meeting Minutes
- Children's Services 04.28.2023 Enhanced ISFC Meeting Agenda
- Children's Services draft TFC SOW
- Children's Services STAN Co TFC screening and referral 4.28.23
- TFC criteria screening and referral form 4.28.23
- Stanislaus_1.2.8_TFC Criteria Screening and Referral Form 4.28.23

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 is in the process of implementing a draft TFC criteria checklist and referral form. Post Review, the MHP resubmitted a draft version of the TFC referral form which it anticipates implementing in the future upon establishing a TFC provider.

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

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Question 3.5.1

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

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

- CalMHSA MHP Documentation Guide -CPSS
- CalMHSA MHP Documentation Guide -LPHA
- CalMHSA MHP Documentation Guide -MHRS
- CalMHSA MHP Documentation Guide -MS
- EHR Navigation & Documentation Training March 2023
- Stanislaus_3.5.1_Provider Agreement with Highlights

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. Per the discussion during the review, the MHP stated staff use documentation guidelines for therapy treatments; however, it does not have established practice guidelines as required in the contract.

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:

- CalMHSA MHP Documentation Guide -CPSS
- CalMHSA MHP Documentation Guide -LPHA
- CalMHSA MHP Documentation Guide -MHRS
- CalMHSA MHP Documentation Guide -MS
- EHR Navigation & Documentation Training March 2023
- Stanislaus_3.5.2_Provider Agreement with Highlights

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. Per the discussion during the review, the MHP provides trainings to staff and providers regarding its documentation guidelines for therapies; however, it has not established practice guidelines as required in the contract.

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:

- Stanislaus_3.5.3_Practice Guidelines_Practice Guidelines for Authorization MH SUD
- Stanislaus_3.5.3_Practice Guidelines_Practice Guidelines for Data Entry of Authorizations
- Stanislaus_3.5.3_Provider Agreement with Highlights
- MHP Beneficiary Handbook page 32

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 has trainings on documentation guidelines, but it has not established practice guidelines.

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.

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.1.5

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

opportunity to consult with the professional who made the authorization decision.

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

- P&P 50.1.116 Authorization for SMHS & DMC-ODS
- Sample Modification NOABD Letter
- Instructions for the NOABD Database

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP includes the name and direct telephone number of the professional who made the authorization decision and offers the treating provider the opportunity to consult with the professional who made the authorization decision. Per the discussion during the review, the MHP stated it has program information on its NOABD and it would review its policy to ensure this requirement is being met. Post review, the MHP submitted an updated policy with the required language that it will implement moving forward.

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

Question 5.1.7

FINDING

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 210(a)(2) and (3) and MHP Contract Exhibit A, Attachment 12, section 2(D). The MHP shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. The MHP may deny services based on Welfare and Institutions Code sections 14184.402, subdivisions (a), (c), and (d), 14059.5; and departmental guidance and regulation.

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

- P&P 50.1.116 Authorization for SMHS & DMC-ODS
- County Approver License Details
- Instructions for the NOABD Database
- County Approver Signature Page

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP does not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the beneficiary. Per the discussion during the review, the MHP stated that it would update its policy to meet the contract requirements. Post review, the MHP submitted an updated authorization policy with the required language that it will implement moving forward.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 210(a)(2) and (3) and MHP Contract Exhibit A, Attachment 12,

section 2(D).

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:

- CalMesa P&P
- Kepro P&P 22-17
- Approver Licenses and Signature list
- Concurrent Review for Psychiatric Inpatient Hospitals
- Crisis Residential Basic Quality Chart Review Tool
- Crisis Residential Documentation Checklist
- Crisis Residential Unit (CRU) Referral Updated 5.10.23
- Crisis Residential Unit (CRU) Chart Audit Process
- Crisis Residential Unit (CRU) Communication access
- Crisis Residential Unit (CRU) Referral and Authorization 1
- Crisis Residential Unit (CRU) Referral and Authorization 2
- Email Crisis Residential Unit (CRU) access
- P&P 50.1.116 Authorization for MH and SUD

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 is currently in the process of establishing its outpatient concurrent review process. Post review, the MHP provided an updated policy with the required language that it will implement moving forward.

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

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:

- April 2023 Invoice
- August 2022 Invoice
- Crisis Residential Unit (CRU) referral samples
- Crisis Residential Unit (CRU)
- 2022-2023 invoice samples
- P&P 50.1.116 Authorization for SMHS and DMC-ODS
- Sample of Email of Invoices Reviewed & Approved for Payment
- September 2022 Invoice
- Approver Licenses and Signature list
- Concurrent Review for Psychiatric Inpatient Hospitals
- Crisis Residential Basic Quality Chart Review Tool
- Crisis Residential Documentation Checklist
- Crisis Residential Unit (CRU) Referral Updated 5.10.23

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 is currently in the process of establishing its outpatient concurrent review process. Post review, the MHP provided an updated policy with the required language that it will implement moving forward.

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:

- CalMesa P&P
- P&P 50.1.116 Authorization for SMHS & DMC-ODS
- Instructions for the NOABD Database
- County Approver License Details
- County Approver Signature Page
- Sample Modification NOABD Letter

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.	9	1	10

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 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 make the determination. Of the 10 Service Authorization Requests reviewed by DHCS, one (1) was not completed within the required timeframe.

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

Question 5.2.16

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

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

- SARS
- P&P 50.1.116 Authorization for SMHS & DMC-ODS
- P&P 50.1.116 Authorization for MH and SUD

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's referral or prior authorization specifies the amount, scope, and duration of treatment that the MHP has authorized. Per the discussion during the review, the MHP stated it is currently in the process of establishing its outpatient concurrent review process. Post review, the MHP provided an updated policy with the required language that it will implement moving forward.

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

Question 5.2.18

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

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

- County concurrent review policy
- Kepro county concurrent review policy & procedure
- Retro TAR
- Approved Retro TAR
- Retro denial evidence of communication to beneficiary 1
- Retro denial evidence of communication to beneficiary 2

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that where the review is retrospective, the MHP's authorization decision is communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information and is communicated to the provider in a manner that is consistent with state requirements. Per the discussion during the review, the MHP referenced a retrospective authorization and acknowledged the communication to the beneficiary was submitted beyond the 30-day time requirement. The MHP stated there was a delay in submission due to the development and implementation of the concurrent review process. Post review, the MHP submitted additional evidence; however, the one notification remained out of compliance with timeliness requirements.

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