CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE ORANGE COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: March 21, 2023 to March 23, 2023

Orange 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 virtual review of the Orange County MHP's Medi-Cal SMHS programs on March 21, 2023 to March 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

The report details the findings from the Medi-Cal SMHS Triennial System Review of the Orange 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 1.1.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 206(c)(1)(ii). The MHP requires subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP.

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

- OC Boilerplate contract - time of service
- Time of services - no P&P

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged the need to update its contract boilerplate language to meet this requirement and would address this moving forward.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 206(c)(1)(ii) and the MHP contract, exhibit A, attachment 8, section (4)(A)(3).

Questions 1.2.5

FINDING
The MHP did not furnish evidence to demonstrate compliance with the 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 is responsible to convene a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems.

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

- CFT meeting & ICC coordinator
- April 2021-IS-CFT
- CFT Plan rev 11-15-2017 minutes sign in sheet signature page
- FSP- CFT Plan – CCFSP
- NA STRTP
- OCMHP Contract 17-94601 2021-2022
- October-2021 CFT modifier
- Pathways_to_Well_Being_Intensive_Services_Therapeutic_Foster_Care P&P
- PWB-IS 90-Day Review Form 100422 tracking log
- STRTP CFT Plan NAI
- STRTP CFT plan SCCS
- STRTP SL January CFT Plan 2023 Olive Crest
- Sample CFT meeting minutes and agendas

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP convenes a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems. During the chart review, two (2) of the five (5) youth beneficiaries reviewed did not include evidence of a CFT occurring every 90 days. Per the discussion during the review, the MHP acknowledged these deficiencies.

DHCS deems the MHP out of compliance with the 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.

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:

- Pathways_to_Well_Being_Intensive_Services_Therapeutic_Foster_Care P&P

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 does

not currently have a TFC provider but is actively working to establish this treatment model.

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:

- Pathways_to_Well_Being_Intensive_Services_Therapeutic_Foster_Care P&P
- TFC Eligibility Criteria Assessment form draft

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. Per the discussion during the review, the MHP has created a draft TFC assessment that it plans to implement moving forward.

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

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 Tuesday, February 14, 2023, at 7:11 a.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she requested information about accessing mental health services in the county concerning his/her child's mental health and disruptive behavior in school. The operator asked for the child's personally identifying information, which the caller provided. The operator explained that the caller had reached the after-hours line and to call back during regular business hours for information.

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

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

TEST CALL #2
Test call was placed on Friday, February 24, 2023, at 10:27 a.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she requested information about accessing mental health services in the county concerning his/her child's mental health and disruptive behavior in school. The operator asked for the child's personally identifying information, which the caller provided. The operator explained the assessment process for receiving services and provided the caller with the location and hours for a walk-in clinic.

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

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

TEST CALL #3
Test call was placed on Wednesday, February 8, 2023, at 3:52 p.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she requested assistance with what he/she described as feeling depressed, unable to sleep, and bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator requested personally identifying information, which the caller provided. The operator explained the screening and assessment process and clinic hours of operation. The operator provided the address to several clinics where the caller could receive services. The operator explained that someone is available 24/7 via the after-hours line if in need of further assistance.

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 Friday, February 17, 2023 at 6:32 a.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she asked for information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling overwhelmed, isolated, and hopeless. The operator requested personally identifying information, which the caller provided. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator provided the screening and assessment process. The operator provided the address of multiple walk-in clinics where the caller could go for treatment. The operator explained that someone is available 24/7 via the after-hours line if in need of further assistance.

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

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

TEST CALL #5
Test call was placed on Tuesday, February 21, 2023, at 9:39 a.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she requested information about accessing mental health services and how to refill his/her anxiety medication. The operator explained the process for accessing mental health services including walk-in services for crisis and psychiatric services. The operator provided the address and hours of operation for several clinics. The caller was also advised to go to any of the clinics for an urgent condition or immediate medication refill 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 #6
Test call was placed on Wednesday, February 2, 2023, at 3:41 p.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she requested information for how to file a complaint in the county. The operator advised the caller that the grievance forms are located on the county website and in the clinic lobby. The operator provided the website and contact numbers, including the Patients' Right's Advocate, for additional information on how to file a grievance.

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

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

TEST CALL #7

The test call was placed on Thursday, March 2, 2023, at 7:40 a.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold language. After selecting the option for English, a recorded greeting provided instructions to dial 911 in an emergency. Once the caller was transferred to a live operator, he/she requested information for how to file a complaint in the county. The operator advised the caller that the grievance forms are located on the county website and in the clinic lobbies and provided the addresses. The operator provided the contact numbers, including the Patients' Right's Advocate, for additional information on how to file a grievance.

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

FINDING

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

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	IN	IN	IN	IN	IN	N/A	N/A	100%
2	OOC	IN	IN	IN	IN	N/A	N/A	80%
3	N/A	N/A	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 partial compliance* with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

Repeat deficiency Yes

Question 4.2.4

FINDING

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

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

- Orange_4.2.4_ written log 0722
- Orange_4.2.4_written Log 0123
- Orange_4.2.4_written log 1022
- Orange_4.2.4_written log 1122d
- Orange_4.2.4_written Log 1222
- Orange_4.2.4_written log_0822
- DHCS Request Test Call Log

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

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	2/14/2023	7:11 a.m.	IN	IN	IN
2	2/24/2023	10:27 a.m.	IN	IN	IN
3	2/8/2023	3:52 p.m.	IN	IN	IN
4	2/17/2023	6:32 a.m.	IN	IN	IN
5	2/21/2023	9:39 a.m.	IN	IN	IN
Compliance Percentage			**100%**	**100%**	**100%**

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

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

COVERAGE AND AUTHORIZATION OF SERVICES

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:

- HCA Medical Necessity and Concurrent Review Inpatient P&P

- Memo_Beacon UM Intake Script
- Orange County Provider Guide - Beacon Concurrent Review - Amendment 1 Final_02.01.22
- Orange County Provider Guide for Beacon Concurrent Review 10.27.21
- 20 TAR samples
- Managed Care Signature Log
- Draft policy & procedure
- Desk procedure for concurrent review
- Extension req. form
- Referral form

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 that it has a draft policy for outpatient concurrent review and that this is an area that it is working to implement. Post review, the MHP submitted a draft policy and concurrent review forms; however, it is not evident that concurrent review occurred during the triennial review period for outpatient specialty mental health services.

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

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

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

4. 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.
5. 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.
6. 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:

- 20 TAR samples
- HCA Medical Necessity and Concurrent Review Inpatient P&P
- Managed Care Signature Log
- NOABD TAR Denial Letter- CD
- NOABD TAR Denial Letter- SP
- NOABD TAR Denial Letter-LC
- NOABD TAR Mod Letter- BG
- NOABD TAR Mod Letter-MS
- Notice of Adverse Benefit Determination 2019 PP 02.02.04
- Retro TAR sample
- TAR NOABD Letter
- Carelon provider guide

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 was not aware of this occurring and it is working to establish a process to meet this requirement. Post review, the MHP provided a concurrent review procedure; however, it is not evident the MHP has this process established as required in the contract.

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 5.2.11

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:

- BBS Registration Printout - Marissa Hernandez - TAY CRP
- CSRF - Tate Tyler - TAY CRP – AMFT
- CSRF - Tate Tyler - TAY CRP – APCC
- CSRF and BBS Res Stmt - Marissa Hernandez - CRP – Lisa
- Extension Request Form - 2022.07
- Functional Capability Assessment
- HCA Medical Necessity and Concurrent Review Inpatient P&P
- Professional License - Tate Tyler - TAY CRP – AMFT
- Professional License - Tate Tyler - TAY CRP – APCC
- TAY CRP ADMISSION P&P
- TAY CRP CHART
- TAY CRP SIGNATURE LOG 22-23
- Draft policy & procedure
- Desk procedure for concurrent review
- Extension req. form
- Referral form

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP utilizes referral and/or concurrent review and authorization for all CRTS and ARTS and does not require prior authorization for these services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it has a draft policy for outpatient concurrent review and this is an area that it is working to implement. Post review, the MHP submitted a draft policy and concurrent review forms; however, it is not evident that

concurrent review occurred during the triennial review period for outpatient specialty mental health services.

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

Question 5.2.12

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

1. The beneficiary, or the provider, requests an extension; or,
2. The MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.

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

- Service Authorization Request samples
- SAR P&P
- SAR Tracking Log Sample

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP extends the timeframe for making an authorization decision for up to 14 additional days under the required conditions. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged the need to update its process and policy moving forward.

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

Question 5.2.13

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS.

a. MHPs may not require prior authorization for the following services/service activities:
    i. Crisis Intervention;
    ii. Crisis Stabilization;
    iii. Mental Health Services, including initial assessment;
    iv. Targeted Case Management;
    v. Intensive Care Coordination; and,
    vi. Peer Support Services
    vii. Medication Support Services.
b. Prior authorization or MHP referral is required for the following services:
    i. Intensive Home-Based Services

ii. Day Treatment Intensive
iii. Day Rehabilitation
iv. Therapeutic Behavioral Services
v. Therapeutic Foster Care

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

- Service Authorization Request samples
- 90 day review IHBS_Authorization
- CFT mtg auth IHB & ICC
- County TBS referral to CYS Admin
- SAR approvers Licenses
- SAR P&P
- SAR Signature Log
- SAR Tracking Log Sample
- SCCS STRTP- CFT mtg Auth. IHBS
- WYS TBS in house referral

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established and implemented policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged the need to update its policy 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:

- Service Authorization Request samples
- County TBS referral to CYS Admin
- SAR approvers Licenses
- SAR P&P
- SAR Signature Log
- SAR Tracking Log Sample
- WYS TBS in house referral

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.	8	2	80%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health conditions requires, not to exceed five (5) business days from the MHP's receipt of the information. Of the 10 Service Authorization Requests (SAR) reviewed by DHCS, two (2) were not authorized within the timeframe. Per the discussion during the review, the MHP acknowledged this deficiency.

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

BENEFICIARY RIGHTS AND PROTECTIONS

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:

- Appeal Process Poster
- Appeal Your Rights
- Grievance Appeal Training

- Grievance or Appeal Form
- Grievance Process Poster
- Grievance Appeal Definitions
- MHP Website Link
- P&P Appeal & Expedited Process
- Template NAR Overturn
- Template NAR Upheld
- P&P Beneficiary-Client Appeal of Actions Process - Highlighted

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 review its policy and provide this information post review. Post review, the MHP submitted a compliant policy that it will implement 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 6.1.17

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:

- 1557 Formal Response Addendum
- Beneficiary Handbook

- Beneficiary Non-Discrimination Notice MHP
- Grievance Tracking Log FY 20-22
- Grievance Appeal Training
- Grievance or Appeal Form
- Grievance Complaint Filing Method for Clients Notice of Nondiscrimination
- P&P Grievance Process
- P&P HCA Grievance Process
- Sample 1 Discrimination Grievance 1
- Sample 2 Discrimination Grievance 2
- Sample 3 Discrimination Grievance
- Template NAR Upheld
- Sample 4 Discrimination Grievance 4
- Sample 5 Discrimination Grievance 5
- Template NGR General
- Template NGR Inability to Contact
- P&P MHRS Grievance Process-DHCS Highlighted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits the required information to the DHCS Office of Civil Rights. Of the five (5) discrimination grievances reviewed by DHCS, it was not evident that the required information was sent to the DHCS Office of Civil Rights. Per the discussion during the review, the MHP acknowledged that this process had not occurred and that it is including this requirement in its trainings. Post review, the MHP submitted a compliant policy that it will implement 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 6.4.7

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

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

- MHP Appeal Log FY20-22
- P&P Appeal & Expedited Process
- Sample Appeal 1
- Sample Appeal 2

- Sample Appeal 3
- P&P Beneficiary-Client Appeal of Actions Process - Highlighted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP allows the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would review its policy and provide this information post review. Post review, the MHP submitted a compliant policy that it will implement moving forward.

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