CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2022/2023

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE SAN FRANCISCO COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: April 18, 2023 to April 20, 2023

San Francisco 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 San Francisco County MHP's Medi-Cal SMHS programs on April 18, 2023 to April 20, 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 1.4.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 435 and MHP contract, exhibit A, attachment 8, section 8(D). The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

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

- San Francisco Post Review Additional Evidence Request (Notes)
- Approved Transmittal ReCert 11072022 AARSProjectAdapt 38JB
- certification and re-certification status tracking
- CertLetter 10282022 AARSProjectADAPT 38JB
- MH Medi-Cal Certification CHECKLIST
- P&P Medi-Cal Certification LINK
- Organizational Provider MC Certification P&P

Internal Documents Reviewed:

- Provider Monitoring Report SF 3.30.23

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certifies, or uses another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS. Of the MHP's 92 providers, 19 provider certifications were overdue. Per the discussion during the review, the MHP stated it would provide evidence of submitted transmittals and actions taken to resolve any overdue certifications. Post review, additional evidence was provided; however, 19 certifications remained overdue.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 435 and MHP contract, exhibit A, attachment 8, section 8(D).

Repeat deficiency Yes

CARE COORDINATION AND CONTINUITY OF CARE

Question 2.1.2

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP Contract, exhibit A, attachment 10, section 1(A)(2); Code of Federal Regulations, title 42, section 438, subdivision 208(b)(2)(i)-(iv); and California Code of Regulations, title 9, section 1810, subdivision 415. The MHP shall coordinate the services the MHP furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries.

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

- DHCS Audit Submission Narrative Statement on Workflow
- Tracking Log for Referrals from MCP's 030122 to 022823
- 3.04-09 San Francisco Continuity of Care Requirements for Medi-Cal Specialty Mental Health Services highlighted p3
- Screening Tool
- Anthem SF BH MOU- addendum Health Homes 12-20-18 Executed cleaned
- BHS Anthem MOU 10-1-14 executed cleaned
- Policy 1.1411 - Access to Treatment
- Complete with DocuSign 1v3 ANTHEM No-Cost 02.27.2023
- MC CBHS SFHP 2017- MOU
- SF Department of Public Health (RSA #2) 12.14.2022 cleaned
- SFDPH SFHP 2017-2020 MOU

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP coordinates the services the MHP furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. Per the discussion during the review, the MHP stated it has screening and tracking tools to ensure timeliness and coordination of care its managed care plan (MCP). Post review, the MHP submitted evidence of its tracking mechanism for beneficiaries referred to and from the MCPs; however, it is not evident that it identified and tracked beneficiaries from San Francisco Health Pan MCP as the MHPs referral tracking mechanism does not include beneficiaries identified by the MCP.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 10, section 1(A)(2); Code of Federal Regulations, title 42, section 438, subdivision 208(b)(1); and California Code of Regulations, title 9, section 1810, subdivision 415.

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:

- 3.04-09 San Francisco Continuity of Care Requirements for Medi-Cal Specialty Mental Health Services highlighted p3
- Screening Tool
- P&P Continuity of Care
- COC Beneficiary Notice Draft Template
- COC Report
- Notification of Authorization

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's Continuity of Care written notifications to the beneficiary comply with Title 42 of the Code of Federal Regulations, part 438.10(d). This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it does not usually deny continuity of care requests and it would review its process. Post review, the MHP submitted a revised policy, which includes providing beneficiaries with required informing materials if a request is denied, that it will implement 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 3.5.1

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:

- 03-MH Declaration-of-Compliance-vBOCC
- New Provider Frequently Asked Questions-Final Draft 4-29-2022
- CYF CBT and DBT annual trainings-flyers and links to resources
- CYF TIPs Analytics All Web Site Data Audience Overview Sep 2020 to Apr 2023
- MI skills handbook 2022
- MI2022 Flyer cleaned
- CBT Resources and more - TIPS website
- Practice Guidelines - Handouts – Resources
- Trauma Focused CBT training
- Trauma Informed Telehealth training
- CBT Resources and more - TIPS website
- Practice Guidelines - Handouts – Resources
- Medication Monitoring Plan 2022
- prescribing practice guidelines public websites

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 that its clinical medication and prescribing guidelines serve as its practice guidelines and that it would provide additional documentation post review. Post review, the MHP provided examples of education and resource materials; however, it is not evident that the MHP has established practice guidelines which meet the requirements of the MHP 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:

- All Medication Guidelines are emailed to all medical staff
- RAMS-Adult#10838 20-21 RPB-1 (Certified)
- MUIC minutes July 2021
- MUIC minutes March 2021
- MUIC minutes May 2021
- MUIC minutes September 2021
- Documentation of Sharing Guidelines-email exchange with client
- Documentation of Sharing Guidelines-note documenting sleep hygiene handouts
- Documentation of Sharing Guidelines-note with med handout
- Documentation of Sharing Guidelines-notes medication handouts
- Documentation of Sharing Guidelines-progress note
- Med Consent Printed
- CBT Resources and more - TIPS website
- Practice Guidelines - Handouts - Resources

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it posts its guidelines on its website, meets regularly with providers, and follows up on individual beneficiary health concerns. Post review, the MHP submitted medication and prescribing guidelines as well as patient education material; however, it is not evident practice guidelines were developed or disseminated during the review period.

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:

- Explanation of Peer Review Audit tool
- Peer Review Audit Tool Mar2021 cleaned
- 2022 Pharmacy Manual
- BHS Prescribing Trends 2022 FINAL
- CYF JV220 DUE 2021
- 2020-21 Progress RPB 1 CERTIFIED RPB cleaned
- Institution 21-22 RPB 1 Signed

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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP explained its utilization review process and its use of the Tools to Improve Practice (TIPs) website as a resource for patient and provider education. Post review, the MHP submitted its peer review audit tool; however, this evidence was insufficient in demonstrating compliance with the regulations as it is not evident that the MHP has 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.

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 Thursday March 9, 2023, at 7:50 a.m. The call was answered after seven (7) rings 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 explained that the caller had reached the afterhours service and could either call back during business hours or leave a message with personally identifiable information for a case worker to return his/her call.

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 3, 2023, at 9:51 a.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was connected to a live operator. The caller requested assistance with what he/she described as feeling depressed and unable to sleep with bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the screening and assessment process. The operator provided the location, phone number, and hours of operation to the nearest clinic. The operator provided additional information for other non-urgent mental health and crisis services.

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

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

TEST CALL #3
Test call was placed on Tuesday, January 31, 2023, at 8:48 a.m. The call was answered after one (1) ring via a phone tree. A recorded message provided instructions to hang up and dial 911 if experiencing an urgent condition. The phone tree directed the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was transferred to 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 explained that the screening and assessment process is conducted by a licensed clinician. The operator informed the caller that once the screening and assessment is completed, the caller would be able to obtain mental health services based on identified needs.

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

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

TEST CALL #4
Test call was placed on Thursday, February 2, 2023, at 7:41 a.m. The call was answered after nine (9) rings via a live operator. The caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator stated that the caller had reached the Suicide Prevention line and inquired where the caller found this number; to which the caller stated the county website. The operator instructed the caller to hang up and dial a different telephone number for further assistance. No additional information was provided.

The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

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 #5

Test call was placed Tuesday, March 21, 2023, at 7:27 a.m. The call was answered after six (6) rings, via a live operator. The caller requested assistance with what he/she described as feeling depressed and unable to sleep with bouts of crying. The operator placed the caller on hold for approximately thirty seconds. When the operator returned, he/she asked if the call could be continued in English, which the caller responded in the affirmative. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator requested the caller's location and provided the caller with a clinic's phone number in his/her immediate area. The operator advised that the caller reach out to the clinic to begin the intake and evaluation process.

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

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

TEST CALL #6
Test call was placed on Monday, March 13, 2023, at 11:42 a.m. The call was answered after one (1) ring via a phone tree. After selecting the option for English, the call was transferred to a live operator. The caller told the operator he/she wanted to file a complaint against a therapist. The operator placed the caller on a brief hold. The operator explained that the caller could either speak to a clinician or file a complaint in writing. The operator informed the caller that he/she can pick up the grievance form in the clinic, it can be mailed, or it can be accessed via the MHP's website.

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 Friday, March 17, 2022, at 7:29 a.m. The call was answered after six (6) rings via a live operator. The caller told the operator he/she wanted to file a complaint against a therapist. The operator explained the caller could file the grievance over the phone, online, or in person. The operator offered to take the grievance over the phone. Additionally, the operator provided the location where the caller could pick up and drop off the grievance form.

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	IN	IN	N/A	IN	N/A	N/A	100%
2	OOC	IN	IN	OOC	IN	N/A	N/A	60%
3	N/A	IN	IN	OOC	IN	N/A	N/A	75%
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:

- FY21-23 Test Call Log
- Log of Access Line Requests for Service – Copy
- Q1 Test Calls (July-Sep 2021)
- Q2 Test Calls (Oct-Dec 2021)
- Q4 (April-June 2021)
- Q3 Test Calls (Jan-Mar 2022)
- Q4 Test Calls (April-June 2022)
- Call logs
- DHCS Test Call Logs

While the MHP submitted evidence to demonstrate compliance with this requirement, one (1) of the five (5) required DHCS test calls were not logged on the MHP's written

log of initial request. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	3/9/2023	7:50 a.m.	IN	IN	IN
2	2/3/2023	9:51 a.m.	IN	IN	IN
3	1/31/2023	8:48 a.m.	IN	IN	IN
4	2/2/2023	7:41 a.m.	OOC	OOC	OOC
5	3/21/2023	7:27 a.m.	OOC	IN	IN
Compliance Percentage			**60%**	**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 *in partial compliance* with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Repeat deficiency Yes

COVERAGE AND AUTHORIZATION OF SERVICES

Question 5.1.5

FINDING

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

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

- NOABD Delay SM AFS 10.21.22 cleaned (1)
- Notice of ABD
- NOAB 1
- NOABD 2

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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it has close relations with providers and hospitals and can communicate with them directly about authorization decisions. Post review, the MHP provided samples copies of authorization denials; however, these denials did not demonstrate compliance to the requirement.

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

Question 5.2.13

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:

- Tracking Mechanism EPSDT Notices Copy of MAST Spreadsheet FY 22-23 (1)
- P&P UM for IHBS and TFC Policy v2 (2)
- PURQC TBS REVIEW FORM (1)
- PURQC TBS CSA
- TBS Authorization Process (1)
- Tracking Mechanism TBS Referral Log (2)
- 3.03-22 Authorization of Outpatient SMHS

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 stated it would review its policies and procedures. Post review, the MHP submitted an updated authorization policy that included the required contract 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:

- Copy of SAR WorkSheet Post tr
- SAR 2 B-A, S
- SAR A, R
- SAR B, A (1)
- SAR D, D
- SAR J, E (signed)
- SAR J, I
- SAR MP, A (signed)
- SAR S, K (updated)
- SAR S, P (updated)
- SAR W, S
- License verification Brad Harms
- Niki Smith License Sep 2021
- 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC
- 3.03-22 Authorization of Outpatient SMHS
- UM for IHBS and TFC Policy v2
- Continued Service Authorization Request (SAR) For Intensive Services cleaned (2)
- Expedited auth letter template

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.	7	3	70%

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 condition requires, not to exceed five (5) business days from the MHP's receipt of the information. Per the discussion during the review, the MHP explained its service authorization request (SAR) process and stated it would submit samples of its SAR approval process post review. Post review, the MHP submitted a sample of ten (10) SARs; however, three (3) were not completed within the required five (5) day timeframe.

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

Question 5.2.15

FINDING
The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016 and Code of Federal Regulations, title 42, section 438, subdivision 210(d)(2)(i). For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.

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

- 3.03-22 Authorization of Outpatient SMHS
- 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC
- Expedited auth letter template

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP explained that it did not receive any expedited requests during the review period but stated it would use a 48-hour timeline if one should occur; however, the MHP acknowledged that it does not identify this process in any policy. Post review, the MHP submitted a revised policy with the required language that it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-016 and Code of Federal Regulations, title 42, section 438, subdivision 210(d)(2)(i).

BENEFICIARY RIGHTS AND PROTECTIONS

Question 6.1.7

FINDING

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(8) and California Code of Regulations, title 9, section 1850, subdivision 205(c)(4); and Code of Federal Regulations, title 42, section 438, subdivision 406(a). At the beneficiary's request, the MHP must identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing SMHS to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary. Assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

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

- BHS Grievance-Appeal Policy (Revised: 4/25/2023)
- P&P 3.11-01 BHS Grievance-Appeal Policy rev 9.22
- San Francisco MHP Beneficiary Handbook English 10.23.20
- Sample of Grievances and Appeals

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP identifies an alternative individual to assist the beneficiary if the individual initially identified by the MHP is the person providing SMHS to the beneficiary requesting assistance. 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 policies. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(8); California Code of Regulations, title 9, section 1850, subdivision 205(c)(4); and Code of Federal Regulations, title 42, section 438, subdivision 406(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:

- BHS Grievance-Appeal Policy (Revised: 4/25/2023)
- P&P 3.11-01 BHS Grievance-Appeal Policy rev 9.22
- San Francisco MHP Beneficiary Handbook English 10.23.20
- Informing Materials - English
- Link to Grievance & Appeal Documents
- FY 20-22 MHP Grievance-Appeals Log redacted
- FY 20-22 Grievance Samples redacted
- FY Tracking Form Redacted

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 that it would process Discrimination Grievances similar to standard grievances, noting additional reporting requirements. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of compliance with MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5).

Question 6.1.15

FINDING

The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1). The MHP must designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

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

- BHS Grievance-Appeal Policy (Revised: 4/25/2023)
- P&P 3.11-01 BHS Grievance-Appeal Policy rev 9.22
- Informing Materials - English
- San Francisco MHP Beneficiary Handbook English 10.23.20
- FY 20-22 MHP Grievance-Appeals Log redacted
- FY 20-22 Grievance Samples redacted
- Tracking Form Redacted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has designated a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated the Grievance and Appeal Officer would serve as the Discrimination Grievances Coordinator. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1).

Question 6.1.16

FINDING
The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2). The MHP shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. The MHP shall not require a beneficiary to file a Discrimination Grievance with the MHP before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

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

- BHS Grievance-Appeal Policy (Revised: 4/25/2023)
- FY20-22 MHP Grievance & Appeal Log redacted
- Tracking Form Redacted
- P&P 3.11-01 BHS Grievance-Appeal Policy rev 9.22
- San Francisco MHP Beneficiary Handbook English 10.23.20
- FY20-22 MHP Grievance Samples- Redacted

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 that it would follow the requirements in processing Discrimination Grievances. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement 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:

- BHS Grievance-Appeal Policy (Revised: 4/25/2023)
- P&P 3.11-01 BHS Grievance-Appeal Policy rev 9.22
- Informing Materials - English
- FY 20-22 MHP Grievance-Appeals Log redacted
- Tracking Form Redacted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits the required information regarding a complaint to the DHCS Office of Civil Rights within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it had not received or identified any discrimination grievances, but would submit the required information within ten days to the Office of Civil Rights when appropriate. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement 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.

PROGRAM INTEGRITY

Questions 7.5.3

FINDING
The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 602(d). The MHP promptly notifies DHCS if the MHP finds a party that is excluded.

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

- P&P Database tracking - monthly verification

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded. Per the discussion during the review, the MHP described its database check process and agreed to provide a sample of completed monthly reports as well as a policy and procedure demonstrating it reports excluded providers to DHCS; however, the MHP stated it had not identified an excluded party during the review period. Post review, no additional evidence was provided.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 602(d).