DEPARTMENT OF HEALTH CARE SERVICES

TRIENNIAL REVIEW OF THE MENDOCINO COUNTY MENTAL HEALTH PLAN

FINDINGS REPORT

Review Dates: January 9, 2019 – January 10, 2019

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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, section 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 Federal and State laws and regulations and/or the contract between DHCS and the MHP.

DHCS conducted an onsite review of the Mendocino County MHPs Medi-Cal SMHS programs on June 9, 2019 through January 10, 2019. 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) 2018/2019 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

The Medi-Cal system review evaluated the MHP's performance in the following categories:

- Section A: Network Adequacy and Availability of Services
- Section B: Care Coordination and Continuity of Care
- Section C: Quality Assurance and Performance Improvement
- Section D: Access and Information Requirements
- Section E: Coverage and Authorization of Services
- Section F: Beneficiary Rights and Protections
- Section G: Program Integrity
- Section H: Other Regulatory and Contractual Requirement

The report is organized according to the findings from each section of the FY 2018/2019 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services, specifically Sections A-H and the Attestation. This report details the requirements 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, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone line and a section detailing information gathered for the "SURVEY ONLY" questions in the Protocol.

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 Plan of Correction (POC) is required for all items determined to be out-of-compliance. The MHP is required to submit a POC to DHCS within 60-days of receipt of the findings report for all system and chart review items deemed out-of-compliance. The POC 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 POC determined not to be effective, the MHP should purpose an alternative corrective action plan to DHCS; and
(5) Description of corrective actions required of the MHP's contracted providers to address findings.

FINDINGS

SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
A.V.B2- The MHP shall demonstrate it has sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for American Indian beneficiaries who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).).

FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.14(b)(1). The MHP shall demonstrate it has sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for American Indian beneficiaries who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).).

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

- BOS Agreement 18-039 w/Round Valley Indian Health Center, Yuki Trails
- Outreach Material
- Cultural Competence Plan
- MOU with Consolidated Tribal Health Project Inc.
- MOU with Round Valley Indian Health Clinic

While, the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall demonstrate it has sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for American Indian beneficiaries who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).).

DHCS deems the MHP out-of-compliance with 442 C.F.R. § 438.14(b)(1). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
A.V.B3-The MHP shall permit American Indian beneficiaries to obtain covered services from out- of-network IHCPs if the beneficiaries are otherwise eligible to receive such services. (42 C.F.R. § 438.14(b)(4).) The MHP shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider. (42 C.F.R. § 438.14(b)(6).)

FINDING

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.14(b)(4) and 42 C.F.R. § 438.14(b)(6). The MHP shall permit American Indian beneficiaries to obtain covered services from out- of-network IHCPs if the beneficiaries are otherwise eligible to receive such services. (42 C.F.R. § 438.14(b)(4).) The MHP shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider. (42 C.F.R. § 438.14(b)(6).).

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

- BOS Agreement 18-039 w/Round Valley Indian Health Center, Yuki Trails
- Outreach Material
- Cultural Competence Plan
- MOU with Consolidated Tribal Health Project Inc.
- MOU with Round Valley Indian Health Clinic

While, the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall permit American Indian beneficiaries to obtain covered services from out- of-network IHCPs if the beneficiaries are otherwise eligible to receive such services. (42 C.F.R. § 438.14(b)(4).) The MHP shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider. (42 C.F.R. § 438.14(b)(6).).

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.14(b)(4) and 42 C.F.R. § 438.14(b)(6). The MHP must complete a POC addressing this finding of non-compliance.

SECTION D: ACCESS AND INFORMATION REQUIREMENTS

REQUIREMENT
D.VI.B-Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).) 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. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number for compliance with the California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1). The seven (7) test calls are summarized below:

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- Policy #II.B-3M-Crisis Services
- Policy #III.A-1-MHP 24 hour Access/Crisis Lines
- Access line instruction manual
- Access line test call review and training meeting minutes
- Language line services, inc. invoice
- September 2018 test call results

Test Call #1 was placed on Friday, September 28, 2018, at 3:07pm. The call was answered after two (2) rings via a live operator. The caller requested information about how to access mental health services. The operator asked for demographic information (e.g. name, contact information). The operator than stated that the caller had reached the crisis center for Mendocino and asked if the caller wanted to come for an office visit. The operator explained the process for obtaining services. The operator stated that the Crisis Center is available 24/7 and someone is always available if the caller decided to call back at any time. The operator also asked if the caller was having any thoughts of suicide or feeling of depression. The caller responded in the negative. The operator provided the caller with the address and the hours of operation of the local clinic. The caller was provided information about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met and about services needed to treat a beneficiary's

urgent condition. The call is deem in compliance with regulatory requirements for protocol requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B2 and D.VI.B3)

Test Call #2 was placed on Monday, October 1, 2018, at 9:07 am. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county and explained the reasons for the request. The operator advised the caller that they reached the crisis line that they could refer the caller to a therapist. The operator suggested that the caller go to the crisis center and provided the address and hours of operation. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, but was not provided information about services needed to treat an urgent condition. The call is deemed in compliance with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1) and OOC with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B2 and D.VI.B3)

Test Call #3 was placed on Thursday, October 4, 2018, at 9:40 p.m. The call was answered after one (1) ring via a live operator. The caller requested SMHS in the county. The operator requested caller's name and explained that the information is confidential. The operator advised that there were two types of counseling services available. The operator asked if the caller was having thoughts of suicide. The caller replied in the negative. The operator asked about the callers insurance and the caller confirmed they had Medi-Cal. The operator explained that walk-in services are available and described the intake and assessment processes. The operator provided the MHP's phone number, address, and hours of operation. The operator reminded the caller that the 24/7 access line is available for a crisis or urgent services. The caller was provided information about how to access SMHS and the caller was provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B2 and D.VI.B3)

Test Call #4 was placed on Friday, October 5, 2018, at 7:19 am. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator informed the caller that they do not have appointments and that they have walk-in services Monday-Friday. The operator explained the assessment process. The operator said they have two locations and provided the hours of operations. The operator provided the address to the Ukiah clinic based on the callers address. The caller was 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. The call is deemed in compliance with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1) (D.VI.B2) and OOC with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B3).

Test Call #5 was placed on Thursday, October 11, 2018, at 7:44am. The call was answered via a live operator. The caller requested information about obtaining medication in the county. The operator informed that caller that they could see an emergency room doctor. The operator asked how the caller obtain medication before. The caller said through another county. The operator informed the caller that they also could get help through the crisis center

or through community care. The operator provided the address and hours or operation of the clinic. 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. The call is deemed in compliance with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B2 and D.VI.B3)

Test Call #6 was placed on Friday, September 28, 2018, at 7:22 a.m. The call was answered after one (1) ring via a live operator. The caller stated that they wanted to file a complaint about their therapist. The operator stated that the caller had reached the Redwood Community Crisis line. The caller repeated that they wanted to file a complaint regarding their therapist. The operator informed the caller that they could go to the Human Resources department to file a complaint and provide the location where the caller would be able to fill out a formal grievance form. The operator explained to the caller that they could contact the patient's right advocate if not satisfied. The operator also stated they were at home and unable to provide the necessary information. The operator then asked for the caller's name and explained that the caller could request to change their therapist. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process. The call is deemed OOC with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B4)

Test Call #7 was placed on Friday, October 5, 2018, at 9:01 a.m. The call was answered after one (1) ring via a live operator. The caller requested information about filing a grievance in the county. The operator informed the caller they could walk-in to the facility to receive the forms and provided the location of the MHP. The caller was provided information about how to use the beneficiary problem resolution and fair hearing process. The call is deemed in compliance with the regulatory requirements CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). (D.VI.B4)

FINDINGS

Test Call Results Summary

Protocol Requirement	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
D.VI.B.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
D.VI.B.2	IN	IN	IN	IN	IN			100%
D.VI.B.3	IN	OOC	IN	OOC	IN			60%
D.VI.B.4						OOC	IN	50%

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1). The MHP must complete a POC addressing this finding of non-compliance.

REQUIREMENT
D.VI.C1-The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, title 9, chapter 11, section 1810.405(f)).

FINDINGS

The MHP did not furnish evidence of its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- 24/7 Access Call log

The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(f). Protocol requirement D.VI.C1 is deemed OOC. The MHP must complete a POC addressing these finding of non-compliance.

The log submitted by the MHP did not include all the DHCS test calls made to the MHP 24/7 toll free access line. The table below details the findings:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	9/28/2018	3:07 PM	OOC	OOC	OOC
2	10/1/2018	9:07 AM	OOC	OOC	OOC
3	10/4/2018	9:40 PM	OOC	OOC	OOC
4	10/5/2018	7:19 AM	OOC	OOC	OOC
5	10/11/2018	7:44 AM	OOC	OOC	OOC
Compliance Percentage			**0%**	**0%**	**0%**

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

SECTION F: BENEFICIARY RIGHTS AND PROTECTIONS

REQUIREMENT
F.I.E3- The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E).

FINDING

The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN 18-010E. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E).

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

- Beneficiary Handbook

- Policy IV.D-2B Beneficiary Problem Resolution-Grievance, Appeal, Expedited Appeal and State Fair Hearing Processes
- Sample acknowledgment letter

While the MHP submitted evidence to demonstrate its compliance with this requirement, the documentation did not address the requirement.

DHCS deems the MHP out-of-compliance with MHSUDS IN 18-010E. The MHP must complete a POC addressing this finding of non-compliance.

Protocol Requirement	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT or NOT WITHIN 5 CALENDAR DAYS		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	44	43	1	98%
APPEALS	5	5	0	100%
EXPEDITED APPEALS	0	0	0	N/A

SECTION G: PROGRAM INTEGRITY

REQUIREMENT
G.II.C-The MHP shall implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).).

FINDING

The MHP did not furnish evidence to demonstrate it complies with the MHP Contract, Ex. A, Att. Section 13 and 42 C.F.R. § 438.608(a)(6). The MHP shall implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).).

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

- Policy #III.C-7 Communication and Inappropriate Activity Reporting

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP policy that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).).

DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6). The MHP must complete a POC addressing this finding of non-compliance.

SURVEY ONLY FINDINGS

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

REQUIREMENT
A.III.F-The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018).
A.III.G- The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018).

FINDING
The MHP furnish evidence to demonstrate it complies with 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 provided evidence that it provides Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC and that it has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

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

- Policy #II.B.7M
- Policy #II.B-7M
- Provider Contract

SUGGESTED ACTION
No further action at this time.

CARE COORDINATION AND CONTINUITY OF CARE

REQUIREMENT
B.III.C- The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.62(b)(1)-(2).).

FINDING
The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.62(b)(1)-(2). The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy.

SUGGESTED ACTION
DHCS recommends, at a minimum, the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements, or to strengthen current processes in this area to ensure compliance in future reviews:

- Develop policies and procedures to address the requirements, including requirements of MHSUDS information notice

REQUIREMENT
B.I.B- The MHP shall coordinate the services the MHP furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b) (2) (i)-(iv), CCR, tit. 9 § 1810.415.)

FINDING
Based on Policy No. II. E-11 (page 5), "Progress notes must be completed within thirty (30) calendar days from date of service." Based on this policy services are provided before the previous service is documented, limiting the ability to coordinate services.

SUGGESTED ACTION

- Develop policies and procedures to ensure services furnished to the beneficiary are coordinated between settings of care.

COVERAGE AND AUTHORIZATION OF SERVICES

REQUIREMENT
E.I.H2- The MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

FINDING
The MHP furnish evidence to demonstrate it complies that the MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

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

- Policy #IV.C-3M-Point of Authorization

SUGGESTED ACTION
No further action at this time.