CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE MENDOCINO COUNTY MENTAL HEALTH PLAN

SYSTEM FINDINGS REPORT

Review Dates: April 5, 2022 to April 6, 2022

Mendocino County Mental Health Plan
FY 2021/2022 Medi-Cal SMHS Triennial Review
Systems Review Findings Report

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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 Mendocino County MHP's Medi-Cal SMHS programs on April 5, 2022 to April 6, 2022. 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) 2021/2022 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 Mendocino County MHP. The report is organized according to the findings from each section of the FY 2021/2022 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 the MHP contract, exhibit A, attachment 8. 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:

- P&P's_Medi-Cal Organizational Provider Selection, Retention, and Certification
- 2392 RCS Medi-Cal Certification and Transmittal
- 2392 RCS Recert Letter 8-21
- Application Medi-Cal Site Cert 2.2022
- Contracted Providers Verification Master Log 12-20-12-21
- Employee Verification Log_Dec2020-Dec2021
- Fire Inspection request-BLANK
- Medi-Cal Certification and Transmittal-BLANK
- Provider Certification and Re-Certification Protocol
- Provider-File-Update-MC-5829-1-BLANK
- Site Cert Sample
- 1.4 Site Cert Manzanita 23CQ Transmittal
- 1.4 Manzanita Site Cert Approval 23CQ

Internal documents reviewed:

- Mendocino County Provider Monitoring Report 3-24-22 SR

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certified, or uses another MHP's certification documents to certify the organizational providers that subcontract with the MHP to provide SMHS. Of the 44 MHP providers, one (1) provider had an overdue certification. Per the discussion during the review, the MHP explained the untimely recertification was due to logistical issues with the site inspection and that the MHP had implemented a CAP. Post review, the MHP resolved the overdue provider certification and submitted verifying documentation of the site's certification status.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

ACCESS AND INFORMATION REQUIREMENTS

Question 4.3.2

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, December 21, 2021, at 1:20 p.m. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county concerning his/her child's behavior. The operator provided the caller with information about the intake and assessment processes as well as the location and hours for the closest walk-in clinic.

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

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

TEST CALL #2
Test call was placed on Tuesday, December 28, 2021, at 7:26 a.m. The call was answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county for self-reported symptoms of depression lasting several weeks. The operator requested personally identifying information, which the caller provided. The operator explained the intake and assessment process, as well as the different types of services that the county offers

once a level of need is determined. The operator provided clinic location information and explained how to access walk-in care, including crisis and urgent 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 Friday, January 7, 2022, at 3:05 p.m. The call was answered after three (3) rings via a live operator. The caller requested information about accessing mental health services in the county to help manage feelings of isolation and fatigue he/she identified were related to caring for his/her elderly parent. The operator requested personally identifying information, which the caller provided. The operator explained the MHP's intake process and provided clinic locations 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. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

FINDING
The call is deemed *in partial 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, December 31, 2021, at 7:45 a.m. The call was answered after two (2) 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 provided the caller instructions on how to transfer his/her Medi-Cal and establish care with a psychiatrist in the county. The operation provided clinic locations and phone numbers. The operator advised the caller that the process may take up to a month and suggested the caller contact his previous doctor in the interim to ask for a refill. The operator also advised the caller that if his/her condition worsened and was unable to refill his subscription, he/she should go to the nearest emergency room for assistance or immediate medication refill.

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

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

TEST CALL #5
Test call was placed on Wednesday, December 8, 2021, at 9:57 a.m. The call was answered after three (3) rings via a live operator. The caller requested information about accessing mental health services in the county for symptoms of depression. The operator informed the caller that he/she could walk into one of the county clinics to make an appointment for an assessment for services. The operator also informed the caller that crisis services were available at the county clinics.

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
The call was placed on Monday, January 10, 2022, at 12:28 p.m. The call was answered after three (3) rings via a live operator. The caller requested information about how to file a grievance regarding the services he/she had received in the county. The caller was transferred to a second operator who advised the caller that grievance forms were located in clinic lobbies. The operator provided clinic locations, hours of operation, and availability of walk-in services. In addition, the operator offered to mail the grievance form and beneficiary resolution information to the caller.

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

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

TEST CALL #7

Test call was placed on Saturday, January 8, 2022, at 6:35 p.m. The call was answered after one (1) ring via a live operator. The caller asked for assistance with filing a grievance regarding a county referred therapist. The operator attempted to locate the grievance form and beneficiary problem resolution informing materials on the county's website but stated he/she was having internet connectivity issues. The operator informed the caller of the county's business hours and instructed him/her to call back when someone would be able to help file the grievance.

The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process.

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).

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0%
2	IN	IN	IN	IN	IN	N/A	N/A	100%
3	N/A	IN	OOC	IN	IN	N/A	N/A	80%
4	N/A	N/A	N/A	N/A	N/A	IN	OOC	50%

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 4.3.4

FINDING
The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, 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:

- P&P's_MHP Access-Crisis Lines
- Access Line Instruction Manual
- 3-2-21 Access Line Staff Training
- 3-3-22 Access Line Staff Training
- 9-15-21 Access Line Staff Training
- Instructions for answering ACCESS Line (sent 10-8-15)
- Language Line Invoice
- 24_7 Access Line Test Call Report FY 21-22 Q1
- 24_7 Access Line Test Call Report FY 21-22 Q2

- Access Line Log
- January 2021 Test Call Summary
- April 2021 Test Call Summary
- September 2021 Test Call Summary
- Test Call Example
- Test Call Guideline Form
- Types of Call Scenarios

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	12/21/2021	1:20 p.m.	OOC	OOC	OOC
2	12/28/2021	7:26 a.m.	OOC	OOC	OOC
3	1/07/2022	3:06 p.m.	OOC	OOC	OOC
4	12/31/2021	7:45 a.m.	OOC	OOC	OOC
5	12/08/2021	9:57 a.m.	OOC	OOC	OOC
Compliance Percentage			**0%**	**0%**	**0%**

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 *out of compliance* with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Repeat deficiency Yes

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, and Federal Code of 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:

- 6.1.4 P&P Beneficiary Problem Resolution - Grievance, Appeal, and Change of Provider Request Processes
- Patients Rights Advocacy brochure English 14 pt font
- Patients Rights Advocacy brochure Spanish 14 pt font
- Grievance & Appeal Process Brochure English Large Print
- Grievance & Appeal Process Brochure Spanish Large Font
- Grievance Poster English
- Grievance Poster-Spanish
- Grievance, Appeal, & Expedited Appeal Brochure Eng 14
- Grievance, Appeal, & Expedited Appeal Brochure Sp 14pt
- Link to G&A Informing Materials Letterhead
- P&P's_Beneficiary Problem Resolution - Grievance and Appeal

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides beneficiaries only one level of 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 policies to ensure the needed language is present. Post review, the MHP submitted a compliant beneficiary resolution policy that it will implement moving forward.

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

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FISCAL YEAR 2021/2022

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES TRIENNIAL REVIEW

OF THE MENDOCINO COUNTY MENTAL HEALTH PLAN

CHART REVIEW FINDINGS REPORT

Dates of Review: 4/5/2022 to 4/6/2022

Chart Review – Non-Hospital Services

The medical records of five 5 adult and five 5 child/adolescent Medi-Cal beneficiaries receiving Specialty Mental Health Services (SMHS) were reviewed for compliance with state and federal regulations; adherence to the terms of the contract between the Mendocino County Mental Health Plan (MHP) and the California Department of Health Care Services (DHCS); and for consistency with the MHP's own documentation standards and policies and procedures regarding medical records documentation. The process included a review of 400 claims submitted for the months of April, May and June of **2021**.

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Medical Necessity

FINDING 8.1.3:
The intervention(s) documented on the progress note(s) for the following Line number(s) did not meet medical necessity since the service provided did not specifically address the mental health condition or impairment identified in the assessment, and was solely**:**

- Clerical: **Line number 4. RR10f, refer to Recoupment Summary for details.** The Progress note for the service claimed on 6/24/21 as TCM for 27 minutes, describes the case manager faxing records associated with a request from the Department of Social Services.

CORRECTIVE ACTION PLAN 8.1.3:
The MHP shall submit a CAP that describes how the MHP will ensure that:

1) Each progress note describes how services reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.
2) Services provided and claimed are not solely clerical.

Client Plans

FINDING 8.4.2a:
One or more client plan(s) was not completed in accordance with the MHP's initial timeliness standards, or updated at least annually. Specifically:

- **Line number 2.** The initial Client Plan was completed late based on the MHP's documentation standards of timeliness. Based on the MHP's documentation standards, "providers have up to sixty (60) days to complete a client's Initial client plan."

- The beneficiary's case had an Episode Opening Date of 9/11/20, but the Initial Client Plan was not completed as signed until 12/28/20. This was prior to the Review Period, and there was no evidence that planned services were provided prior to the Client Plan completion.

CORRECTIVE ACTION PLAN 8.4.2a:
Due to the transition to the new Documentation Standards that will take effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements.

Progress Notes

FINDING 8.5.1:
Progress notes did not include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically:

- **Line numbers 1, 3, and 5.** One or more progress note was not completed within the MHP's written timeliness standard of 14 calendar days after provision of service. Five (1 percent) of all progress notes reviewed were completed late (99% compliance).

CORRECTIVE ACTION PLAN 8.5.1:
The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.

FINDING 8.5.2:
Documentation of services provided to, or on behalf of, a beneficiary by one or more persons at one point in time did not include all required components. Specifically:

- **Line numbers 5 and 7.** While progress note(s) themselves did not accurately document the number of group participants or the units of time for services rendered by more than one provider on one or more group progress notes, the MHP was able to provide separate documentation listing the number of participants and the units of time for services rendered by more than one provider in each group.

CORRECTIVE ACTION PLAN 8.5.2:
The MHP shall submit a CAP that describes how the MHP will ensure that progress notes**:**

1) Contain the actual number of clients participating in a group activity.
2) Document and differentiate the units of direct service, travel and documentation times for each provider/facilitator whenever a claim represents services rendered by more than one (1) provider within the same activity or session, including groups, "team meetings" and "case consultations".

FINDING 8.5.3:
Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically:

- **Line number 2:** The type of Specialty Mental Health Service (SMHS) (e.g., Medication Support, Targeted Case Management) documented on the progress

note was not the same type of SMHS claimed. **RR5, refer to Recoupment Summary for details.**

The progress note for the service claimed as Collateral service on 5/20/21 for 50 minutes, describes a Targeted Case Management service of providers having a conference with CPS staff regarding decisions about the client's newborn child.

CORRECTIVE ACTION PLAN 8.5.3:
The MHP shall submit a CAP that describes how the MHP will:

1) Ensure that all Specialty Mental Health Services claimed are:
   a) Actually provided to the beneficiary.
   b) Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).
   c) Claimed for the correct service modality billing code, and units of time.

Provision of ICC Services and IHBS for Children and Youth

FINDING 8.6.1:

1) The MHP did not furnish evidence that it has a standard procedure for providing and documenting individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs.

   Although the MHP provided written policies and procedures that were written in a manner consistent with current state regulations and guidance (e.g. *Medi-Cal Manual For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, Third Edition, January 2018*), a review of chart materials did not demonstrate that MHP staff have a clear practice of making written individualized determinations of eligibility for ICC services and IHBS.

   Within chart records, although there was evidence of a variety of children's services being provided to children and youth, it was challenging to identify specific documentation that confirmed that determinations were made regarding a child's eligibility for ICC services and IHBS.

CORRECTIVE ACTION PLAN 8.6.1:
The MHP shall submit a CAP that describes how it will ensure that:

1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.

2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.
3) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

ANALYTICS AND RESEARCH METHODS SECTION
1/19/2022

Short-Doyle/Medi-Cal Approved Claims
Random Sample of Clients
Confidential Patient Information
See California Welfare and Institutions Code Section 5328 and
HIPAA Privacy and Security Rules

April 1 2021 through June 30 2021

Total # of Claims 400 **# of claims disallowed** 2 **Mendocino**
Percentage Out of Compliance 0.5%

LINE #	CIN	DOB	PCCN	PROV #	NPI	DATE OF SERVICE	SF	UNIT OF TIME	AMOUNT APPROVED	FFP	FMAP	APPROVED AIDCODE	RR#	REASON(S) FOR RECOUPMENT	HICPCS CODE
2	94314870A	4/14/1990	0000366455666	23CQ	1831523091	5/20/2021	30	50	$130.50	$73.34	56	60	5	Mismatch. Claimed as Collateral, but Progress Note describes TCM service.	
4	96057039A	2/28/1985	0000368374502	23C7	1902247786	6/24/2021	1	27	$63.45	$35.66	56	6E	10f	Solely clerical service	
									$193.95	**$109.00**					

2