



Advocate Fact Sheet: Evaluating Mental Health Plans' Provision of Medi-Cal Specialty Mental Health Services

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Introduction

Medi-Cal beneficiaries in California receive mental health services through two separate managed care systems. Medi-Cal Managed Care Plans (MCPs) are responsible for providing non-specialty mental health services and County Mental Health Plans (MHPs) are responsible for providing specialty mental health services (SMHS). This bifurcated system often serves as a barrier for beneficiaries seeking to access mental health services, because it leads to enrollee confusion and its success depends on effective coordination between the plans, which is oftentimes non-existent. In a related NHeLP fact sheet, we discussed the tools available to advocates and beneficiaries to ensure that MCPs and MHPs comply with federal, state, and contractual obligations in place to help beneficiaries navigate the complicated mental health system.¹ This fact sheet focuses on the provision and delivery of SMHS and provides an analysis of the tools and processes that are available to hold MHPs accountable to serve Medi-Cal beneficiaries.

Triennial Review

The Department of Health Care Services (DHCS) conducts audits of MHPs once every three years. The timetable of these MHP reviews contrasts with audits of MCPs, which take place on an annual basis. These triennial reviews, which are required under state law and as part of California's section 1915(b) waiver authorizing MHPs to provide SMHS, are designed to monitor compliance with state and federal law and contractual requirements through a document review and on-site evaluation of MHPs' policies and practices.² The triennial reviews are the source of most of the information publicly available about MHPs, their policies and practices, and their effectiveness in providing SMHS. As such, advocates serving clients in need of SMHS should be aware of the process and should review the documentation provided by MHPs throughout the review, once publicly available, as well as monitor DHCS's determination of compliance and the plan's submission of a plan of correction (POC) where

required of the MHP by DHCS to remedy violations identified. See further discussion of the POC process below.

Triennial Review Process

DHCS follows a predetermined schedule for reviews in periods of three years. For example, the current evaluation schedule began in fiscal year 2018–2019 and ends in fiscal year 2020–2021. At the beginning of each fiscal year, DHCS releases a MHSUDS Information Notice containing a description of the review process and several enclosures, including the triennial review [schedule](#) for that fiscal year.³ The number of MHPs DHCS evaluates each year depends on several factors, but usually ranges between 18 and 20 counties. There are several steps in the process, but the on-site review takes place over four days, after which DHCS determines whether the MHP is out of compliance with any of the requirements evaluated. Advocates should be aware of when the triennial review for the MHP in their county is taking place in order to monitor the evaluation.

The first step in the triennial review process is a desk review of documentation that MHPs are required to submit to DHCS 30 days before the date of the on-site review. Prior to the on-site review, DHCS provides MHPs with a [checklist](#) that includes all the required documentation to demonstrate compliance with requirements to be evaluated during the review. Some of these documents include: Policies and Procedures (P&Ps) for linguistic access; cultural competency plan and training plan; P&Ps on Notices of Action; P&Ps on Problem Resolution; the MHP Implementation Plan; Memoranda of Understanding (MOU) with Managed Care Plans; Provider Monitoring Protocols; and Guidelines on Medical Necessity and Assessments. In addition, prior to the on-site review, the MHP director must complete and sign an [attestation](#) certifying compliance with several requirements regarding utilization of funding, avoidance of conflict of interest, accreditation, and the provision of information regarding services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.⁴ MHPs must complete and submit this attestation at least 10 days before the on-site review.

The on-site review consists mainly of interviews with key MHP personnel. During these interviews, DHCS seeks information about topics derived from the Triennial Review Protocol (discussed below). In addition, during the on-site review, DHCS reviews a random sample of beneficiary medical records to verify that the MHP provided medically necessary services, assess the MHP's and their network providers' compliance with state-established documentation requirements and, to assess reimbursement of federal funding.⁵

Triennial Review Protocol

In order to monitor MHP compliance with state and federal requirements, advocates should familiarize themselves with the [Triennial Review Protocol](#), a tool utilized by DHCS to review MHPs' compliance with all laws and policies. DHCS releases its Protocol at the beginning of each fiscal year (as an enclosure to the MHSUDS Information Notice announcing the triennial reviews for that fiscal year) and it contains detailed descriptions of all requirements to be reviewed by DHCS through the desk and on-site review. The protocol is provided in the form of tables summarizing the requirements and the source of the requirement (state law, federal law, contract or policy), as well as instructions for reviewers, which include suggested documentation for MHPs to demonstrate compliance with the requirements and additional guidance for state reviewers. While the protocol serves as a tool for DHCS reviewers, it is available to the public and it is used by MHPs to prepare for the on-site review. Advocates should be aware that while the documentation requested in the protocol is described as "suggested documentation," on many occasions MHPs are required to have such documentation in place and failure to produce them would lead to a finding of non-compliance requiring corrective action by the MHP. In essence, these are "required documentation" despite DHCS describing them as suggested.

The protocol is divided into the following sections:⁶

- 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 Requirements
- Section I: Chart Review–Non-Hospital Services (i.e., discussion of specific chart documentation)
- Section J: Chart Review–SD/MC Hospital Services
- Section K: Utilization Review–SD/MC Hospital Services

Advocates should pay close attention to sections A through F, which focus on availability and provision of services and address the difficulty of navigating the bifurcated mental health system, through evaluation of plans' coordination practices, availability of and ease of access to information for beneficiaries, and protection of due process rights. In particular, Section B on care coordination and continuity of care provides one of the few instances where DHCS evaluates transitions between MHPs and MCPs. Under this section, for example, DHCS [Evaluating Mental Health Plans' Provision of Medi-Cal Specialty Mental Health Services](#)

reviews MOUs between the plans to make sure that plans are complying with all requirements and to ensure seamless access to medically necessary mental health services, regardless of which plan is responsible for their provision.

Plans of Correction

If DHCS determines that an MHP is out-of-compliance during an on-site review, the department must issue a Notice of Noncompliance, which includes findings and any corrective action(s) the MHP must take.⁷ For all non-compliant items, the MHP must submit a POC within 60 days that includes a description of corrective actions the plan will take, including milestones, a timeline for implementation of corrective actions, and proposed evidence of correction to submit to DHCS. Advocates should monitor DHCS's [website](#) for postings of Notices of Noncompliance and corresponding POCs in order to be aware of areas where MHPs are out-of-compliance and to monitor plans' implementation of corrective actions. While DHCS needs to approve each POC, implementation of corrective actions is not evaluated until the next triennial review. As such, advocates play an important role in holding plans accountable following a finding of non-compliance. DHCS may also require a POC from a plan after an investigation and determination that a MHP has violated a law, contract requirements or a policy at any time outside of the triennial review. For example, DHCS recently conducted a review of MHPs' compliance with federal network adequacy requirements pursuant to 42 C.F.R. § 438.207, and found that 29 MHPs were partially complying and, as such, were required to submit corrective action and subject to ongoing monitoring.⁸ State findings of violations and any POCs are posted on DHCS' website.

Other Tools to Evaluate MHPs

Performance Outcome System Data

In addition to the triennial review process and corresponding documents, there are several resources advocates should use to monitor provision of SMHS. One of these resources is the [Performance Outcome System \(POS\) data](#), which contains several important data reports pertaining to MHPs, such as the Psychosocial Services Chart and the Consumer Perception Survey.

The Psychosocial Services Chart provides a yearly snapshot of utilization of mental health services among all Medi-Cal beneficiaries. Information about beneficiaries under 21 is provided independently of information on adult beneficiaries, but the charts provide similar information. They include the total number of beneficiaries accessing mental health services, the number of beneficiaries receiving SMHS through an MHP, the number of beneficiaries receiving non-specialty mental health services through an MCP, and the number of

beneficiaries receiving mental health services from both an MHP and MCP. This last number pertains to individuals with conditions for which both plans are responsible, such as eating disorders. The Psychosocial Services Charts are currently the only resource that provide detailed information about the number of beneficiaries accessing mental health services by both delivery systems. Advocates should familiarize themselves with the charts and data, and use the information they contain to monitor overall utilization and access gaps, as well as advocate for improvements regarding access to services. There are additional charts available on the POS website as well that provide data on SMHS for children and adults by county, as well as SMHS data specifically related to children and youth in foster care or involved in the child welfare system.

Consumer Perception Services

The Performance Outcome System data also includes current and archived Consumer Perception Surveys. MHPs are required to survey a sample of their beneficiaries twice a year, in May and November.⁹ Similar to the Psychosocial Services Charts, the Consumer Perception Surveys are divided into surveys for beneficiaries under 21 and surveys for adult beneficiaries. They include information about the overall satisfaction of beneficiaries receiving SMHS and about their perception on several issues, including access, quality and appropriateness of services, beneficiary participation in treatment planning, outcome of services rendered, functioning post-services, and social connectedness as a result of the services. DHCS's Performance Outcome System website includes surveys from fiscal years 2012–2013 to 2015–2016.

Quality Improvement Work Plans

In addition to the resources described above, advocates should monitor MHPs' Quality Improvement Work Plans (QIWP). MHPs are required to create and maintain QIWPs as part of their contract with DHCS.¹⁰ These plans are designed to address more systematic problems identified during the triennial review and include additional quality improvement or evaluation strategies the MHP is pursuing or will pursue to improve access to and delivery of SMHS. Plans are required to make their respective QIWPs available to the public and all MHPs post QIWPs on their website. Plans are also responsible for evaluating and updating their QIWPs on an annual basis.

Most MHP QIWPs address, in one way or another, care coordination with MCPs or the interface between mental health and physical health and cover improvements in: MOUs and monitoring MOU effectiveness, provision of consultation and training about psychiatric services to primary care physicians and other MCP providers, information sharing practices, number of services to consumers with dual diagnoses of mental health and substance use disorders, and

the tracking of referrals from primary care providers to MHPs. Advocates should be aware of the information regarding quality practices contained in QIWP in order to effectively hold plans accountable to meet their requirements under state law, federal law, or contract. Advocates may access QIWP from all MHPs through DHCS's [website](#).

External Quality Review

Federal regulations require states to conduct external quality reviews (EQRs) of all managed care plans and prepaid inpatient health plans (PIHPs) with which the state contracts for provision of Medicaid services. In California, these entities include MHPs, which have been classified as PIHPs. DHCS has contracted with Behavioral Health Concepts, Inc. (BHC) to serve as External Quality Review Organization (EQRO) and to conduct quality evaluations for MHPs in each county on an annual basis. The annual reports include the evaluation of quality, timeliness, and access to care under the plan, recommendations based on the plan's strengths and weaknesses, and an appraisal of how well a plan responded to the prior year report's recommendations. These reports are available on the DHCS [website](#) and on BHC's [website](#).

Annual Beneficiary Grievance and Appeal Reports

DHCS regulations require MHPs to submit an Annual Beneficiary Grievance and Appeal Report (ABGAR) providing a summary of enrollee grievances, appeals, and expedited appeals that took place during the previous fiscal year.¹¹ MHPs are required to classify grievances, appeals, and expedited appeals by type, subject area, and final disposition and to further categorize the actions as part of one of the following: actions, access, quality of care, change of provider, confidentiality concern, or other. Plans must also make public the number of grievances, appeals and expedited appeals submitted. Using this data from plans, DHCS submits an annual report to the Centers for Medicare and Medicaid Services (CMS) summarizing the results from plans. This report is available on DHCS's [website](#). Advocates should evaluate this report to understand the prevalence of grievances and appeals submitted to their county MHP, which may serve as an indication of the effectiveness of MHPs' actions to ensure access to care and of the quality of care that plans are providing. In addition, while reports submitted by individual plans are not available in desegregated form, advocates should submit Public Records Act (PRA) requests when additional information specific to plans is needed. In addition to these reports, advocates should review the MHP beneficiary handbook to ensure it adequately and accurately provides information for beneficiaries on their rights, including the right to notice and file a grievance or appeal. Finally, advocates should review the MHP template notices of adverse benefits determinations required to be provided to beneficiaries who are denied services to ensure the MHP is complying with the state and federal laws and policies.

Conclusion

Given the complicated nature of Medi-Cal's mental health delivery system, advocates should understand and take advantage of the tools available to evaluate and monitor MHPs' performance. The tools discussed in this fact sheet provide information about areas under state law, federal law, policy or contract, where MHPs are out-of-compliance, as well as actions to be taken by the plan to improve such practices and begin complying with the requirements. Some of these tools also provide a snapshot of the rate at which beneficiaries are accessing mental health services, as well as information about beneficiary satisfaction with respect to their interaction with the mental health system. Advocates working on access to mental health services in California should familiarize themselves with these tools and use them to effectively advocate for their clients' rights.

ENDNOTES

¹ See Abigail Coursolle, Nat'l Health Law Prog., *Advocate Fact Sheet: Monitoring Plans' Provision of Mental Health Services to Medi-Cal Beneficiaries* (2019), <https://healthlaw.org/resource/advocate-fact-sheet-monitoring-plans-provision-of-mental-health-services-to-medi-cal-beneficiaries/>.

² See CAL. CODE REGS. tit. 9, § 1810.380.

³ For the most recent MHSUDS Information Notice on the triennial review process, see Cal. Dep't Health Care Servs., MHSUDS Information Notice 18-054 (Nov. 2, 2018) [hereinafter MHSUDS Info. Notice 18-054], https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-18-054_Annual_Review_Protocol/MHSUDS_Information_Note_18-054_FY_2018-2019_Annual_Review_Protocol.pdf.

⁴ *Id.* at 5.

⁵ *Id.* at 3–4.

⁶ *Id.* at 3.

⁷ CAL. CODE REGS. tit. 9, § 1810.380(b).

⁸ Cal. Dep't Health Care Servs., Letter to Richard C. Allen, CMS Director (Aug. 2, 2019), <https://www.dhcs.ca.gov/formsandpubs/Documents/Assurance-of-Compliance-Cover-Letter-MHSD.pdf>.

⁹ Cal. Dep't Health Care Servs., MHSUDS Information Notice 18-013 (March 17, 2018) [hereinafter MHSUDS Info. Notice 18-013], https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_Information_Note_18-013_Spring_2018_CPS-FINAL.pdf.

¹⁰ Cal. Dep't of Health Care Servs., *Sample Contract Boilerplate for County Mental Health Plans*, at Ex. A, Attach. 5, https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf.

¹¹ CAL. CODE REGS. tit. 9, § 1810.375(a).