COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 01, POLICY 016

MEDI-CAL PROVIDER MONITORING

POLICY NUMBER:	5-1-016
SYSTEM OF CARE:	BEHAVIORAL HEALTH
FINALIZED DATE:	03.27.2024
EFFECTIVE:	07.01.2022
SUPERSEDES # :	Supersedes Policy #'s: 5-5-003 Medi-Cal Site Certifications 5-5-006 Utilization Management Authorization Consistency Executed 5-10-004 Access Line Test Call Guideline Executed 6-5-014 BH Utilization Management Executed 6-5-017 SUD Annual Onsite Monitoring Executed PP 403 Auditing and Monitoring Activities (10-16-08) PP 510 Medi-Cal Provider Certification and Verification (10-20-08) PP 510 Medi-Cal Provider Certification and Procedures Manual (signed) PP 1103 Chart Audit (11-4-08) PP 1109 Peer Review (10-24-08) PP 1116 Organizational Provider Selection and Retention (10-24-08) PP 1115 Provider File for Medi-Cal Reimbursement (10-24-08) QM-MH-0502-Access Test Calls 040116

A. PURPOSE: To establish a uniform policy to provide information and guidance regarding Yolo County Health & Human Services Agency (HHSA) Behavioral Health (BH) Plan's Utilization Management Program as well as monitoring, oversight, and recoupment standards to verify and oversee programs and operations provided through the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), in compliance with State and Federal

laws and regulations and/or the terms of the contract with the Department of Health Care Services (DHCS).

B. RELATED DOCUMENTS:

1. HHSA Medi-Cal Site Certification Protocol and Corrective Action Plan (CAP)
2. Substance Use Disorder (SUD) Monitoring Protocols and CAPs
3. Mental Health Monitoring Protocols and CAPs

C. DEFINITIONS:

1. **Drug Medi-Cal Organized Delivery System Services (DMC-ODS):** Yolo County HHSA BH and Network Providers of Substance Use Disorder (SUD) services.

2. **DHCS:** The California Department of Health Care Services.

3. **Administrator:** Yolo County HHSA BH is the administrator of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan, hereby referred to as the "Administrator".

4. **Mental Health Plan:** Yolo County HHSA BH and Network Providers of SMHS.

5. **Network Providers:** Any provider, group of providers, or entity that has a network provider agreement with Yolo County HHSA BH and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2).

6. **Onsite Review (MHP site certification):** Reviews conducted for any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries. This is not required for public school or satellite sites.

7. **Specialty mental health services:** Include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, Medication Support Services, Targeted Case Management, Crisis Intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

8. **Site Certification Facility Types**: DHCS certifies all new county-owned and operated providers, as well as re-certifying all county-owned and operated provider moves/address changes. DHCS also re-certifies those County Mental Health staffed providers as specified in DMH Letter 10- 04. MHP is responsible for certifying, re-certifying, and monitoring all its contracted network providers, as well as the re-

certification of certain county-owned or operated providers as specified in DMH Letter 10-04.

9. **Satellite Sites**: is defined as a site that is owned, leased, or operated by an MHP or a network provider at which specialty mental health services are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site, at which specialty mental health services are delivered by no more than two MHP employees or contractors of the provider. Note: A satellite must have an NPI #.

D. POLICY: It is the policy of Yolo County HHSA BH ("The Administrator") to conduct performance monitoring and oversight activities throughout the MHP and DMC-ODS systems of care for its network providers.

Performance monitoring and oversight activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. (42 C.F.R. § 438.330(a)(e)(2)) and shall be monitored in accordance with local, state and federal regulations and any specific funding grants. The Administrator shall review network programs and operations to:

1. Assess capacity and accessibility to quality care,
2. Monitor the handling of grievances and appeals,
3. Report compliance issues,
4. Verify that medically necessary services are provided to Medi-Cal beneficiaries, who meet medical necessity criteria, in compliance with State and Federal laws and regulations and/or the terms of the contract between DHCS and the Administrator,
5. Ensure all network providers are enrolled with the state as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 Code of Federal Regulations part 455, subparts B and E. (42 C.F.R. § 438.608(b).

In an effort to improve the performance of the state's managed care program, in accordance with 42 Code of Federal Regulations part 438.66(c), the following data collected from its monitoring activities shall be utilized to improve performance. The Administrator shall submit these items, when applicable, to DHCS (42 C.F.R. §438.604(b).) at a frequency and level specified by DHCS and Center for Medicare and Medicaid Services (CMS). (42 C.F.R. § 438.242(c)(2).):

1. Enrollment and disenrollment data;
2. Member grievance and appeal logs;
3. Provider complaint and appeal logs;
4. The results of any beneficiary or provider satisfaction survey;
5. Performance on required quality measures;
6. Medical management committee reports and minutes
7. Annual Quality Improvement plan;
8. Audited financial and encounter data;

9. Medical loss ratio summary reports; and
10. Customer service performance data.

E. PROCEDURE:

1. **<u>Medi-Cal Site Certification (MHP Only):</u>** The MHP shall certify, or use another MHP's certification documents to certify, network providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435(MHP Contract, Ex. A, Att. 8), for facility types where the MHP is responsible for site certification.
    a. Medi-Cal site certification and recertification shall occur prior to the date on which the provider begins to deliver services under the contract with the MHP and thereafter at least every three (3) years, or upon:
        i. Major staffing changes
        ii. Change of ownership or corporate/organizational restructuring
        iii. Addition of Day Treatment/Rehabilitation or Medication Support Services when medications are administered or dispensed from the provider site
        iv. There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
        v. Change in location
        vi. Complaints
        vii. Unusual events, accidents, or injuries requiring medical treatment for clients, staff, or members of the community
        viii. As provided for by state or federal regulations.

    b. The earliest date that the provider may begin delivering covered services at a site subject to on-site review is the latest of the following dates:
        i. The date the provider's request for certification is received by DHCS
        ii. The date the site was operational, or
        iii. The date that fire clearances was obtained

    c. The MHP shall complete any required on-site review of a network providers site within six (6) months of the date that the provider begins delivering covered services to beneficiaries at the pending site, except in the event of public emergency situations where DHCS has provided specific waivers or guidance regarding this requirement.

    d. Medi-Cal site certification and recertification shall utilize the DHCS Provider Certification and Recertification Protocol and the MHP shall complete both a system and on-site review and monitor, at minimum, the following:
        i. Organizational Policies and Procedures and supporting evidence :
            1. Personnel policies and procedures,

2. General operating procedures,
3. Service delivery policies,
4. Any required state or federal notices (DRA),
5. Procedures for reporting unusual occurrences relating to health and safety issues; and
6. Procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available

ii. Business Licenses and additional license(s) necessary to operate, including any required certifications;
iii. Evidence of Liability Insurance;
iv. The organizational provider's head or chief of service, as defined Cal. Code Regs., tit. 9, sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.;
v. Valid Fire Clearance for space owned, leased or operated and used for services or staff;
vi. Individual provider certification and recertification verifications, including verification that the organizational provider has sufficient staff to claim federal financial participation (FFP) for the services that are delivered to beneficiaries as described in California Code of Regulations, title 9, sections 1840.344 through 1840.358, as appropriate and applicable.
vii. Posted brochures and notices, including threshold languages and large print
viii. Inspection of the physical plant of any site owned, leased, or operated by the provider and used for services or staff to ensure the site is clean, sanitary and in good repair.
ix. Record storage, access, and maintenance that meets applicable state and federal standards
x. For providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
    1. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.
    2. Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.
    3. All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
    4. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense, or administer medication.

5. Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.
6. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated, and abandoned drugs in a manner consistent with state and federal laws.
7. Policies and procedures are in place for dispensing, administering, and storing medications

xi. For providers that provide day treatment intensive or day rehabilitation, the written description of the day treatment intensive and/or day rehabilitation program that complies with Attachment 2, Section 3 of the MHP contract.
    1. If an on-site review of a provider would not otherwise be required but the provider offers day treatment intensive and/or day rehabilitation, at a minimum, the provider's written program description for compliance with the requirements Attachment 2, Section 3 of the MHP contract.

e. When piggy-backing from another county's Medi-Cal certification or recertification, the MHP shall not activate services that the host county provider is not certified to provide. If the MHP requires activation of services not certified by the host county, the MHP shall be responsible for completing its own Medi-Cal site certification.

f. In the event the network provider has not met the requirements contained within the DHCS Provider Certification and Recertification Protocol, the MHP shall place the organization on a corrective action plan (CAP) that shall be resolved within six (6) months of the identified deficiencies. The Administrator shall execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but shall terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected beneficiaries. (42 C.F.R. § 438.602(b)(2).)

g. Network providers that are unable to meet the requirements contained within the DHCS Provider Certification and Recertification Protocol may appeal an adverse decision. All appeals shall be directed to the Administrator's BH Compliance Committee for final decision. The Administrators BH Compliance Committee shall give practitioners or groups of practitioners who apply to be contract providers and with whom the Administrator decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).)

2. **Provider Monitoring:** The Administrator shall monitor the performance of its network providers and internal programs on an ongoing basis for compliance with the terms of their contract and shall subject the providers' performance to periodic formal review.
    a. Monitoring shall include:
        i. Systems Review: The Systems review shall consist of a review of policies and procedures and any supporting evidence.
            1. SUD only: The systems review also includes a review of personnel files.
        ii. Onsite Review: The Onsite review shall consist of visiting the physical site where service is being provided to ensure the site is safe, clean and provides appropriate disability access requirements.
        iii. Utilization Review (UR): The Utilization review shall consist of a review of services to ensure that all medically necessary covered services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 C.F.R., § 438.210(a)(3)(i)). Effective July 1, 2022, UR processes shall be in alignment with California Advancing and Innovating Medi-Cal (CalAIM) documentation reform requirements.
            1. Utilization review shall ensure that:
                a. DMC-ODS: beneficiaries have appropriate access to SUD services, that services are medically necessary, that the ASAM Criteria shall be used to determine placement into the appropriate level of care, and that the interventions are appropriate for the diagnosis and level of care.
                b. MHP: beneficiaries have appropriate access to SMHS, that services are medically necessary, and that criteria for beneficiary access to SMHS is established.
            2. The review of clinical documentation shall be conducted utilizing an identified sampling method and frequency.
            3. The review will utilize a UR tool that focuses on the requirements of CalAIM documentation reform that went into effect July 1, 2022
        iv. Compliance Review: The compliance review shall be conducted by the HHSA BH Compliance Officer or designee.
        v. Fiscal Review: The fiscal review shall be conducted in accordance with the County of Yolo policy for audits conducted by external entities and fiscal monitoring review.
    b. Monitoring frequency shall be as follows:
        i. Each DMC-ODS network provider per legal entity shall be monitored at least annually, using the Administrators developed protocol.

ii. Each MHP network provider and internal HHSA program shall be monitored at least every three (3) years and may be monitored using the DHCS Provider Certification and Recertification Protocol, or a protocol developed by the Administrator that shall include all required components.

c. Monitoring shall be conducted by appropriate individuals, operating within their scope of practice and competence.
    i. Compensation to individuals or entities that conduct contract monitoring shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.
d. Utilization decisions shall be made in a fair, impartial, and consistent manner.
e. The Administrator may place appropriate limits on a service based on criteria applied under the State Plan, such as criteria for access to services and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration and scope to reasonably achieve the purpose for which the services are furnished.
    i. The Administrator shall not impose quantitative treatment limitations, aggregate lifetime or annual dollar limits as defined in 42 C.F.R. 438.900, for any beneficiary receiving services.
    ii. The Administrator shall not impose non-quantitative treatment limitations for services in any benefit classification (i.e., inpatient and outpatient) unless the Administrator's policies and procedures have been determined by DHCS to comply with Title 42 of the Code of Federal Regulations, subpart K.
f. The Administrator shall have mechanisms to detect both underutilization of services and overutilization of services.
g. The Administrator may disallow claims and/or recoup funds, as appropriate, in accordance with federal and state requirements, including CalAIM documentation reform standards. Recoupment shall be focused on fraud, waste, and abuse.
h. If the Administrator identifies deficiencies or areas of improvement, the Administrator and the provider shall take corrective action (MHP Contract, Ex. A, Att. 8). It shall be the responsibility of the provider to clear all deficiencies within six (6) months of the identified deficiencies unless approval for extension has been provided by the Administrator.
    i. In the event the provider does not clear CAPS within the agreed upon time frame, the Administrator has the right to withhold payments until such a time that the deficiencies are cleared. The Administrator BH Compliance Committee shall be informed of all unresolved CAPS to determine decisions regarding payment withholding, including the right to initiate further investigations.

i. SUD only: The Administrator shall notify DHCS within 2 weeks of completion of programmatic and fiscal monitoring in accordance with state contracts. A monitoring review shall be considered complete once the Administrator has issued either a notice of full compliance or a final CAP.
j. In addition to the UR conducted by the Administrator, it is generally the expectation that contract providers conduct their own audit/utilization review processes.

3. **Network Adequacy Monitoring:** The Administrator shall implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health and substance use disorder services within the Administrators delivery system.
    a. The Administrator shall submit to DHCS, documentation on which the State bases its certification that the Administrator has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in Title 42 C.F.R. Part 438.206.

    b. The Administrator shall complete a Network Adequacy Certification Tool (NACT) or the reporting mechanism identified by DHCS, for all network providers at the organizational, site and rendering provider level of detail.
        i. The organizational level refers to the provider's legal entity.
        ii. The site level refers to the physical location of the provider.
        iii. The rendering provider refers to the individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries.

    c. In addition to the NACT, the Administrator shall submit supporting documentation. This supporting documentation shall include, at a minimum, all the following, separately for both children/youth and adults when applicable:
        i. Timeliness access
        ii. Alternative Access Standards
        iii. Network Provider Contracts
        iv. Language Capacity
        v. American Indian Health
        vi. Continuity of Care
        vii. Attestations from the Administrator
        viii. Additional or alternative supporting documentation as specified by DHCS

4. **24/7 BH Access Line Monitoring:** The Administrator shall ensure that services are available 24 hours a day, 7 days a week, when medically necessary and monitor the

responsiveness and effectiveness of the 24-hour toll-free Access Line through conducting routine test calls.

a. Test calls shall be conducted in English and non-English languages, including the county's threshold languages, to assess language accessibility.

b. The Administrator shall ensure that training is provided to staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities.

c. Test calls shall assess the Access Line's:
    i. Language capability in all languages spoken by beneficiaries of the county.
    ii. Ability to provide accurate and timely information to beneficiaries about how to access MHP and DMC-ODS services, including services required to assess whether medical necessity criteria are met.
    iii. Ability to provide accurate and timely information to beneficiaries about services needed to treat a beneficiary's urgent condition.
    iv. Ability to provide accurate and timely information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.
    v. Ability to log all requests for services made by phone, in person, or in writing. The log shall contain, at minimum, the following required elements:
        1. Name of the beneficiary.
        2. Date of the request.
        3. Initial disposition of the request.
        4. Results of test calls shall:
            a. Inform future QI activities, as needed, such as process improvements and feedback / training provided to the Access Line provider.
            b. Be reported to the Yolo County HHSA BH Quality Management Department for logging and reporting to DHCS according to DHCS reporting requirements.

5. **<u>State Submission Monitoring</u>**: The Administrator shall submit any data, documentation, or information relating to the performance of the entity's obligations as required by the State or the United States Secretary of Health and Human Services. (42 C.F.R. § 438.604(b).) and shall include at a minimum the following to DHCS (42 C.F.R. §438.604(b).) at a frequency and level specified by DHCS:

a. Client Services Information (CSI): The Administrator shall electronically submit CSI data, including CSI Assessment (CSI-A) data within 60 days from the end of the last day of the report month.

b. Pediatric Symptom Checklist (PSC-35) and Child and Adolescent needs and Strength (CANS): The Administrator shall collect and report to DHCS the data obtained from PSC-35 and CANS effective July 1, 2018 and shall be electronically submitted to DHCS within 60 days from the end of the last day of the report month.

c. California Outcomes Measurement System (CalOMS) Monitoring & Reporting: The Administrator shall:
    i. Comply with data collections and reporting requirements established by DHCS, including data compliance standards established for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines and reporting methods.
    ii. Ensure submission includes CalOMS admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "Provider no activity" report records in an electronic format approved by DHCS.
    iii. Electronically submit CalOMS treatment data within 45 days from the end of the last day of the report month.
    iv. Notify DHCS if there is a system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements. The Administrator shall report the problem in writing before the established data submission deadlines. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Administrator to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).
    v. Treatment providers that continually fail to meet submission requirements shall be reported to the Administrator's BH Compliance Committee.

d. Drug and Alcohol Treatment Access Report (DATAR): The Administrator shall:
    i. Ensure that DATAR submissions are complied with by all treatment providers.
    ii. Each network provider is enrolled in DATAR to allow for data entry into the DATAR system.
    iii. Monitor compliance with DATAR data entry and ensure that all DATAR reports are submitted to DHCS by the 10th of the month following the report activity month, in an electronic copy format as provided by DHCS.
    iv. Ensure at minimum 95% of required DATAR reports have been completed by treatment providers by the due date.
    v. Notify DHCS if there is a system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR

report, and/or to meet data compliance requirements. The Administrator shall report the problem in writing before the established data submission deadlines. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Administrator to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).

vi. Treatment providers that continually fail to meet submission requirements shall be reported to the Administrator's BH Compliance Committee.

e. UCLA Level of Care (LOC) submission: The Administrator shall submit American Society of Addiction Medicine (ASAM) LOC data for all DMC beneficiaries using an electronic copy format as provided by DHCS, and submit to the approved DHCS system. ASAM LOC Data shall be cumulative and shall be submitted at least monthly, no later than 45 days after the month of service.

F. REFERENCES:

1. 9 C.C.R § 1810.440
2. 42 C.F.R. § 438.66
3. 42 C.F.R. § 438.330
4. 42 C.F.R. § 438.210
5. 42 C.F.R. § 438.242
6. 42 C.F.R. § 438.604
7. 42 C.F.R. § 438.900
8. 42 C.F.R. § 438.910
9. MHP Contract
10. DMC-ODS Intergovernmental Agreement
11. DMH Letter No.: 10-04
12. DHCS Behavioral Health Information Notice (BHIN) No.: 19-051
13. DHCS BHIN No.: 20-021

Approved by:

Karleen Jakowski, LMFT

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Karleen Jakowski, LMFT, Mental Health Director **Date**
Yolo County Health and Human Services Agency