Placer/Sierra Mental Health Plan

Fiscal Year 2021/22 Medi-Cal Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Requirement

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 (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries (3rd ed., Jan. 2018), p. 34.)

DHCS Finding 1.2.7

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. Per the discussion during the review, the MHP stated that it has a contract in place to provide TFC services, however it is currently in the process of recruiting TFC parents. The MHP stated that Intensive Services Foster Care is used in lieu of TFC for high risk children and youth who are involved with child welfare and probation. Post review, the MHP submitted evidence of a contract to provide TFC services, however, it is not evident that the MHP has the capacity to provide TFC services at this time.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description

- Revise screening tool to include TFC
- Train staff how to use screening tool
- Placer has a provider contract in place to provide TFC services
- Continuous recruitment of TFC providers

Proposed Evidence/Documentation of Correction

- Finalized screening tool
- List of staff training dates
- Provider TFC contract

Ongoing Monitoring (if included)

- Program Manager to monitor existing TFC contracts regarding their ability to provide TFC on an on-going basis

Person Responsible (job title)

- Leslie Medina, Program Manager
- Leslie Roth, Program Manager

Implementation Timeline:

- Screening tool: by 7-31-22
- Staff training: by 9-30-22

Requirement

The MHP shall 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 1810.435. (MHP Contract, Ex. A, Att. 8, sec. 8(D).)

DHCS Finding 1.4.4

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 contract with the MHP to provide

SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certifies, or uses another MHP's certification documents to certify, the organizational providers that contract with the MHP to provide SMHS. Per the discussion during the review, the MHP explained that it had encountered technical

difficulties when certifying its providers and was currently working with its DHCS liaison to update site certifications. Post review, DHCS reviewed the updated Provider Monitoring Report and found that the five (5) unresolved provider certifications remained overdue.

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

Corrective Action Description

Placer MHP has worked to resolve the 5 overdue provider certifications identified at the time of this review: 3177, 31AW, 31BD, 31CF, 31CG. These provider's recertifications have been submitted to DHCS: 3177, 31AW, 31BD and 31CG. Placer will submit provider 31CF's certification termination, once a billing issue is resolved with DHCS.

Placer will submit the certification termination for 31CF within 10 business days of the billing issue resolution. Placer anticipates the certification termination can be submitted by 9/1/22.

Proposed Evidence/Documentation of Correction

The Provider Monitoring Report should reflect the evidence of Placer's submissions, once the submissions are processed by DMH. If necessary, Placer can provide email evidence showing the submissions have been made to DMH.

Ongoing Monitoring (if included)

Placer MHP will continue to monitor the Provider Monitoring Report on a minimum monthly basis to ensure all site certifications are submitted timely.

Person Responsible (job title)

MHP Analyst

Implementation Timeline:

9/1/22

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Requirement

The QAPI Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. (MHP Contract, Ex. A, Att. 5, sec. 2(a)(1).)

DHCS Finding 3.2.2

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors activities including, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review in the QAPI Work Plan. This requirement was not included in its fiscal year 2021-2022 QAPI Work Plan. Per the discussion during the review, the MHP stated it monitors these activities, however, during its fiscal year 2020-2021 External Quality Review Organization review, the MHP was informed that these activities were not required in the QAPI Work Plan. Post review, the MHP submitted QAPI Work Plans from previous fiscal years, however, it did not provide evidence the required monitoring activities were in included in its current QAPI Work Plan.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5.

Corrective Action Description

The Placer-Sierra MHP has reviewed the suggestions from the MHP EQRO site review and findings report, the ODS EQRO site review and findings report, and the discussion and findings from the Triennial review and is implementing a section within the QAPI workplan to include a bulleted list of all quality assurance items and monitoring activities separate from the quality improvement components.

Proposed Evidence/Documentation of Correction

Placer Sierra QAPI will include the monitoring activities within the 2022/2023 workplan.

Ongoing Monitoring (if included)

The Placer-Sierra QAPI is completed annually and a subsequent effectiveness plan is completed to show effectiveness. The effectiveness plan will include a response to the completion of the monitoring activities and highlight any area of concern that may be included as a quality improvement items in addition to monitoring in future plans. The plans are submitted to DHCS annually.

Person Responsible (job title)

- MHP Analyst
- ODS Analyst
- Sierra County Analyst

Implementation Timeline:

9/1/2022

Requirement

The QAPI Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. (MHP Contract, Ex. A, Att. 5, sec. 2(a)(1).)

DHCS Finding 3.2.5

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals listed in the below requirements:

1. Responsiveness for the Contractor's 24-hour toll-free telephone number.

2. Timeliness for scheduling of routine appointments.

3. Timeliness of services for urgent conditions.

4. Access to after-hours care.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses the accessibility of services within its service delivery area, including goals for timeliness of services for urgent conditions or access to after-hours care in its QAPI Work Plan. Per the discussion during the review, the MHP stated that these goals are not included in the QAPI Work Plan because these services do not have a measurable impact. Post review, the MHP provided QAPI Work Plans from previous fiscal years demonstrating inclusion of these requirements, however it was unable to provide evidence that the required monitoring activities are included in its current QAPI Work Plan.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5.

Corrective Action Description

The Placer-Sierra MHP has reviewed the suggestions from the MHP EQRO site review and findings report, the ODS EQRO site review and findings report, and the discussion and findings from the Triennial review and is implementing a section within the QAPI workplan to include a bulleted list of all quality assurance items and monitoring activities separate from the quality improvement components.

Proposed Evidence/Documentation of Correction

Placer Sierra QAPI will include the monitoring activities within the 2022/2023 workplan.

Ongoing Monitoring (if included)

The Placer-Sierra QAPI is completed annually and a subsequent effectiveness plan is completed to show effectiveness. The effectiveness plan will include a response to the completion of the monitoring activities and highlight any area of concern that may be included as a quality improvement items in addition to monitoring in future plans. The plans are submitted to DHCS annually.

Person Responsible (job title)

- MHP Analyst
- ODS Analyst
- Sierra County Analyst

Implementation Timeline:

9/1/2022

Requirement

The MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. (MHP Contract, Ex. A, Att. 5, sec. 6(D); 42 C.F.R. § 438.236(d); CCR, tit. 9, § 1810.326.)

DHCS Finding 3.5.3

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP

must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP takes steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. Per the discussion during the review, the MHP stated that these required areas are reviewed at provider meetings, discussed in work groups, and are modified based on input from providers, contractors, and stakeholders. Post review, the MHP submitted a tracking mechanism for policy implementation, however, this evidence was insufficient in demonstrating compliance with this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Corrective Action Description

Placer county is in the process of updating is Practice Guidelines to align with the recent and ongoing changes being implemented through CalAIM. Placer County will ensure that the Practice Guidelines are compliant with MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. Placer County will also complete annual reviews of the Practice Guides with the Quality Improvement Committee to demonstrate effectiveness and monitor for compliance with MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Proposed Evidence/Documentation of Correction

Update Practice Guidelines

Ongoing Monitoring (if included)

Quality Improvement Committee meeting minutes

Person Responsible (job title)

- QM Manager
- QA Supervisor

Implementation Timeline:

12/31/22

ACCESS AND INFORMATION REQUIREMENTS

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:

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, tit. 9, §§ 1810.405, subd. (d); 1810.410, subd. (e)(1).)

DHCS Finding 4.3.2

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The toll-free telephone number provides information to beneficiaries to the below listed requirements:

1. The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.

2. The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.

3. The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.

4. The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

The seven (7) test calls are summarized below.

TEST CALL #1

Test call was placed on Thursday, November 18, 2021, at 3:26 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 disruptive behavior in school. The operator provided the caller the phone number for the MHP's children's services and transferred the caller. The caller heard a recorded message which included locations and addresses for mental health services in the county, as well as the option to speak to a live operator. Upon connecting with the live operator, the caller was provided information on how to obtain a referral for services, locations for children's mental health services, phone numbers, 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.

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 Monday, November 22, 2021, at 2:55 p.m. The call was answered after two (2) rings via a live operator. The caller explained he/she was feeling down and unable to eat, sleep, or get out of bed for the past several weeks. The operator assessed the caller for the need for crisis services and provided information to obtain immediate care. The operator asked for personally identifying information, which the caller provided. The operator provided the caller information regarding the assessment process to determine his/her level of care, clinic locations, option for a telephone appointments, and transportation 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 Monday, November 8, 2021, at 7:37 a.m. The call was answered after three (3) rings via a live operator. The caller asked the operator for information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling overwhelmed, isolated, and hopeless. The operator asked for personally identifying information, which the caller provided. The operator provided the hours of operation and locations of two (2) clinics in the county nearest to the caller. The operator stated the caller would receive counseling services and that if medication was needed it would be determined through the counseling process.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was 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 Monday, November 22, 2021 at 9:22 a.m. The call was answered after one (1) ring 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 informed the caller he/she needed to get an intake form and put the caller on hold for approximately one (1) minute. The operator asked for personally identifying information, which the caller provided. The operator provided the caller the walk-in clinic locations, hours of operation, options for counseling, and the medication refill telephone number.

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 #5

Test call was placed on Friday, November 19, 2021, at 7:34 a.m. The call was answered immediately via a live operator. The caller explained he/she was currently taking care of his/her ill mother and was feeling down and depressed. The operator stated that he/she could go to a walk-in clinic and explained the assessment process to determine his/her level of care. The operator provided the location of clinics and provided the option to be transferred to someone qualified to conduct an assessment via telephone. The caller declined and ended the call.

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 #6

Test call was placed on Wednesday, November 17, 2021, at 1:24 pm. The call was answered after one (1) ring by a live operator. The caller requested information on how to file a complaint about a therapist he/she was seeing through the county. The operator placed the caller on a brief hold before informing the caller that he/she would be transferred to a staff member who works for the adult system of care. Upon being transferred the caller heard a voicemail recording stating that the caller had reached the Patients' Rights Advocate. The voicemail recording instructed the caller to leave a message with personally identifying information to receive a return call. No additional information was provided.

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).

TEST CALL #7

Test call was placed on Monday, November 22, 2021, at 7:42 am. The call was answered after two (2) rings via a live operator. The caller asked how to file a complaint against a therapist he/she was seeing through the county. The operator explained that the caller can file a grievance over the phone, pick up a grievance form at the clinic, or print a form via the county's website. The operator explained that the caller could mail or fax the form to the county. The operator offered to take information orally from the caller concerning his/her grievance, which caller declined.

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

FINDING

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

SUMMARY OF TEST CALL FINDINGS

Test Call Findings								
Required Elements	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**Compliance Percentage**
1	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	N/A
2	**IN**	**IN**	**IN**	**IN**	**IN**	**N/A**	**N/A**	100%
3	**N/A**	**IN**	**OOC**	**OOC**	**OOC**	**N/A**	**N/A**	25%
4	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**OOC**	**IN**	50%

Corrective Action Description

Findings The MHP is updating its training materials and is scheduling trainings for the call center access points, with an emphasis on the beneficiary problem resolution process.

The Adult Intake Services (AIS) call center and Family and Children's Services (FACS) call center received training post triennial in 2018-2019, but during the COVID-19 Pandemic, we were unable to complete in-person trainings which is required for these groups, as their staff are not on dedicated computers or are working in shifts. To have a single source of information and answer questions, it is necessary to complete trainings during staff meetings with as many present as possible. After receiving the findings response from DHCS in 2022, additional language and training is being incorporated into the trainings provided to the Adult Intake Services call center and Family and Children's Services call centers.

The number of overall trainings for the call centers is two (2) annually, with ad-hoc training and technical assistance available as needed.

The Placer County Systems of Care Problem Resolution Guide and Placer County Systems of Care Appeal/Grievance Form was provided to call AIS center staff on August 6, 2019, along with a question-and-answer session regarding how to respond to callers who ask about or want to file a grievance, appeal, or expedited appeal. Due to the COVID-19 Pandemic and new staff onboarding, it is necessary to review and re-message the trainings so that all staff are aware of requirements and that new staff are not receiving inaccurate information.

A short desk reference/job aid for the call center staff will be provided during the training to provide additional guidance.

Placer County Quality Management will administer the Placer County Beneficiary Protection Training annually to the contracted staff at Adult Intake Services (AIS). This will align with current practice which requires Placer County Health and Human Services staff to complete this training annually.

In addition, the test call training materials and the associated Survey Monkey continues to be updated and refined. The Test Call Training Manual has been updated to current expectations and will be distributed as Test Callers complete training. The test call training will be administered as individuals are identified to be assigned test callers and annually thereafter, as long as they continue to be identified assigned test callers. All assigned test callers will complete training prior to completing test calls on behalf of Placer County Systems of Care. Volunteers (unassigned individuals) who are not contracted or employed by Placer County, but complete a test call in a language other

than English on behalf of an assigned individual, will fall under the responsibility of the assigned individual for training materials and survey completion.

A schedule is being completed and staff will be assigned to complete calls each month.

Placer County continues to complete a minimum of 36 test calls per year on the Behavioral Health call centers for MHP and 12 test calls for Substance Use Services. The Quality Improvement Workplan includes a minimum of 12 calls annually be designated as grievance calls.

Proposed Evidence/Documentation of Correction

- Placer County Call Center Access Team Training PowerPoint
- AIS Training and Sign-in sheet
- Systems of Care Problem Resolution Guide
- Grievance Appeal Form in English large print
- Problem Resolution Process Guide for call centers
- Beneficiary Protection Training
- 24-7 Test Call Training
- Survey Monkey Test Calls
- Test Call schedule
- Placer County 24-7 Test Call Manual

Ongoing Monitoring (if included)

Review of completed test calls and submission of the DHCS 24/7 Test Call Report

Person Responsible (job title)

MHP Analyst

Implementation Timeline:

Completion date scheduled for 12/31/2022

Requirement

The written log(s) contain the following required elements:

a) Name of the beneficiary.

b) Date of the request.

c) Initial disposition of the request.

(CCR, tit. 9, § 1810.405, subd. (f).)

DHCS Finding 4.3.4

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.

While the MHP submitted evidence to demonstrate compliance with this requirement, two (2) of the five (5) required DHCS test calls did not include the beneficiary's name in the MHP's written log of initial request.

The table below summarizes DHCS' findings pertaining to its test calls:

Log Results					
Test Call #	**Date of Call**	**Time of Call**	**Name of the Beneficiary**	**Date of the Request**	**Initial Disposition of the Request**
1	11/18/2021	3:26 p.m.	OOC	IN	IN
2	11/22/2021	2:55 p.m.	OOC	IN	IN
3	11/8/2021	7:37 a.m.	IN	IN	IN
4	11/22/2021	9:22 a.m.	IN	IN	IN
5	11/19/2021	7:34 a.m.	IN	IN	IN
Compliance Percentage			**60%**	**100%**	**100%**

Corrective Action Description

Placer County records and maintains a written log on the initial requests for SMHS from beneficiaries of the MHP. The log for Placer and Sierra counties were submitted as evidence of compliance for this metric. Placer County logs an average of 25,000 calls per year, including SMHS, Substance Use Services, IHSS, and APS. The following actions have been completed or are in queue to implement in the next 30 days:

The MHP has updated its training materials and schedule of trainings for the call center access points, with an emphasis on the beneficiary problem resolution process and to highlight how to attend to and log urgent conditions

The number of overall trainings for the call centers is two (2) annually, with ad-hoc training and technical assistance available as needed.

Proposed Evidence/Documentation of Correction

- Placer County Call Center Access Team Training PowerPoint

- AIS Training and Sign-in sheet
- FACS Training and Sign-in sheet
- 24-7 Test Call Training
- Survey Monkey Test Calls Template
- Placer County 24-7 Test Call Manual
- Test Call schedule

Ongoing Monitoring (if included)

Review of completed test calls and submission of the DHCS 24/7 Test Call Report. In addition, the test call training materials and the associated Survey Monkey continues to be updated and refined. The Test Call Training Manual has been updated to current expectations and will be distributed as Test Callers complete training. The test call training will be administered as individuals are identified to be assigned test callers and annually thereafter, as long as they continue to be identified assigned test callers. All assigned test callers will complete training prior to completing test calls on behalf of Placer County Systems of Care. Volunteers (unassigned individuals) who are not contracted or employed by Placer County, but complete a test call in a language other than English on behalf of an assigned individual, will fall under the responsibility of the assigned individual for training materials and survey completion.

A schedule is being completed and staff will be assigned to complete calls each month.

Placer County continues to complete a minimum of 36 test calls per year on the Behavioral Health call centers for MHP and 12 test calls for Substance Use Services. The Quality Improvement Workplan includes a minimum of 12 calls annually be designated as grievance calls. The test call schedule will be updated to include calls for Urgent Conditions and define Urgent Conditions for test callers.

Person Responsible (job title)

MHP Analyst

Implementation Timeline:

Completion Date of 12/31/2022

COVERAGE AND AUTHORIZATION OF SERVICES

Requirement

MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. (MHSUDS IN No. 19-026.)

DHCS Finding 5.2.8

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.

DHCS reviewed samples of authorizations to verify compliance with regulatory requirements. The service authorization sample verification findings are detailed below:

Requirement	# of Services Authorizations in compliance	# of Service Authorizations out of compliance	Compliance Percentage
Regular Authorization: The MHP makes a decision regarding a provider's request for prior authorization not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.	5	11	31%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes decisions regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information. Of the 16 Service Authorization Requests (SARs) reviewed, four (4) were not approved within the timeframe and seven (7) were not signed by a licensed professional or did not have proof of receipt by the MHP to ensure compliance. Per the discussion during the review, the MHP stated that SARs are usually authorized within two (2) business days, however it acknowledged that its multi-step process may have caused some to be approved beyond the required timeframe. Post review, the MHP provided its SAR policy and a desk guide, however it was unable provide proof all SARs had met the time standard for approval.

DHCS deems the MHP in partial compliance with MHSUDS 19-026.

Corrective Action Description

- Training for relevant staff on SAR policy/requirements
- Create workgroup to discuss tracking authorization due dates

Proposed Evidence/Documentation of Correction

- List of training dates for staff

Ongoing Monitoring (if included)

- To be determined following workgroup

Person Responsible (job title)

- Leslie Roth, Program Manager

Implementation Timeline:

- Develop workgroup: 7-30-22
- Staff training of SAR policy/requirements: 9-30-22

Requirement

Pursuant to (W&I) Code Section 14717.1(b)(2)(F), the MHP has a procedure for expedited transfers within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction. (MHSUDS IN No. 18-027; see WIC § 14717.1, subd. (b)(2)(F), (g).)

DHCS Finding 5.3.8

The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-027, and California Welfare and Institution Code, section 14717, subdivision 1(b). The MHP must have a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it was not aware of any expedited transfers occurring in the past three (3) years and that it would submit its policy demonstrating compliance for this requirement. The MHP submitted a practice guideline post review, however, it did not include the MHP's procedure for expedited transfers.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-027, and California Welfare and Institution Code, section 14717, subdivision 1(b).

Corrective Action Description

- Create workgroup to amend current Presumptive Transfer P&P and form
- Roll-out and train relevant staff on updated P&P

Proposed Evidence/Documentation of Correction

- Updated Presumptive Transfer P&P
- Updated Presumptive Transfer form
- List of staff training

Ongoing Monitoring (if included)

- Any ongoing monitoring recommended from workgroup to be added

Person Responsible (job title)

- Leslie Medina, Program Manager
- Leslie Roth, Program Manager

Implementation Timeline:

- Create workgroup: 7-31-22
- Update Presumptive Transfer P&P and form: 9-30-22
- Roll-out policy and train staff: 11-30-22

Requirement

A waiver processed based on an exception to presumptive transfer shall be contingent upon the MHP in the county of original jurisdiction demonstrating an existing contract with a SMHS provider, or the ability to enter into a contract within 30 days of the waiver decision, and the ability to deliver timely SMHS directly to the foster child. That information shall be documented in the child's case plan. (WIC, § 14717.1, subd. (d)(6).)

DHCS Finding 5.3.9

and Institution Code, section 14717, subdivision 1(d)(6). The MHP must ensure a waiver processed based on an exception to presumptive transfer shall be contingent upon the MHP in the county of original jurisdiction demonstrating an existing contract with a SMHS provider, or the ability to enter into a contract within 30 days of the waiver decision, and the ability to deliver timely SMHS directly to the foster child. That information shall be documented in the child's case plan.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures presumptive transfer waivers are processed as specified in the contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it has not had any presumptive transfer waiver requests in the past three (3) years and that it would submit its policy demonstrating compliance for this requirement. The MHP submitted a practice guideline post review, however, it did not include the MHP's ability to enter into a contract within 30 days of the waiver decision.

DHCS deems the MHP out of compliance with California Welfare and Institution Code, section 14717, subdivision 1(d)(6).

Corrective Action Description

- Create workgroup to amend current Presumptive Transfer P&P
- Roll-out and train relevant staff on updated P&P

Proposed Evidence/Documentation of Correction

- Updated Presumptive Transfer P&P
- List of staff training

Ongoing Monitoring (if included)

- Any ongoing monitoring recommended from workgroup to be added

Person Responsible (job title)

- Leslie Roth, Program Manager

Implementation Timeline:

- Create workgroup: 7-31-22
- Update Presumptive Transfer P&P: 9-30-22
- Roll-out policy and train staff: 11-30-22

Requirement

The MHP must provide beneficiaries with a NOABD under the following circumstances:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.(42 C.F.R. § 438.400(b)(1).)

2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2).) 3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3).)

4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4).)

5) The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5).).

6) The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7).)

(MHSUDS IN No. 18-010E; MHP Contract, Ex. A, Att. 12, sec. 9.)

DHCS Finding 5.4.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination under the circumstances listed below:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.

2. The reduction, suspension or termination of a previously authorized service.

3. The denial, in whole or in part, of a payment for service.

4. The failure to provide services in a timely manner.

5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides Notice of Adverse Beneficiary Determinations (NOABDs) to beneficiaries for failure to provide services in a timely manner. Per the discussion during the review, the MHP stated that SARs are usually authorized within two (2) business days, however it acknowledged that its multi-step process may cause some to be approved beyond the required timeframe. Post review, the MHP submitted its SAR policy and desk guide, however, this evidence did not demonstrate relevant NOABDs are sent for untimely SAR authorization or there are procedures in place for this process.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400.

Corrective Action Description

- Training for relevant staff on SAR policy/requirements
- Create Avatar report to track authorization due dates

- Training for relevant staff on how to use new Avatar report
- Train staff to monitor new Avatar report and to provide NOABDS as appropriate

Proposed Evidence/Documentation of Correction

- List of training dates for all three trainings
- Sample of new Avatar report

Ongoing Monitoring (if included)

- Relevant Supervisors/Managers to monitor new Avatar report on a daily basis

Person Responsible (job title)

- Leslie Roth, Program Manager

Implementation Timeline:

- Staff training of SAR policy/requirements: 9-30-22
- Creation of new Avatar report: 10-31-22
- Staff training of new Avatar report: 12-31-22
- Staff training of NOABD requirements: 12-31-22

Requirement

At the request of the beneficiary, when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att. 2, sec. 1(E); CCR, tit. 9, § 1810.405, subd. (e)).

DHCS Finding 5.5.2

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 405(e). The MHP must ensure, at the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse).

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides a second opinion by a licensed mental health professional, other than a psychiatric technician or a licensed vocational nurse. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that psychiatrists and the medical director conduct second opinions. The MHP stated that an updated policy would be provided post review, however, no additional evidence of this process was provided.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 405(e).

Corrective Action Description

Placer County updated Services and Practices Policy 1240 Service Provider Change Requests to include information on beneficiaries requests a second opinion. The title of the policy and language within the policy now include “requests for second opinion” when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria. Placer County QA program supervisor will meet with the program supervisor and program manager for SMHS to ensure that their teams are trained and implementing this policy.

Placer County will also update the Beneficiary Protection training that staff are required to take on an annual basis. This training provide education on beneficiary rights. Placer will ensure that information on a beneficiary’s right to request a second opinion

Proposed Evidence/Documentation of Correction

Updated policy SP 1240 Service Provider Change Requests and Requests for Second Opinion.

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

- QA Program Supervisor
- Clinic Services Program Supervisor
- Behavioral Health Program Manager

Implementation Timeline:

10/31/22

BENEFICIARY RIGHTS AND PROTECTIONS

Requirement

1) The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12, sec. 1(B)(5); 42 C.F.R. § 438.406(b)(1).)

2) The acknowledgment letter shall include the following: a) Date of receipt b) Name of representative to contact

c) Telephone number of contact representative

d) Address of MHP(MHSUDS IN No. 18-010E.)

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

DHCS Finding 6.1.5

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements:

1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.

2. The acknowledgment letter shall include the following: a. Date of receipt

b. Name of representative to contact

c. Telephone number of contact representative

d. Address of Contractor

3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP acknowledges receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. Per the discussion during the review, the MHP stated it would research the one (1) beneficiary grievance that was not sent an acknowledgement letter within five (5) calendar days of receipt. Post review, the MHP provided a statement explaining it could not determine why the grievance was processed incorrectly.

In addition, DHCS reviewed grievance, appeals, and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below:

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**26**	**25**	**1**	**96%**
APPEALS	**N/A**	**N/A**	**N/A**	**N/A**

EXPEDITED APPEALS	**N/A**	**N/A**	**N/A**	**N/A**

Corrective Action Description

The Placer County QA Program Supervisor and the Placer County Patient's Rights Advocate met on June 3, 2022, and updated the Grievance and Appeals log to include "Grievance Received Letter Due" and "Grievance Received Letter Sent" columns. This will allow for better tacking and ensure that acknowledge of receipt letters are sent to beneficiaries in a timely manner and are compliant with MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. It is part of the Patients' Rights Advocate role to receive and addresses the grievances and appeals. The Patients' Right Advocate reviews this log daily and will monitor when grievance and appeals are received and the timeline for when the acknowledgement of receipt letters are due.

Proposed Evidence/Documentation of Correction

Updated Grievance and Appeal Logs

Ongoing Monitoring (if included)

QA Supervisor and Patients' Rights Advocate will meeting monthly to review grievance and appeals received and monitor for compliance.

Person Responsible (job title)

- QA Program Supervisor
- SOC Patient's Rights Advocate

Implementation Timeline:

6/3/2022

Requirement

Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); CCR, tit. 9, § 1850.205, subd. (d)(1); MHP Contract, Ex. A, Att. 12, sec. 2(A).)

DHCS Finding 6.2.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP records grievances, appeals, and expedited appeals in a log within one (1) working day of the date of receipt of the grievance, appeal, or expedited appeal. Per the discussion during the review, the MHP stated it would research the two (2) grievances that were not logged within one (1) working day of receipt of the grievance. Post review, the MHP provided a statement explaining one grievance was not date stamped due to a clerical error and it could not determine the reason for the other error.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

Corrective Action Description

The Placer County QA Program Supervisor and the Placer County Patient's Rights Advocate met on June 3rd, 2022, to discuss and develop a plan of action for this item. The Patient's Rights Advocate will meet with the administrative supervisor to ensure proper training on receiving and timestamping grievances, appeals, and expedited appeals. In addition, the grievance and appeals logs have been updated to include a column titled "date received" for more adequate monitoring and compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

Proposed Evidence/Documentation of Correction

Updated grievance and appeal logs

Ongoing Monitoring (if included)

The Placer County QA Program Supervisor and the Patients' Rights Advocate will meet monthly to review grievance and appeals received and monitor for compliance.

Person Responsible (job title)

- QA program supervisor
- Patient Rights Advocate

Implementation Timeline:

Requirement

Provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted. (CCR, tit. 9, § 1850.206, subd. (c); MHP Contract, Ex. A, Att. 12, sec. 3(C).)

DHCS Finding 6.3.3

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c). The MHP must provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides written notification to the beneficiary or the appropriate representative of the resolution of a grievance. Per the discussion during the review, the MHP stated it would research the one (1) grievance that was not provided written notification of the resolution of a grievance. Post review, the MHP provided a statement explaining that the MHP had processed the grievance incorrectly.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below:

	# OF SAMPLE REVIEWED	RESOLUTION NOTICE		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	**26**	**25**	**1**	**96%**
APPEALS	**N/A**	**N/A**	**N/A**	**N/A**
EXPEDITED APPEALS	**N/A**	**N/A**	**N/A**	**N/A**

Corrective Action Description

The Placer County QA Program Supervisor and the Placer County Patient's Rights Advocate met on June 3rd, 2022. The grievance and appeal log were updated to include columns titled "Status" and "Resolved/Referred". The logs also include a column titled "Date Beneficiary Notified". The Patients' Rights Advocate monitors these logs daily and will use these three columns to ensure that beneficiaries are provided written notification of the resolution of the grievance and appeal and to ensure that Placer County is compliant with DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c).

Proposed Evidence/Documentation of Correction

Updated Grievance and Appeals logs

Ongoing Monitoring (if included)

QA Supervisor and Patients' Rights Advocate will meeting monthly to review grievance and appeals received and monitor for compliance.

Person Responsible (job title)

- QA Program Supervisor
- Patients' Rights Advocate

Implementation Timeline:

6/3/2022

PROGRAM INTEGRITY

Requirement

The MHP ensures collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control. (42 C.F.R. §§ 455.101, 455.104.)

DHCS Finding 7.4.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 101 and 104. The MHP must ensure collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures collection of disclosures of ownership, control, and relationship information for persons who have ownership or control interest in the MHP. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that the Placer Clerk-Recorder's Office collects and tracks the mental health staffs' 700 Forms. The MHP stated that staff receive emails notifying them to complete the required disclosure form. The MHP stated it would provide

additional evidence from the Clerk-Recorder's Office and examples of this process post review, however, no additional evidence was submitted.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 101 and 104.

Corrective Action Description

Placer county has updated the contract boilerplate for sub-contractors, that is being executed in all sub-contracts moving forward, to outline the requirement more clearly. QM and HHS Contracts team have met to outline further boilerplate updates that will be implemented by the next contract renewal cycle. QM and HHS Contracts will be working on developing a training for providers and contract monitors, forms to include within and external to the boilerplate and monitoring workflow to ensure all required submissions are collected in compliance with regulations.

Proposed Evidence/Documentation of Correction

Contract boilerplate update, Disclosure forms, Training, Provider meeting minutes

Ongoing Monitoring (if included)

Measures of Effectiveness text, and frequency if included

Person Responsible (job title)

QM Program Manager

Implementation Timeline:

6/30/2022

Requirement

The MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. (42 C.F.R. § 455.434(b)(1)-(2).)

The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104. (MHP Contract, Ex. A, Att. 13.)

DHCS Finding 7.4.3

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13. The MHP must require providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. Per the discussion during the review, the MHP stated that a staff member was in the process of developing a policy to address this requirement and it would submit the policy post review. The MHP submitted a highlighted contract boilerplate post review, however, it was deficient in meeting this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13.

Corrective Action Description

Placer county has updated the contract boilerplate for sub-contractors, that is being executed in all sub-contracts moving forward, to outline the requirement more clearly. QM and HHS Contracts team have met to outline further boilerplate updates that will be implemented by the next contract renewal cycle. QM and HHS Contracts will be working on developing a training for providers and contract monitors, forms to include within and external to the boilerplate and monitoring workflow to ensure all required submissions are collected in compliance with regulations.

Proposed Evidence/Documentation of Correction

Contract boilerplate update, Disclosure forms, Training, Provider meeting minutes

Ongoing Monitoring (if included)

Measures of Effectiveness text, and frequency if included

Person Responsible (job title)

QM Program Manager

Implementation Timeline:

6/30/2022

Requirement

Disclosures must include:

a) The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.

b) The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address; c) Date of birth and Social Security Number (in the case of an individual);

d) Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);

e) Whether the person (individual or corporation) with an ownership or control interest in the MHP's network provider is related to another person with ownership or control interest in the same or any other network provider of the MHP as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

f) The name of any other disclosing entity in which the MHP or subcontracting network provider has an ownership or control interest; and

g) The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

h) The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.

(42 C.F.R. § 455.104 (b).)

DHCS Finding 7.4.4

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13. The MHP's network providers must be required to submit updated disclosures. Disclosure must include all aspects listed below:

1. The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.

2. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;

3. Date of birth and Social Security Number (in the case of an individual);

4. Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);

5. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

6. The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and

7. The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

8. The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires network providers to submit updated disclosures with the required elements. Per the discussion during the review, the MHP stated that a staff member was in the process of developing a policy to address this requirement and it would submit the policy post review. The MHP submitted a base contract, a policy and procedure, and a draft contract exhibit post review, however, this evidence was deficient in demonstrating it ensures network providers are adhering to this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104 MHP contract, exhibit A, attachment 13.

Corrective Action Description

Placer county has updated the contract boilerplate for sub-contractors, that is being executed in all sub-contracts moving forward, to outline the requirement more clearly. QM and HHS Contracts team have met to outline further boilerplate updates that will be implemented by the next contract renewal cycle. QM and HHS Contracts will be working on developing a training for providers and contract monitors, forms to include within and external to the boilerplate and

monitoring workflow to ensure all required submissions are collected in compliance with regulations.

Proposed Evidence/Documentation of Correction

Contract boilerplate update, Disclosure forms, Training, Provider meeting minutes

Ongoing Monitoring (if included)

Measures of Effectiveness text, and frequency if included

Person Responsible (job title)

QM Program Manager

Implementation Timeline:

6/30/2022

Requirement

The MHP must submit disclosures and updated disclosures to DHCS or HHS including information regarding certain business transactions within 35 days, upon request.

1. The ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request (42 C.F.R. § 455.105 (b)(1).); and
2. Any significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105 (b)(2).)
3. The MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1. and 2. within 35 days upon request. (42 C.F.R. § 455.105 (b).)

DHCS Finding 7.4.5

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. Per the discussion during the review, the MHP stated that a staff member was in the process of developing a policy to address this requirement and it would submit the policy post review. The MHP submitted a base contract and a contract exhibit post review, however, this evidence was deficient in demonstrating proper disclosure to DHCS.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Corrective Action Description

Placer county has updated the contract boilerplate for sub-contractors, that is being executed in all sub-contracts moving forward, to outline the requirement more clearly. QM and HHS Contracts team have met to outline further boilerplate updates that will be implemented by the next contract renewal cycle. QM and HHS Contracts will be working on developing a training for providers and contract monitors, forms to include within and external to the boilerplate and monitoring workflow to ensure all required submissions are collected in compliance with regulations.

Proposed Evidence/Documentation of Correction

Contract boilerplate update, Disclosure forms, Training, Provider meeting minutes

Ongoing Monitoring (if included)

Measures of Effectiveness text, and frequency if included

Person Responsible (job title)

QM Program Manager

Implementation Timeline:

6/30/2022

Requirement

The MHP shall submit the following disclosures to DHCS regarding the MHP's management:

1. The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)

2. The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part 455.101.

DHCS Finding 7.4.6

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2). The MHP must submit disclosure to DHCS of identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosure forms to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. Per the discussion during the review, the MHP stated that a staff member was in the process of developing a policy to address this requirement and it would submit the policy post review. The MHP submitted a base contract and a contract exhibit post review, however, this evidence was deficient in demonstrating proper disclosure to DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2).

Corrective Action Description

Placer county has updated the contract boilerplate for sub-contractors, that is being executed in all sub-contracts moving forward, to outline the requirement more clearly. QM and HHS Contracts team have met to outline further boilerplate updates that will be implemented by the next contract renewal cycle. QM and HHS Contracts will be working on developing a training for providers and contract monitors, forms to include within and external to the boilerplate and monitoring workflow to ensure all required submissions are collected in compliance with regulations.

Proposed Evidence/Documentation of Correction

Contract boilerplate update, Disclosure forms, Training, Provider meeting minutes

Ongoing Monitoring (if included)

Measures of Effectiveness text, and frequency if included

Person Responsible (job title)

QM Program Manager

Implementation Timeline:

6/30/2022