Medi-Cal Behavioral Health Corrective Action Plan (CAP)

Alpine

Compliance Review Date: 8/23/2022

Corrective Action Plan Fiscal Year: 2021-22

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
SMHS Systems Review			
Requirement: Federal Code of Regulations, Title 42, subdivision 206(c)(1)(i) **Finding 1.1.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. Triennial review will focus on timeliness of all urgent appointments and physician appointments.	**Corrective Action Description:** During the time of gathering evidence for the FY21-22 Triennial Review, it was noted by ACBHS compliance staff that the format of the tracking sheet was not inclusive of all data elements required, and was not developed in a way to track all required elements. Prior to the Triennial Review, ACBHS compliance staff revamped the tracking log to meet the requirement and put it into effect at that time. The revised tracking log will continue to be utilized for the current fiscal year and each subsequent year moving forward.	Already implemented for this year, and each subsequent year thereafter.	Alpine CAP Document #1 – 1.1.3a Revamped Access and Information Log

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1. Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment 2. Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evidence that the MHP meets Department standards for timely access to care and services, taking into account the urgency of need for services. Of the 29 psychiatry appointments reviewed by DCHY, one (1) did not meet the 96-hour timeframe. Per the discussion during the review, the MHP stated that the log it originally provided to DHCS as evidence has been revamped to better track	**Ongoing Monitoring:** The revised tracking log is maintained on a daily basis by an Administrative assistant III, positioned at the front desk of ACBHS. The AAIII's role with this log is not only data entry, but to ensure that all required data elements are complete and reported correctly by the clinicians. Outstanding elements are color-coded for ease of tracking by the AAIII. Compliance staff (Fiscal & Administrative Supervisor) monitor the log regularly via verbal reports from the AAIII, and by reviewing the log itself at least monthly, or more often as necessary. Any missing data elements are immediately followed up on with the clinicians to ensure all requirements are met, documented and recorded.		

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timeliness standards moving forward. The MHP was provided the opportunity to submit additional evidence, including Notice of Adverse Beneficiary Determinations (NOABDs) sent to beneficiaries for failing to meet the timeliness standards; however, no additional evidence was provided post review.			
Requirement: Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018 **Finding 1.2.2:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must have an affirmative responsibility to determine if children and youth meet medical necessity criteria need in ICC and IHBS. While the MHP submitted evidence to	**Corrective Action Description:** Although ACBHS does not provide this service in county (service is unavailable), it is understood that the requirement of assessment (and possible referral) must still be met. ACBHS has failed to meet this requirement. ACBHS compliance staff will work with the contracted Clinical Coordinator, Kathryn Hill, and with Kingsview (EHR provider) to develop and implement an adequate assessment tool that meets this requirement. Once the tool is developed and installed into the EHR, ACBHS clinicians will ensure it is	March 31, 2023	Once an appropriate assessment tool has been developed and implemented, the tool will be submitted as evidence.

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demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth for ICC and IHBS services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it is not assessing for ICC and IHBS services at this time and does not have a screening tool to assess the need for these services.	utilized and documented in the case file for each child or youth assessed. **Ongoing Monitoring:** Per the compliance plan and policy, client case files are reviewed regularly for accuracy and completeness. The use and implementation of the assessment tool will be enveloped into the chart review process to ensure compliance.		
Requirement: Federal Code of Regulations, Title 42, section 438, subdivision 206(b)(1) **Finding 1.2.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must maintain and monitor network of appropriate providers that is supported by written agreements and is sufficient to provide access to ICC and IHBS services for all eligible beneficiaries, including those with	**Corrective Action Description:** ACBHS does not provide this service in county (service unavailable). Should the need arise, ACBHS would contract with a provider out-of-county to provide these services. ACBHS does not retain a provider on contract on an ongoing basis as these services have yet to have been needed for any Alpine residents. Thus, a contract or agreement would be developed at the time of referral specific to the case and provider. Alpine	Template contract is already implemented and in use.	Alpine CAP Document #2 – 1.2.3a Contract Template for ICC/IHBS/TFC services

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limited English proficiency. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide access to ICC and IHBS services for all eligible beneficiaries, including those with limited English proficiency. Per the discussion during the review, the MHP stated that if there were a need for ICC or IHBS services, it would contract out to meet this need. The MHP was provided the opportunity to submit a sample contract or single case agreement to demonstrate this practice; however no additional evidence was submitted post review.	County utilizes a general contract template developed by Alpine County Counsel, and attaches a scope of work and budget to the contract to specifically detail the services to be provided. **Ongoing Monitoring:** Per the compliance plan and policy, all contracted providers are monitored regularly to ensure compliance with all regulations and requirements. Should the need for this service arise and a contract be developed, ACBHS Compliance staff will monitor that contract and service documentation as required. That practice will continue each subsequent year thereafter.		
Requirement: Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based	**Corrective Action Description:** It is understood that CFT meetings must occur as necessary. ACBHS	March 31, 2023	Minutes of the meetings held will be submitted as evidence by

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Finding 1.2.4: The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must have Child and Family Team (CFT) composition that always, as appropriate, includes a representative of the MHP and/or a representative from the mental health treatment team. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has Child and Family Team (CFT) composition that always, as appropriate, includes a representative of the MHP and/or a representative from the mental health treatment team. Per the discussion during the review, the MHP stated it has conducted CFT meetings during the triennial review period and they included all appropriate parties. The MHP was provided the opportunity to submit the CFT meeting minutes	Clinicians will provide documentation of meetings held during the review period of FY2019-2022 and will ensure all meetings are documented correctly and accurately this fiscal year and each subsequent year thereafter. **Ongoing Monitoring:** Per the compliance plan and policy, client case files are reviewed regularly for accuracy and completeness. The documentation of CFT meetings will be enveloped into the chart review process to ensure compliance.		the implementation deadline.

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or sign in sheets to demonstrate this process has occurred; however, no additional evidence was provided post review.			
Requirement: 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 **Finding 1.2.5:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must convene a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child and welfare or juvenile probation systems. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP conducts CFT meetings for all	**Corrective Action Description**: Current ACBHS policy does not reflect this requirement. Thus, ACBHS is out of compliance with this requirement. ACBHS compliance staff will review and revise the appropriate policies to ensure compliance with this requirement. Once the policy is revised, training on the revised procedure will be provided to the ACBHS clinicians by the Contracted Clinical Coordinator, and the training will be renewed on an annual basis. ACBHS clinicians will implement the procedure at that time and will ensure all documentation reflects the implementation. Individual charts will be monitored according to policy for the current year and each subsequent year thereafter.	March 31, 2023	Revised policy(s) and documentation of training on the revised procedure will be submitted as evidence by the implementation deadline.

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children and youth receiving ICC, IHBS, or TFC regardless of child welfare or juvenile probation involvement. Per the discussion during the review, the MHP stated it would review its process and update its policy language as needed. The MHP was provided the opportunity to submit CFT meeting minutes or sign in sheets and appropriate related policies to demonstrate compliance; however, no additional evidence was provided post review.	**Ongoing Monitoring:** Per the compliance plan and policy, client case files are reviewed regularly for accuracy and completeness. The documentation of CFT meetings will be enveloped into the chart review process to ensure compliance. Additionally, documentation of initial and annual training will be maintained to ensure all appropriate staff are trained on the requirement.		
Requirement: 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 **Finding 1.2.6:** The MHP did not furnish evidence to demonstrate compliance with this requirement.	**Corrective Action Description:** It is understood that an ICC Coordinator is required should this service be provided. Due to the extremely small, rural composition of Alpine County (1100 residents total, and 7-25 clients total at a given time), these services are not available in the county. Thus, they would be contracted out of county should the need arise. The need for these services is	March 31, 2023	Revised policies and documentation of training will be submitted as evidence by the implementation deadline.

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The MHP must have an established ICC Coordinator, as appropriate, who serves as the single point of accountability. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established an ICC Coordinator who serves as the single point of accountability. This requirement was not included in any evidence provided by the MHP. Per discussion during the review, the MHP stated is previously had a designated ICC Coordinator, however it does not have an ICC Coordinator at this time. The MHP was provided the opportunity to submit the CFT meeting minutes or sign in sheets to demonstrate this process has occurred; however, no additional evidence was provided post review.	so rare that it is not feasible for the county to employ an ICC Coordinator specifically; rather the procedure is to appoint the primary clinician as the ICC Coordinator for the specific case. The Clinician acts as the single point of accountability for the individual case. Current ACBHS Policies and Procedures do not reflect this requirement. ACBHS compliance staff will review and revise appropriate and related policies to ensure this requirement is clearly included and that the procedure is clear. Once policies are revised, training will be provided to the ACBHS clinical team by the contracted Clinical Coordinator to ensure understanding and compliance. Documentation will be maintained of the initial training and annually thereafter. Once training is completed, this practice will be implemented for the current year and each subsequent year thereafter. **Ongoing Monitoring:** Per the compliance plan and policy, client case files are		

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	reviewed regularly for accuracy and completeness. The documentation of CFT meetings will be enveloped into the chart review process to ensure compliance. Additionally, documentation of initial and annual training will be maintained to ensure all appropriate staff are trained on the requirement.		
Requirement: 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 **Finding 1.2.7**: The MHP did not furnish evidence to demonstrate compliance with this requirement. 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	**Corrective Action Description:** ACBHS does not provide this service in county (service is unavailable), and it has not been needed to date. Should the need arise, ACBHS would contract with a provider out-of-county to provide this service. ACBHS does not retain a provider on contract on an ongoing basis as these services have yet to have been needed for any Alpine residents. Thus, a contract or agreement would be developed at the time of referral specific to the case and provider. Alpine County utilizes a general contract template developed by Alpine County Counsel, and attaches a scope of work and budget to	Template contract is already implemented and in use.	Alpine CAP Document #3 – 1.2.7a Contract Template for ICC/IHBS/TFC services

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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 it currently does not provide TFC services, but it would create a single case agreement to contract for this services if there were a need. The MHP was provided the opportunity to submit a sample contract or single case agreement to demonstrate this practice; however no additional evidence was submitted post review.	the contract to specifically detail the services to be provided. **Ongoing Monitoring:** Per the compliance plan and policy, all contracted providers are monitored regularly to ensure compliance with all regulations and requirements. Should the need for this service arise and a contract be developed, ACBHS Compliance staff will monitor that contract and service documentation as required. The practice will continue each subsequent year thereafter.		
Requirement: Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018 **Finding 1.2.8:** The MHP did not furnish evidence to demonstrate compliance with this requirement.	**Corrective Action Description:** Although ACBHS does not provide this service in county (service is unavailable), it is understood that the requirement of assessment (and possible referral) must still be met. ACBHS has failed to prove that it meets this requirement during the initial assessment process. ACBHS compliance staff will work	March 31, 2023	Once an appropriate assessment tool has been developed and implemented, the tool and documentation of training will be submitted as evidence.

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The MHP must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth to determine if they meet medical necessity criteria for TFC. Per the discussion during the review, the MHP stated that it does not have a TFC screening tool, but that TFC assessment is part of its initial assessment for services for children and youth. The MHP was provided the opportunity to submit evidence of this process, including evidence TFC criteria are evaluated for children and youth; however, no additional evidence was provided post review. This is a repeat deficiency.	with the contracted Clinical Coordinator, Kathryn Hill, and with Kingsview (EHR provider) to develop and implement an adequate assessment tool that meets this requirement. Once the tool is developed and installed into the EHR, training will be provided to the ACBHS clinicians by the contracted Clinical Coordinator, and the clinicians will ensure it is utilized and documented in the case file for each child or youth assessed. This will be completed for the current year and each subsequent year thereafter. **Ongoing Monitoring:** Per the compliance plan and policy, client case files are reviewed regularly for accuracy and completeness. The use and implementation of the assessment tool will be enveloped into the chart review process to ensure compliance.		

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Requirement: MHP Contract, Exhibit A, Attachment 8 **Finding 1.4.4:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, Title 9, Section 1810, subsection 435. 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. Of the three (3) MHP provider sites, two (2) had overdue certifications. Per the discussion during the review, the MHP acknowledged the need to improve its tracking process to	**Corrective Action Description:** It is understood that provider certifications must occur initially and be maintained thereafter. ACBHS does not have any in-county contracted providers (ACBHS is the only provider in Alpine County), so no certifications of contracted providers are completed by ACBHS. However, it is understood that obtaining proof of the provider's certification by their host county's MHP is required. ACBHS has not met this requirement and is subsequently out of compliance. ACBHS compliance staff will review and revise the contracted provider monitoring tool utilized in annual monitors of contracted providers to ensure this requirement is included in the documentation obtained by ACBHS as part of that monitoring process. Additionally, related ACBHS policies will be revised to ensure this requirement is included in the procedures to be followed. Once revised, these practices will be implemented in the current year and each subsequent year	March 31, 2023	Once completed, the revised related ACBHS policy(s) and revised monitoring tool(s) will be submitted as evidence.

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ensure provider sites maintain current certifications.	thereafter. **Ongoing Monitoring:** Per the compliance plan and policy, client case files are reviewed regularly for accuracy and completeness. The use and implementation of the assessment tool will be enveloped into the chart review process to ensure compliance.		
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059 **Finding 2.5.1:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must establish continuity of care procedures in accordance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. The procedures must address the below requirements: 1. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the MHP must be	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.	This policy and requirement are already implemented.	Alpine CAP Document #4 – 2.5.1a Policy #AC-760 Coordination and Continuity of Medi-Cal SMHS

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given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (e.g., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner); 2. SMHS shall continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice; 3. A beneficiary, the beneficiary's authorized			

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representatives, or the beneficiary's provider may make a direct request to the MHP for continuity of care; 4. Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request; and 5. The MHP must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation & auxiliary aids/services. The MHP did not submit evidence that it has established continuity of care procedures in accordance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. Per the discussion during the review, the MHP stated it has a policy in place addressing this			

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requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.			
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059 **Finding 2.5.2:** The MHP did not furnish evidence to demonstrate compliance with this requirement. Following identification or a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary. The MHP did not submit evidence that it makes a good faith effort to enter info a contract with a provider if a pre-existing relationship is	**Corrective Action Description**: It is understood that a policy and procedure must be in place to adhere to this requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.	This policy and requirement are already implemented.	Alpine CAP Document #5 – 2.5.2a Policy #AC-760 Coordination and Continuity of Medi-Cal SMHS

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identified. Per the discussion during the review, the MHP stated it has a policy in place addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.			
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059 **Finding 2.5.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure each continuity of care request must be completed within the below listed timelines: 1. Thirty calendar days from the date the MHP received the request; 2. Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.	This policy and requirement are already implemented.	Alpine CAP Document #6 – 2.5.3a Policy #AC-760 Coordination and Continuity of Medi-Cal SMHS

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appointments or other pressing care needs; or 3. Three calendar days if there is a risk of harm to the beneficiary. The MHP did not submit evidence that it ensure that each continuity of care request is completed within the required timelines. Per the discussion during the review, the MHP stated it has a policy in place addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.			
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059 **Finding 2.5.4:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure if the provider meets all of the required conditions and the beneficiary's request is	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial	This policy and requirement are already implemented.	Alpine CAP Document #7 – 2.5.4a Policy #AC-760 Coordination and Continuity of Medi-Cal SMHS

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granted, the MHP must allow the beneficiary to have access to that provider for a period of up to 12-months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. The MHP did not submit evidence that it allows beneficiaries to have access to the requested provider for a period of up to 12-months depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. Per the discussion during the review, the MHP stated it has a policy in place addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.	monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.		
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this	This policy and requirement are already implemented.	Alpine CAP Document #8 – 2.5.5a Policy #AC-760 Coordination and

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Finding 2.5.5: The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure when the continuity of care agreement has been established, the MHP must work with the provider to establish a Client Plan and transition plan for the beneficiary. The MHP did not submit evidence that it works with the out-of-network provider to establish a client plan and a transition plan for the beneficiary once the continuity of care agreement has been established. Per the discussion during the review, the MHP stated it has a policy in place addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.	requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.		Continuity of Medi-Cal SMHS
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this	This policy and requirement are already implemented.	Alpine CAP Document #9 – 2.5.6a Policy #AC-760 Coordination and

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Finding 2.5.6: The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, as specified below listed requirements: 1. The MHP's approval of the continuity of care request; 2. The duration of the continuity of care arrangement; 3. The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and 4. The right to choose a different provider from the MHP's provider network. The MHP did not submit evidence that it notifies the beneficiary and/or the beneficiary's authorized	requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.		Continuity of Medi-Cal SMHS

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representative, in writing, information outlined in MHSUDS 18-059 upon approval of a continuity of care request. Per the discussion during the review, the MHP stated it has a policy in place addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.			
Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059 **Finding 2.5.7:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure the written notification to a beneficiary regarding his/her continuity of care request complies with the below listed requirements: 1. The MHP's denial of the beneficiary's continuity of care request;	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.	This policy and requirement are already implemented.	Alpine CAP Document #10 – 2.5.7a Policy #AC-760 Coordination and Continuity of Medi-Cal SMHS

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2. A clear explanation of the reasons for the denial; 3. The availability of in-network SMHS; 4. How and where to access SMHS from the MHP; 5. The beneficiary's right to file an appeal based on the adverse benefit determination; 6. The MHP's beneficiary handbook and provider directory. The MHP did not submit evidence that it ensures written notification to beneficiaries regarding denial of continuity of care requests include information outlined in MHSUDS 18-059. Per the discussion during the review, the MHP stated it has a policy in place addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.			

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Requirement: Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059 **Finding 2.5.8:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. The MHP did not submit evidence that it notifies the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition the beneficiary's care at the end of the continuity of care period. Per the discussion during the review, the MHP stated it has a policy in place	**Corrective Action Description:** It is understood that a policy and procedure must be in place to adhere to this requirement. ACBHS does already have a policy in place addressing this requirement; Policy #AC-760 Coordination and Continuity of Medi-Cal Specialty Mental Health Services. ACBHS neglected to submit the policy for the Triennial monitor. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.	This policy and requirement are already implemented.	Alpine CAP Document #11 – 2.5.8a Policy #AC-760 Coordination and Continuity of Medi-Cal SMHS

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addressing this requirement. The MHP was provided the opportunity to submit this policy; however, no additional evidence was provided post review.			
Requirement: MHP Contract, Exhibit A, Attachment 5 **Finding 3.1.8:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must implement mechanisms to monitor the safety and effectiveness of medication practices meeting the below listed requirements: 1. Under the supervision of a person licensed to prescribe or dispense medication 2. Performed at least annually 3. Inclusive of medications prescribed to adults and youth While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the	**Corrective Action Description:** Kinsgview Corporation is contracted by ACBHS to provide telepsychiatry to residents of Alpine County. This is the only way ACBHS clients can obtain medication monitoring as it is not a service available within the county. Kingsview not only contracts with the psychiatrist for this service, but also completes external reviews of all client charts for medication services and maintains records of all such chart reviews. Upon request, the results and documentation of these monitors are available and provided to ACBHS. Kingsview provided a copy of the related policies and procedures, the medication monitoring tool used for the reviews, as well as completed monitors for Alpine County clients. All policies and tools are	This policy and requirement are already implemented.	-Alpine CAP Document #12 – 3.1.8a Kingsview Policy (1) for Medication Monitoring, Alpine CAP Document #13 – 3.1.8b Kingsview Policy (2) for Medication Monitoring, Alpine CAP Document #14 – 3.1.8c Kingsview Monitoring Tool, Alpine CAP Document #15 – 3.1.8d Kingsview Monitoring Tool – Youth, Alpine CAP Document #16 – 3.1.8e Kingsview Revised Monitoring Tool, and Alpine CAP Document #17 – 3.1.8f Sample Completed Kingsview Monitor

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
MHP has implemented mechanisms to monitor the safety and effectiveness of medication practices. Per the discussion during the review, the MHP stated medication monitoring it performed by a contractor. The MHP was provided the opportunity to submit evidence of this process, including monitoring reports, tools and training materials; however, no additional evidence was provided post review.	attached to this monitor, as well as one completed monitor conducted by Kingsview. These are submitted as evidence of compliance. **Ongoing Monitoring:** This policy has been implemented already and will be updated as necessary.		
Requirement: MHP Contract, Exhibit A, Attachment 5 **Finding 3.2.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence that Quality Improvement activities, including performance improvement projects (PIPs), have contributed to	**Corrective Action Description:** As stated during the review, ACBHS does have draft PIPs written, but has been unable to implement them due to a lack of staff. In 2019 when the PIPs were originally drafted, ACBHS employed 17-20 staff, including the specific staff required to implement the PIPs. However, at the onset of the Covid-19 pandemic, ACBSH saw immediate loss of staff due to mandated furloughs, reassignment of staff to other departments	March 31, 2023	Drafted PIPs will be submitted as evidence by the implementation deadline.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
meaningful improvement in clinical care and beneficiary service. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence of Quality Improvement Activities, including performance improvement projects. Per the discussion during the review, the MHP stated it has developed performance improvement projects, but they are not active due to lack of staff available to implement the projects.	in the county, elimination of positions, and other losses due to retirement or loss of workforce in the county. In 2021, ACBHS was down to 6 employees total; all supervisory and management positions were vacant, including the Clinical Coordinator required to implement the PIPs. Throughout 2022, ACBHS has maintained its 6 staff, and has gained an interim Director and an interim (contracted) Clinical Coordinator. However, the contracted Clinical Coordinator is also the full-time Clinical Director of another county and is able to dedicate only the minimal contracted hours for Alpine County. Thus, the PIPs remain in draft form and will not be implemented until ACBHS is able to obtain and maintain the necessary staff. However, as part of the BHQIP process, Alpine County is working with CalMHSA and IDEA Consulting to explore the options and possibilities of developing PIPs that can be implemented with the		

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
	current staffing and resources available. It is understood that PIPs are required and that ACBHS is currently out of compliance. Once the PIPs are drafted that can be implemented with the current staffing and resources available, they will be submitted as evidence of compliance. **Ongoing Monitoring:** n/a		
Requirement: MHP Contract, Exhibit A, Attachment 5 **Finding 3.3.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure the MHP Quality Assessment and Performance Improvement (QAPI) program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the Quality Improvement program. While the MHP submitted evidence to demonstrate compliance with this	**Corrective Action Description:** ACBHS has not met this requirement during the review period, and is consequently out of compliance. ACBHS compliance staff will reinstitute the QIC process and will ensure beneficiaries and family members are invited to participate as representatives in the process. An updated QIC roster, and a sign in sheet will be maintained along with the documentation of meetings. Documentation will be submitted as evidence of compliance by the implementation deadline. **Ongoing Monitoring:** n/a	March 31, 2023	Documentation of an updated QIC roster, a sign in sheet and QIC meeting minutes will be submitted as evidence by the implementation deadline.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
requirement, it is not evident that the MHP includes active participation from beneficiaries and family members in the planning, design, and execution of the Quality Improvement program. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that beneficiaries are not currently involved in the Quality Improvement Committee (QIC). The MHP was provided the opportunity to submit evidence of beneficiary and family involvement in past quality improvement activity, including a QIC rosters; however, no further evidence was submitted post review.			
Requirement: MHP Contract, Exhibit A, Attachment 5, Federal Code of Regulations, Title 42, Section 438, subdivision 236(b); California Code of Regulations, Title 9, Section 1810, Subdivision 326	**Corrective Action Description:** ACBHS does have Practice Guidelines in place that are communicated to all providers. These practice guidelines are attached to this monitor and submitted as evidence.	Practice Guidelines are already in policy and in effect.	Alpine CAP Document #18 – 3.5.1a Policy #AC-2110 Practice Guidelines for Medi-Cal Mental Health Services, Alpine CAP Document #19 – 3.5.1b

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
Finding 3.5.1: The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must have practice guidelines, which meet the requirements of the MHP Contract. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has implemented practice guidelines that meet the requirement of the MHP contract. Per the discussion during the review, the MHP stated it has practice guidelines in place. The MHP was provided the opportunity to submit the practice guidelines it has implemented; however, no further evidence was submitted post review.	**Ongoing Monitoring:** n/a		Practice Guidelines – Trauma Focused CBT, Alpine CAP Document #20 – 3.5.1c Practice Guidelines – Medications Acute Stress PTSD, Alpine CAP Document #21 – 3.5.1d Practice Guidelines – Medications Borderline Personality Disorder, Alpine CAP Document #22 – 3.5.1e Practice Guidelines – Medications Bipolar, Alpine CAP Document #23 – 3.5.1f Practice Guidelines – Medications Major Depressive Disorder, Alpine CAP Document #24 – 3.5.1g Practice Guidelines – Medications OCD, Alpine CAP Document #25 – 3.5.1h Practice Guidelines – Medications Panic Disorder, Alpine CAP

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
			Document #26 – 3.5.1i Practice Guidelines – Medications Schizophrenia, Alpine CAP Document #27 – 3.5.1j Practice Guidelines – Motivational Interviewing, and Alpine CAP Document #28 – 3.5.1k Practice Guidelines – Medication Suicide
Requirement: Federal Code of Regulations, Title 42, Section 438, subdivision 10(f)(1) **Finding 4.1.1:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. While the MHP submitted	**Corrective Action Description:** As stated during the review, ACBHS does have a template letter to comply with this requirement. Please see attached submission as evidence. **Ongoing Monitoring:** n/a	Practice Guidelines are already in policy and in effect.	Alpine CAP Document #29 – 4.1.1a Template Letter Notice of Termination of Provider

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. Per the discussion during the review, the MHP stated that the need to terminate a contract provider has not occurred but it does have a template letter if this were to occur. The MHP was provided the opportunity to submit the template letter; however, no further evidence was submitted post review.			
Requirement: MHP Contract, Exhibit A, Attachment 11, and Federal Code of Regulations, title 42, Section 438, Subdivision 10(d)(3) **Finding 4.2.2:** The MHP did not furnish evidence to demonstrate	**Corrective Action Description:** As stated during the review, Alpine County does not have a threshold language. However, ACBHS does provide necessary materials in Spanish (even though it is not a prevalent non-English language in Alpine County).	March 31, 2023	No attachments at this time.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
compliance with this requirement. The MHP must make its written materials that are critical to obtaining services available in the prevalent non-English languages in the County. This includes, at a minimum, the below listed materials: 1. Provider Directory; 2. Beneficiary Handbook; 3. Appeal and Grievance Notices; 4. Denial and Termination Notices; and 5. MHP's mental health education materials While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes its written materials that are critical to obtaining services available in the prevalent non-English languages in the county. The MHP did not submit evidence of denial notice, termination notice, or	Review of the materials was initiated upon completion of the review, but is not yet completed. ACBHS will continue to review all critical written materials to ensure accuracy in Spanish and will update/revise as necessary. Once complete, all critical written materials in Spanish will be submitted as evidence of compliance, by the determined deadline. **Ongoing Monitoring:** On a regular basis, ACBHS will review all critical written material to monitor for compliance with relevant regulations and requirements and will update or revise them as necessary. This will occur for the current year and each subsequent year thereafter.		

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
provider Directory in Spanish. Per the discussion during the review, the MHP stated it would review its non-English material to verify if it has these templates. The MHP was provided the opportunity to submit the template letter; however, no further evidence was submitted post review.			
Requirement: Department of Mental Health, Information Notice, No. 10-02 **Finding 4.2.5:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must have a mechanism for ensuring accuracy of translated materials in terms of both language and culture. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a mechanism for ensuring accuracy of translated materials in terms of both language and culture. Per the	**Corrective Action Description:** ACBHS currently contracts with a consultant who can provide this information and support in obtaining compliance with this requirement. ACBHS will collaborate with the contracted consultant to meet this requirement. Once complete, all necessary documentation will be submitted as evidence of compliance, by the determined deadline. **Ongoing Monitoring: On** a regular basis, in collaboration with the contracted consultant, ACBHS will review all critical written material to monitor for compliance with	March 31, 2023	No attachments at this time.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
discussion during the review, the MHP stated it would contact its contractor for samples of the translated material verification process as well as contract language outlining this requirement. The MHP was provided the opportunity to submit the template letter; however, no further evidence was submitted post review.	relevant regulations and requirements and will update or revise them as necessary. This will occur for the current year and each subsequent year thereafter.		
Requirement: California Code for Regulations, Title 9, Chapter 11, Section 1810, Subdivision 405(f) **Finding 4.3.4:** The MHP did not furnish evidence to demonstrate compliance with this requirement. 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	**Corrective Action Description:** ACBHS maintains a daily log for all requests for services, including requests of information. The log includes all reports from the after-hours service who cover the phones during non-business hours. Each morning, a report is received from the after-hours service listing any activity since phones were rolled to them the night before. If there is anything missing from the log, or if a test call report is received and it is noted that it was excluded from the nightly report, ACBHS compliance staff contacts the after-hours service to inform	March 31, 2023	No attachments at this time.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
to demonstrate compliance with this requirement, one (1) of five (5) required DHCS test calls were not logged on the MHP's written log of initial request. Partial compliance deemed.	them of the issue and to request a CAP to address the issue. This process is followed each time a discrepancy is noted. ACBHS will research this specific test call and inquire about why it was omitted from the afterhours report, and will request the CAP as appropriate. Once completed, documentation will be submitted as evidence of compliance with this requirement. **Ongoing Monitoring:** This log is maintained, updated and reviewed on a daily basis by administrative staff. On a regular basis, ACBHS compliance staff reviews the log for accuracy and completeness. Internal monitoring will continue according to policy for the current year and each subsequent year thereafter.		
Requirement: MHP Contract, Exhibit A, Attachment 6, and Federal Code of Regulations, Title 42, Section 438, Subdivision 210(b)(3) **Finding 5.1.2:** The MHP did not	**Corrective Action Description:** ACBHS contracts with Kingsview Corporation for all telepsychiatry services, which is what the TARs reviewed were for. The finding is correct that one of	Issue already fixed and process already in place.	No attachments at this time.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
furnish evidence to demonstrate compliance with this requirement. The MHP must have any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has any decision to deny a service authorization request to authorize a service in the amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. Of the four (4) TARs received, one (1) TAR did not have a signature by a	the TARs was missing a signature. The issue was presented to Kingsview and they stated they will ensure all TARs contain all required elements, including signatures, from this point forward. ACBHS administrative staff will also review each TAR received to ensure it contains all required elements and will inform Kingsview immediately of any discrepancies to allow time for them to be fixed. This practice will be completed for the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will continue to perform internal monitoring for the current year and each subsequent year thereafter.		

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. Partial compliance deemed.			
Requirement: Federal Code of Regulations, Title 42, Section 438, Subdivision 400 **Finding 5.4.1:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must provide beneficiaries with a Notice of Adverse Benefit Determination (NOABD) 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.	**Corrective Action Description:** ACBHS has changed the Access and Information Log (tracking sheet for requests for services) to better capture NOABDs for the circumstances specific to request services. However, ACBHS has failed to monitor or track NOABDs for circumstances of psychiatry appointments or grievances and appeals. ACBHS will review and revise its current policies and procedures and will develop a monitoring mechanism for all NOABDs, including all required data points. ACBHS compliance staff will work with Kingsview, Kathryn Hill (contracted Clinical Coordinator), IDEA (contracted consultant) and the Patient Rights Advocate (Chris Houston) to develop, train and implement the NOABD procedure for ACBHS. Once the procedure	March 31, 2023	No attachments at this time.

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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 42CFR section 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 beneficiaries with NOABDs for failure to provide services in a timely manner and	and mechanisms are developed, full training will be provided to all ACBHS staff, and will be refreshed on an annual basis. **Ongoing Monitoring:** ACBHS will provide full training on the procedures on an annual basis, and will maintain documentation of training completed. ACBHS will conduct monthly monitoring of the NOABD tracking mechanism to confirm completeness and accuracy, and to ensure NOABDs are being provided every time one is required. This will be completed in the current year, and each subsequent year thereafter.		

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
failure to act within timeframes provided in the regulation regarding standard resolution of grievances or appeals. Of the 29 psychiatry appointments reviewed, 21 did not meet the 15 business day timeframes. Of the 23 urgent appointments reviewed, one (1) did not meet the 96-hour timeframe. Of the two (s) grievances reviewed by DHCS, the MHP did not demonstrate the grievances met the timeliness standard and did not require NOABDs. The MHP was provided the opportunity to submit the evidence of the NOABDs sent to beneficiaries and that the grievances were resolved within the timeliness standards; however, no further evidence was submitted post review.			
Requirement: Judicial Council Forms, JV219 **Finding 5.6.1:** The MHP did not furnish evidence to demonstrate	**Corrective Action Description:** ACBHS does have policies in place addressing this requirement. See attachments. **Ongoing Monitoring:** ACBHS will review	Policies already in place.	Alpine CAP Document #30 – 5.6.1a Policy #AC-525 Presumptive Transfers and Alpine CAP Document #31

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
compliance with J this requirement. The MHP must maintain policies and procedures ensuring an appropriate process for the management of Forms JV220, JV220(A), JV221, JV222, and JV223 and that related requirements are met. The MHP did not submit evidence that it has policies and procedures ensuring appropriate process for the management of Forms JV220, JV220(A), JV221, JV222, and JV223 and that related requirements are met. Per the discussion during the review, the MHP stated is has a policy in place addressing this requirement. The MHP was provided the opportunity to submit the evidence of the NOABDs sent to beneficiaries and that the grievances were resolved within the timeliness standards; however, no further evidence was submitted post review.	the policies on an ongoing basis and revise or update as needed.		– 5.6.1b Policy #AC-816 Prescribing Psychotropic Medications to Children-Youth In Foster Care

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
Requirement: MHP Contract, Exhibit A, Attachment 12 and Federal Code of Regulations, Title 42, Section 438, Subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice, No 18-010E **Finding 6.1.5:** The MHP did not furnish evidence to demonstrate compliance with this requirement. 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 receive of each grievance, appeal and request for expedited appeal of adverse benefit determinations to the beneficiary in writing 2. The acknowledgement letter shall include the following:	**Corrective Action Description:** ACBHS does have a procedure in place, as well as a Patient's Rights Advocate to assist with this procedure should a grievance or complaint be filed. However, due to the overwhelming loss of all management within 1 year at ACBHS, the tracking and maintenance of documentation pertaining to this requirement was not understood by the remaining staff person assigned this responsibility. ACBHS compliance staff will review policies and procedures for this requirement and in collaboration with the contracted consultant and the PRA, will revise the procedures as needed. Once completed, ACBHS will provide training on the procedure, including documentation and maintenance of information, to all ACBHS staff. This will occur for the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or	March 31, 2023	Once complete, ACBHS will submit the policies/procedures and training documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
a. Date of receipt b. Name of presentative 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 to the beneficiary in writing or that the acknowledgement is postmarked within five (5) calendar days of receipt of the grievance. Two (2) grievances were identified in FY2019-20. DHCS requested copies of the acknowledgement letters for these grievances to ensure	update as needed, and will provide annual training to all ACBHS staff.		

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
compliance to the requirement. The MHP did not provide evidence post review.			
Requirement: Federal Code of Regulations, Title 42, Section 438, Subdivision 416 and California Code of Regulations, Title 9, Section 1850, Subdivision 205 **Finding 6.2.1:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one (1) 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 maintains a grievance and appeal log and records grievances within one (1) working day of the date of receipt of the	**Corrective Action Description:** ACBHS does have a procedure in place to ensure this is completed. However, due to the overwhelming loss of all management within 1 year at ACBHS, the tracking and maintenance of documentation pertaining to this requirement was not understood by the remaining staff person assigned this responsibility. ACBHS compliance staff will review policies and procedures for this requirement and will revise the procedures as needed. Once completed, ACBHS will provide training on the procedure, including documentation and maintenance of information, to all ACBHS staff. This will occur for the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed, and will provide	March 31, 2023	Once complete, ACBHS will submit the policies/procedures and training documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
grievance. Two (2) grievances were identified in FY19-20. DHCS requested copies of these grievances to ensure compliance to this requirement. The MHP did not provide any additional evidence post review.	annual training to all ACBHS staff.		
Requirement: California Code of Regulations, Title 9, Section 1850, Subdivision 205(d)(2) **Finding 6.2.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must record in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, appeals and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. While the MHP	**Corrective Action Description:** ACBHS does have a procedure in place to ensure this is completed. However, due to the overwhelming loss of all management within 1 year at ACBHS, the tracking and maintenance of documentation pertaining to this requirement was not understood by the remaining staff person assigned this responsibility. ACBHS compliance staff will review policies and procedures for this requirement and will revise the procedures as needed. Once completed, ACBHS will provide training on the procedure, including documentation and maintenance of information, to all ACBHS staff. This will occur for the current year and each	March 31, 2023	Once complete, ACBHS will submit the policies/procedures and training documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP records in the grievance and appeal log or another central location determined by the MHP, the final dispositions of grievances, including the date the decision is sent to the beneficiary. Two (2) grievances were identified in FY19-20. The MHP grievance and appeal log included a disposition column, however details of the disposition were not present for these grievances. The MHP was provided with the opportunity to submit the grievances and supporting documentation to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.	subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed, and will provide annual training to all ACBHS staff.		
Requirement: Federal Code of Regulations, Title 42, Section 438, Subdivision 408(a)-(b)(1)	**Corrective Action Description:** ACBHS does have a procedure in place to ensure this is completed.	March 31, 2023	Once complete, ACBHS will submit the

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
Finding 6.3.2: The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each grievance within the 90 day timeliness standards. Two (2) grievances were identified in FY19-20. Per the discussion during the review, the MHP stated it includes resolution dates on the grievance and appeal log. DHCS requested copies of the resolution letters to ensure compliance with this requirement. The MHP was provided with the opportunity to submit the grievances and supporting documentation to	However, due to the overwhelming loss of all management within 1 year at ACBHS, the tracking and maintenance of documentation pertaining to this requirement was not understood by the remaining staff person assigned this responsibility. ACBHS compliance staff will review policies and procedures for this requirement and will revise the procedures as needed. Once completed, ACBHS will provide training on the procedure, including documentation and maintenance of information, to all ACBHS staff. This will occur for the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed, and will provide annual training to all ACBHS staff.		policies/procedures and training documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			
Requirement: California Code of Regulations, Title 9, Section 1850, Subdivision 206(c) **Finding 6.3.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must provide written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of 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 and documentation of the	**Corrective Action Description:** ACBHS does have a procedure in place to ensure this is completed. However, due to the overwhelming loss of all management within 1 year at ACBHS, the tracking and maintenance of documentation pertaining to this requirement was not understood by the remaining staff person assigned this responsibility. ACBHS compliance staff will review policies and procedures for this requirement and will revise the procedures as needed. Once completed, ACBHS will provide training on the procedure, including documentation and maintenance of information, to all ACBHS staff. This will occur for the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise	March 31, 2023	Once complete, ACBHS will submit the policies/procedures and training documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
notification or efforts to notify the beneficiary, if he or she could not be contacted. Two (2) grievances were identified in FY19-20. DHCS requested copies of the resolution letters to ensure compliance with this requirement. The MHP was provided with the opportunity to submit the grievances and supporting documentation to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.	or update as needed, and will provide annual training to all ACBHS staff.		
Requirement: Federal Code of Regulations, Title 42, Section 438, Subdivision 406(b)(4) **Finding 6.4.4:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must allow the beneficiary to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing. The MHP must	**Corrective Action Description:** ACBHS does have a procedure in place to ensure this is completed. However, due to the overwhelming loss of all management within 1 year at ACBHS, the tracking and maintenance of documentation pertaining to this requirement was not understood by the remaining staff person assigned this responsibility. ACBHS compliance staff will review policies and procedures for this	March 31, 2023	Once complete, ACBHS will submit the policies/procedures and training documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals in case of expedited resolution. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP informs the beneficiary of the limited time available for making arguments of fact or law, in person and in writing sufficiently in advance of the resolution timeframe for appeals and expedited resolution. Per the discussion during the review, the MHP stated that the beneficiary is notified during the appeals process. The MHP was provided with the opportunity to submit the grievances and supporting documentation to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.	requirement and will revise the procedures as needed. Once completed, ACBHS will provide training on the procedure, including documentation and maintenance of information, to all ACBHS staff. This will occur for the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed, and will provide annual training to all ACBHS staff.		

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
Requirement: MHP Contract, Exhibit A, Attachment 13, and Federal Code of Regulations, Title 42, Section 438, Subdivision 608(a)(1) **Finding 7.1.4:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP Regulatory Compliance Committee (RCC) at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements of this contract. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a Regulatory Compliance Committee (RCC) at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements of the contract. Per the discussion during the review, the	**Corrective Action Description:** ACBHS has not conducted a compliance meeting since 2020. Thus ACBHS is out of compliance for this requirement. ACBHS compliance staff will ensure the policies and procedures related to this requirement are current and will re-establish the compliance meeting process to meet this requirement. All sign in sheets, rosters, and meeting minutes will be maintained and submitted as evidence of compliance by the determined deadline. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed, and will ensure compliance meetings are conducted and documented according to policy.	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
MHP stated they used to conduct a quarterly compliance meeting, however this is no longer occurring. The MHP was provided with the opportunity to submit the evidence of these meetings including agendas and sign in sheets to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			
Requirement: MHP Contract, Exhibit A, Attachment 13, and Federal Code of Regulations, Title 42, Section 438, Subdivision 608(a)(6) **Finding 7.2.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information	**Corrective Action Description:** ACBHS will research current policies and procedures to ensure compliance with this requirement. If it is determined that there is not a policy or procedure in place regarding this requirement, one will be developed, trained and implemented in the current year, and training will be renewed each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed.	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
about rights of employees to be protected as whistleblowers. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implements and maintains written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. Per the discussion during the review, the MHP stated it will research if it has a policy or procedure in place for this requirement. The MHP was provided with the opportunity to submit the evidence to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
Requirement: MHP Contract, Exhibit A, Attachment 13, and Federal Code of Regulations, Title 42, Section 438, Subdivision 608(a)(8) **DHCS Finding 7.2.4:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must implement and maintain arrangements or procedures that include provision for the Contractor's suspension of payments to a network provider for which there is a credible allegation of fraud. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implements and maintains arrangements or procedures that include provision for the Contractor's suspension of payments to a network provider for which there is a credible allegation of fraud. Per the discussion during the review, the MHP stated it will research if it has a	**Corrective Action Description:** ACBHS will research current policies and procedures to ensure compliance with this requirement. If it is determined that there is not a policy or procedure in place regarding this requirement, one will be developed, trained and implemented in the current year, and training will be renewed each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed.	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
policy or procedure in place for this requirement. The MHP was provided with the opportunity to submit the evidence to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			
Requirement: Federal Code of Regulations, Title 42, Section 455, Subdivision 101 and 104 **DHCS Finding 7.4.1:** The MHP did not furnish evidence to demonstrate compliance with this requirement. 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	**Corrective Action Description:** ACBHS will research current policies and procedures to ensure compliance with this requirement. If it is determined that there is not a policy or procedure in place regarding this requirement, one will be developed, trained and implemented in the current year, and training will be renewed each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed.	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
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 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. Per the discussion during the review, the MHP stated it will research if it has a policy or procedure in place for this requirement. The MHP was provided with the opportunity to submit the evidence to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			
Requirement: MHP Contract, Exhibit A, Attachment 13 **DHCS Finding 7.4.5:** The MHP did	**Corrective Action Description:** ACBHS will research current policies and procedures to ensure	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
not furnish evidence to demonstrate compliance with this requirement. The MHP must submit disclosures and updated disclosures to the Department of Health and Human Services (DHHS) including information regarding certain business transaction 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	compliance with this requirement. If it is determined that there is not a policy or procedure in place regarding this requirement, one will be developed, trained and implemented in the current year, and training will be renewed each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed.		with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
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 DHCS as required per regulations. Per the discussion during the review, the MHP stated it will research if it has a policy or procedure in place for this requirement. The MHP was provided with the opportunity to submit the evidence to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			
Requirement: California Code of Regulations, Title 9, Section 1840, Subdivision 314(d), and Federal Code of Regulations, Title 42, Section 455, Subdivision 412 **DHCS Finding 7.6.1:** The MHP did not furnish evidence to demonstrate	**Corrective Action Description:** ACBHS will revise its current policies and procedures to ensure compliance with this requirement. This will be done in the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
compliance with this requirement. The MHP must ensure providers of services that require a license, registration or waiver maintain a current license, registration or waiver. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures providers of services that require a license, registration or waiver maintain a current license, registration or wavier. Per the discussion during the review, the MHP stated it will update its policy moving forward to include this process. The MHP was provided with the opportunity to submit the evidence to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.	the policies on an ongoing basis and revise or update as needed.		
Requirement: United States Code, Title 42, Section 1396u-2(d)(6), Federal Code of Regulations, Title	**Corrective Action Description:** ACBHS will revise its current policies and procedures to ensure	March 31, 2023	Once complete, ACBHS will submit the documentation as evidence of compliance

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
42, Section 438, Subdivision 602, and BHIN N. 20-071 **DHCS Finding 7.6.3:** The MHP did not furnish evidence to demonstrate compliance with this requirement. The MHP must ensure all applicable network providers, including individual rendering providers and Specialty Mental Health facilities enroll through DHCS' Provider Application and Validation for Enrollment (PAVE) portal (unless the facility is required to enroll via CDPH). While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures all applicable network providers enroll through DHCS' PAVE portal (unless the facility is required to enroll via CDPH). Per the discussion during the review, the MHP stated it will update its policy moving forward to include this process. The MHP was provided with	compliance with this requirement. This will be done in the current year and each subsequent year thereafter. **Ongoing Monitoring:** ACBHS will review the policies on an ongoing basis and revise or update as needed.		with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
the opportunity to submit the evidence to demonstrate compliance with this requirement. The MHP did not provide any additional evidence post review.			
Finding 8.2.1: Assessments were not completed in accordance with regulatory and contractual requirements, specifically: 1. Six initial assessments and two (2) update assessments were not completed within the initial timeliness or update frequency requirements specified in the MHP's written documentation standards: (the MHP standard requires initial assessments to be completed within five (5) business days of a beneficiary's Episode Open Date, and update assessments completed within 365 days from completion of the previous assessment.)	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that assessments are completed in accordance with the initial timeliness and update frequency requirements specified in the MHP's written documentation standards. ACBHS's current policies and procedures are stricter than the regulation or requirement. All of the findings noted above are in compliance with regulation requirements. ACBHS will revise the written policies and procedures to fall in line with the regulations and requirements to ensure compliance with the regulations, as well as ACBHS written policies and procedures. **Ongoing Monitoring:** Internal chart reviews will be conducted according to policy to	March 31, 2023	Once revisions are completed to the policies and procedures, they will be submitted as evidence of compliance with this requirement. ACBHS clinicians will continue to complete assessments within the required timeliness standards.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
The following are specific findings from the chart sample: Line #3. Episode Open Date = 6/12/19, Initial Assessment = 7/23/19 Line #4. Episode Open Date = 9/13/19, Initial Assessment = 10/1/19 Line #5. Episode Open Date = 6/12/19, Initial Assessment = 6/27/19 Line #7. Episode Open Date = 9/21/18, Initial Assessment = 10/9/18 Line #8. Episode Open Date = 1/25/19, Initial Assessment = 2/15/19 Line #9. Episode Open Date = 2/8/19, Initial Assessment = 2/21/19 Line #2. Prior Assessment = 3/19/18, Current Assessment = 5/21/19 Line #7. Prior Assessment = 10/9/18, Current Assessment = 10/27/21	ensure compliance with completion of assessments.		
Finding 8.2.2: The Update Assessment for Line #2 did not address all of the required elements specified in the MHP contract. Specifically: 1. Medications, including	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP contract with the Department. ACBHS will review the	March 31, 2023	Once revisions are completed to the policies and procedures and additional training is provided, the documents will be submitted as

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
information about medications the beneficiary has received, or is receiving, to treat mental health conditions (the only medications recorded were for the treatment of one or more medical conditions), and; 2. A current diagnosis, i.e. – the only diagnosis determination found was completed on 3/16/18, during the completion of the beneficiary's previous assessment, with no evidence that the diagnosis was reviewed as part of the Update Assessment which was completed on 5/21/19.	current policies and procedures and revised or update as necessary. It is believed this issue will cease now that Documentation Reform is in place for CalAIM. The template in the EHRS does not allow for missed information, ensuring that all components are in place. Additional training will be provided to the clinical team regarding documentation requirements and components of assessments. **Ongoing Monitoring:** Internal chart reviews will be conducted according to policy to ensure compliance with completion of assessments.		evidence of compliance with this requirement.
Finding 8.3.2: Two medication consents for Line #2 did not contain all of the required elements specified in the MHP Contract with the Department. 1. Reasonable alternative treatments available, if any; 2. Duration of taking the	**Corrective Action Needed**: The MHP has already identified the issue of an organizational provider using a noncompliance Medication Consent form. The MHP also submitted written attestation from the provider that the MHP's standard Medication Consent is now used. Therefore, no Corrective Action	N/A	N/A

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
medication; 3. Possible side effects if taken longer than 3 months; 4. Consent once given may be withdrawn at any time.	Plan is required for this finding. **Ongoing Monitoring:** n/a		
Finding 8.4.2: Client plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards). Specifically: 1.Line #4. The Initial Client Plan was not completed until after one (1) Individual Psychotherapy session was provided and claimed. Specifically: Plan completed on 10/4/19, but therapy session provided on 10/1/19. (Review of the chart indicated that this service was not provided on an	**Corrective Action Needed:** Due to the transition to the new Documentation Standards that took effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements. **Ongoing Monitoring:** n/a	N/A	N/A

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
unplanned or urgent basis.)			
Finding 8.4.3: Three client plans did not include all of the required elements identified in the MHP Contract. Specifically: 1. Three goals/treatment objectives were not specific, observable, and/or quantifiable: a. Line #5. Plan completed 6/24/19 b. Line #10. Plans completed 8/25/19 and 12/16/19	**Corrective Action Needed:** Due to the transition to the new Documentation Standards that took effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements. **Ongoing Monitoring:** n/a	N/A	N/A
Finding 8.4.11: One of two (2) Client Plans submitted for Line #10 did not contain a signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title. Specifically: 1. Missing provider professional degree, licensure, or job title on the Client Plan completed 12/16/19	**Corrective Action Needed:** Due to the transition to the new Documentation Standards that took effect July 1, 2022, a CAP is not required for this item. However, please note that the MHP is expected to continue to ensure compliance with its policies and all current documentation requirements. **Ongoing Monitoring:** n/a	N/A	N/A

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
Finding 8.5.1: Progress notes did not all include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically: 1. Line #1, 4, 5,6,7 and 10. Fourteen progress notes, or 10.7% of all progress notes reviewed, were not completed within the MHP's written timeliness standard of three (3) business days after provision of services (89.3% compliance). 2. Line #2, 7, 8, 9, 10. The service time documented on 28 progress notes was greater than the Units of Time (UOT) claimed. The MHP reported that, in each case, the reason for the discrepancy was that travel times were not claimed although they were included on the notes. (Pursuant to CCR Title 9 Section 1840.316(b)(1), The exact number of minutes used by the	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document: 1. Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards. 2. Service dates and times recorded on progress notes match their corresponding claims. 3. Interventions and other documentation are individualized for each service provided. ACBHS will review the current policies and procedures and revised or update as necessary. Additional training will be provided to the clinical team regarding documentation and billing requirements. **Ongoing Monitoring:** Internal chart reviews will be conducted according to policy to ensure compliance with completion of	March 31, 2023	Once revisions are completed to the policies and procedures and additional training is provided, the documents will be submitted as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
persons providing a reimbursable service shall be reported and billed. As such, these services are to be claimed with the actual and specific number of minutes for each services, and are not to be rounded up in 15-minute increments). 3. Line #10. Two progress notes contained the exact same intervention verbiage, and therefore those progress notes were not individualized in terms of the specific interventions applied, as specified in the MHP contract with the Department. Specifically: a. Progress notes for Individual Therapy on 11/8/19 and 11/22/19 contained the same verbiage.	assessments.		
Finding 8.5.2: Documentation of services provided to, or on behalf of, a beneficiary by more than one Person at the same point in time did not include all required components. Specifically:	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that progress notes: 1. Contain the actual number of clients participating in a group activity, the	March 31, 2023	Once revisions are completed to the policies and procedures and additional training is provided, the documents will be submitted as

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
1. Lines # 5 and 6. Six group session progress notes did not document the specific involved of each provider in the context of the mental health needs of the beneficiary. RR8a, refer to Recoupment Summary for details. 2. Lines #5 and 6. Six group session progress notes did not document the amount of time of involvement of each provider claimed, including the clear identification and differentiation of direct service, travel and documentation times, if appropriate. RR8b, refer to Recoupment Summary for details. 3. Lines #1, 5 and 6. While 15 group session progress notes did not accurately document the number of group participants, the MHP was able to provide separate documentation listing the number of participants in each group.	number and identification of all group provider/facilitators, the correct type of service (e.g., Group Rehabilitation or Group Psychotherapy), and date of service. 2. Document and differentiate the contribution, specific involvement, and units of direct service, travel and documentation times for each provider/facilitator whenever a claim represents services rendered by more than one (1) provider within the same activity or session, including groups, "team meetings" and "case consultations". 3. Contain accurate and complete documentation of claimed service activities, that the documentation is consistent with services claimed, and that services are not claimed when billing criteria are not met. 4. Include a clinical rationale when more than one (1) provider renders services within the same group session or activity. ACBHS will review the current policies and		evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
	procedures and revised or update as necessary. Additional training will be provided to the clinical team regarding documentation and billing requirements.		
Finding 8.5.3: Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically: 1. Line # 9 and 10. For Mental Health Services claimed, the service activity (e.g., Therapy versus Rehab or Individual versus Family Therapy) identified on the progress note was not consistent with the specific service activity actually documented in the body of the progress note. 2. Line #9. 11/12/19, SF=30, UOT=85 minutes. Service activity labeled as "Individual Therapy" was actually a "family session" based on the note contents. 3. Line #10. 11/8/19, SF=30, UOT-70 minutes. Service activity	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that all Specialty Mental Health Services are: 1. Claimed for the correct service modality billing code, and units of time. 2. Accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department. 3. Describe the type of service or service activity, the date of service and the amount of time to provide the service, as specified in the MHP Contract with the Department. ACBHS will review the current policies and procedures and revised or update as necessary. Additional training will be provided to the clinical team regarding documentation and billing requirements.	March 31, 2023	Once revisions are completed to the policies and procedures and additional training is provided, the documents will be submitted as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
labeled as "Individual Therapy" was actually a "family session" based on the note contents.	**Ongoing Monitoring:** Internal chart reviews will be conducted according to policy to ensure compliance with completion of assessments.		
Finding 8.6.1: 1. While the MHP furnished evidence that it has a standard procedure, to be documented in each "Comprehensive Assessment", for providing individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22, it reported this procedure was not implemented during the chart review period. 2. The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS, and that if appropriate, such services were	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that 1. Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for IHBS and ICC services. 2. Each beneficiary under age 22 who is authorized to received Specialty Mental Health Services also receives and individualized determination of eligibility and need for ICC services and IHBS prior to or during the development of the beneficiary's Initial Client Plan. 3. The determination is documented in a standard, consistent and recognizable manner as part of the medical record. ACBHS will review the current policies and procedures and revised or update as	March 31, 2023	Once revisions are completed to the policies and procedures and additional training is provided, the documents will be submitted as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
included in their Client Plan: a. Line #s 7, 8, 9, and 10	necessary. Additional training will be provided to the clinical team regarding documentation and billing requirements. **Ongoing Monitoring:** Internal chart reviews will be conducted according to policy to ensure compliance with completion of assessments.		
Finding 8.6.3: The content of one or more progress notes claims as Targeted Case Management (Service Function Code "01") indicated that the service provided was consistent with an ICC/CFT service activity, and could have been claimed as an ICC case management services (Service Function Code "07"): 1. Line #10, 10/3/19, OUT=80 minutes, content consistent with a CFT meeting 2. Line #10. 11/1/19, UOT=22 minutes, content consistent with an ICC service. 3. Line #10, 11/14/19, UOT=70	**Corrective Action Needed:** The MHP shall submit a CAP that describes how the MHP will ensure that All ICC services are documented and claimed accurately with the correct procedure code, procedure modifier, mode of service and service function code. ACBHS will review the current policies and procedures and revised or update as necessary. Additional training will be provided to the clinical team regarding documentation and billing requirements. **Ongoing Monitoring:** Internal chart reviews will be conducted according to policy to	March 31, 2023	Once revisions are completed to the policies and procedures and additional training is provided, the documents will be submitted as evidence of compliance with this requirement.

Deficiency Number and Finding	Corrective Action Description and Mechanism for Monitoring	Corrective Action Implementation Date	Evidence of Correction
minutes, content consistent with a CFT meeting.	ensure compliance with completion of assessments.		

Submitted by: Teri McAlpin **Date: 12/15/2022**

Title: *(Former)* Compliance Staff, Fiscal & Administrative Supervisor