El Dorado County Behavioral Health
FY 21/22 Specialty Mental Health Services Triennial Review
CORRECTIVE ACTION PLAN – CHART FINDINGS

➢ Medical Necessity: Finding 8.1.3

Finding

The interventions documented on three (3) progress notes for the following Line number did not meet medical necessity since the service provided did not specifically address the mental health condition or impairment identified in the assessment, and was solely:

- Transportation: Line number 1. RR10e, refer to Recoupment Summary for details.

The MHP shall submit a CAP that describes how the MHP will ensure that: 1) Each progress note describes how services reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning. 2) Services provided and claimed are not solely transportation, clerical, or payee related. 3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, sections 1830.205(b), 1830.210 (EPSTD) and MHSUDS IN. NO. 21053.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct monthly documentation trainings as a component of the standing staff meetings, including documenting medical necessity
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty
- Develop and maintain staff training logs
- Review/update chart review checklist to include medical necessity and progress note standards
- Review policies and procedures; update as necessary
- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

➢ Assessment: Finding 8.2.1

Finding

Assessments were not completed in accordance with regulatory and contractual requirements, specifically: One or more assessments were not completed within the update frequency requirements specified in the MHP's written documentation standard which states that Assessments are updated at leased annually:

- Line number 2 Assessments. Prior = 02/15/2020; Current = 02/18/2021
- Line number 5 Assessments. Prior = 12/12/2019; Current = 05/20/2022

The MHP shall submit a CAP which: 1) Provides evidence that the MHP has written documentation standards for assessments, including required elements or timeliness and frequency as required in the MHP Contract with the Department. 2) 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.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct monthly documentation trainings as a component of the standing staff meetings, including assessment standards
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty
- Develop and maintain staff training logs
- Review/update chart review checklist to include assessment standards
- Review policies and procedures; update as necessary
- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

➢ Assessment: Finding 8.2.3

Finding

Four assessments reviewed did not include the signature of the person who completed the assessment (or electronic equivalent) that includes the person's professional degree, licensure, job title: Line numbers 3, 4, 5 and 7.

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes: 1) The signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service. 2) The signature of the qualified person (or electronic equivalent) with the professional degree, licensure or title of the person providing the service. 3) The date the signature was completed and the document was entered into the medical record.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct monthly documentation trainings as a component of the standing staff meetings, including signature requirements
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty
- Develop and maintain staff training logs
- Review/update chart review checklist to include signature requirements
- Review policies and procedures; update as necessary

- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

➢ Medication Consent: Finding 8.3.1

Finding

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

- Line number 3: There was no written medication consent form found in the medical record for this beneficiary who was being prescribed a psychotropic medication during the chart review period according to one or more Medication Support progress notes.

MHP shall submit a CAP to address actions it will implement to ensure the following: 1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP. 2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Review medication consent template; update as necessary
- Conduct monthly documentation trainings as a component of the standing staff meetings, including medication consent standards
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty
- Develop and maintain staff training logs
- Review/update chart review checklist to include medication consent standards
- Review policies and procedures; update as necessary
- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated medication consent form, if applicable
- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

➢ Medication Consent: Findings 8.3.2 and 8.3.3

Per DHCS, a CAP is not required for these findings.

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

➢ Client Plans: Findings 8.4.2, 8.4.3, 8.4.8, 8.4.10, and 8.4.11

Per DHCS, a CAP is not required for these findings.

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

➢ Progress Notes: Finding 8.5.1

Finding

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

- Line numbers 1, 2, 4, 5, 7, 8 and 10. 53 progress notes (16.4% of the 324 progress notes reviewed) were not completed within the MHP's written timeliness standard of 3 business days after provision of service (83.6% compliance).
- Line number 8. Progress notes reviewed were missing evidence of coordination and communication with community resources or external providers or agencies, when appropriate.
- Line numbers 1, 5 and 7. 29 progress note were missing the provider's professional degree, licensure, or job title (9% of all progress notes reviewed).

1. The MHP shall submit a CAP that describes how the MHP will ensure that the MHP has written documentation standards for progress notes, including timeliness and frequency, as required by the MHP Contract with the Department.
2. The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document: a) 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. b) Coordination with or referral to community resources and other agencies or providers, when appropriate, as specified in the MHP Contract with the Department. c) The provider's/providers' professional degree, licensure, or job title.
3. The MHP shall submit a CAP that describes how the MHP will ensure that Specialty Mental Health Services claimed are accurate and are actually provided to the beneficiary.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct monthly documentation trainings as a component of the standing staff meetings, including progress note standards
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty

- Develop and maintain staff training logs
- Review/update chart review checklist to include progress note standards
- Review policies and procedures; update as necessary
- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

➢ Progress Notes: Finding 8.5.2

Finding

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

- Line numbers 1 and 7. Twelve progress notes did not document the specific involvement of each provider in the context of the mental health needs of the beneficiary. RR8a, refer to Recoupment Summary for details.
- Line numbers 1 and 5. While two (2) progress notes themselves 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.

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 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[..] Include a clinical rationale when more than one (1) provider renders services within the same group session or activity.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct monthly documentation trainings as a component of the standing staff meetings, including progress note standards
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty
- Develop and maintain staff training logs
- Review/update chart review checklist to include progress note standards
- Review policies and procedures; update as necessary
- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

➢ Progress Notes: Finding 8.5.3

Finding

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

- Line number 1. The Specialty Mental Health Service (e.g., Therapy, Targeted Case Management, Rehabilitation) documented on the progress note was not the same type of service modality claimed. RR5, refer to Recoupment Summary for details.
- Line numbers 6, 9 and 10. The Type of Service (e.g., Therapy, Rehabilitation, TCM, Intensive Care Coordination) identified on the progress note was not consistent with the specific service activity actually documented in the body of the progress note.

The MHP shall submit a CAP that describes how the MHP will: 1) Ensure that all Specialty Mental Health Services claimed are: a) Claimed with the correct service modality billing code. 2) Ensure that all progress notes: a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department. b) Include a Type of Service which is accurate in describing the actual activity or intervention documented in the body of the same progress note. c) Are completed within the timeline and frequency specified in the MHP Contract with the Department, and as specified in the MHP's written documentation standards.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct monthly documentation trainings as a component of the standing staff meetings, including progress note standards
- Conduct quarterly peer chart reviews to provide staff with examples of accurate documentation
- Provide individualized training to staff who continue to have difficulty
- Develop and maintain staff training logs
- Review/update chart review checklist to include progress note standards
- Review policies and procedures; update as necessary
- Add quarterly review of training and chart reviews to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated chart review checklists
- Updated policies, if applicable
- Updated standing QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and consistent staff training.

El Dorado County Behavioral Health
FY 21/22 Specialty Mental Health Services Triennial Review
CORRECTIVE ACTION PLAN – SYSTEM FINDINGS

➢ Question 1.1.3

Finding

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). 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.

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 evident that the MHP meets Department standards for timely access to care and services, taking into account the urgency of need for services. The MHP was unable to provide a log identifying timeliness for physician and urgent care appointments. Per the discussion during the review, the MHP acknowledged issues in the data tracking and stated it is working on establishing an improved process for tracking timeliness standards moving forward.

Corrective Action Description

El Dorado County Behavioral Health (EDCBH) has developed the following action items to address this finding:

- Implement a new Access Log
- Implement a new intake process
- Review policies and procedures; update as necessary
- Train relevant staff
- Conduct test calls
- Add monthly review to the standing QIC agenda and minutes
- Review and document monthly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Access Log template
- Updated policies, if applicable
- Staff training materials/logs

- Test call results
- Updated standing QIC agenda and minutes template

Ongoing Monitoring
The QIC will review compliance with these requirements at least monthly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title
Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:
Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and staff training.

➢ Question 1.2.7

Finding
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. Per the discussion during the review, the MHP stated that it has had discussions with providers to establish this service but it currently does not have a TFC contract in place.

Corrective Action Description
EDCBH will work with local Foster Family Agency and County Social Services to identify possible TFC organizational providers to serve El Dorado County clients. Historically, local TFC families have been difficult to identify. Working through local partnerships may help to identify these resources. EDCBH is also exploring the possibility of posting an RFQ in an effort to elicit responses from additional TFC resources.

Proposed Evidence/Documentation of Correction
If a TFC provider contract is successfully curated, a copy of the TFC contract will be submitted as evidence of the correction.

Ongoing Monitoring
A TFC provider would be monitored per EDCBH policy, and state and federal requirements.

Person Responsible and Job Title
Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:
Within 30 calendar days, once a TFC provider contract has been curated.

➢ Question 1.2.8

Finding
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. 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 it does not have an assessment tool for TFC, but that TFC placement can be discussed in the Child Family Team (CFT) meetings.

Corrective Action Description
EDCBH has developed the following action items to address this finding:
- Update the assessment process and documentation to specifically address TFC
- Review policies and procedures; update as necessary
- Train relevant staff
- Add TFC determination to the standing CFT meeting agenda and minutes templates
- Add TFC review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction
The following documentation will be submitted to DHCS as evidence of the corrective actions:
- Assessment update that includes the TFC determination
- Updated policies, if applicable
- Staff training materials/logs
- Updated CFT and QIC agenda and minutes templates

Ongoing Monitoring
The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title
Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:
Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and staff training.

➢ Question 1.4.3

Finding

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a) (1). The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP gives practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. Per the discussion during the review, the MHP stated it has never had a reason to deny a contractor's request to provide services.

Corrective Action Description

Historically, EDCBH has not denied contracts with interested providers. In order to ensure compliance in any future instances, EDCBH has developed the following action items to address this finding:

- Develop a letter template that meets the notification requirement
- Review policies and procedures; update as necessary
- Train relevant staff
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Written letter template
- Updated policies, if applicable
- Staff training materials/logs
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; process implementation; and staff training. If a provider is denied in the future, a copy of the written notification will be retained for DHCS review.

➢ Question 1.4.4

Finding

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS. Of the 36 MHP provider sites, four (4) had overdue certifications. Per the discussion during the review, the MHP acknowledged the overdue providers. Post review, three (3) provider sites remained overdue.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Update/maintain a certification calendar/tickler to ensure timely recertifications
- Review policies and procedures; update as necessary
- Train relevant staff
- Conduct outstanding recertification activities
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Certification calendar/tickler
- Completed recertification materials
- Updated policies, if applicable
- Staff training materials/logs
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for calendar, policy, and QIC template updates; and August 20, 2023 (6 months) for process implementation, staff training, and recertification completion.

➢ Question 2.1.2

Finding

The MHP did not furnish evidence to demonstrate compliance with the MHP Contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, section 438, subdivision 208(b)(1). The MHP must provide the beneficiary information on how to contact their designated person or entity. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides the beneficiary information on how to contact their designated person or entity. Per the discussion during the review, the MHP stated the beneficiaries are provided contact information during the first phone call and are provided the provider directory.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Develop a specific process to meet this notification requirement
- Review policies and procedures; update as necessary
- Train relevant staff
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Samples of the effective notification process
- Updated policies, if applicable
- Staff training materials/logs
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for policy updates; and August 20, 2023 (6 months) for process implementation, staff training, and sample collection.

➢ Question 2.4.2

Finding

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, subdivision 370(a)(5). The MHP must has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the dispute is being resolved. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. Per the discussion during the review, the MHP stated that it is in the process of amending its Memorandums of Understanding (MOU) with its MCPs to include this language.

Corrective Action Description

Historically, EDCBH has not had dispute issues with its MCPs. To mitigate any issues in the future, EDCBH has developed the following action items to address this finding:

- Update MOUs to reflect dispute resolution requirements
- Review policies and procedures; update as necessary
- Train relevant staff
- Add dispute review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated MOUs
- Updated policies, if applicable
- Staff training materials/logs
- Updated QIC agenda and minutes templates

Ongoing Monitoring

QI and Contracts staff will ensure compliance with these requirements if there are disputes with the MCPs that involve beneficiary care. The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for needed policy and QIC template updates; and August 20, 2023 (6 months) for revised MOU development and staff training.

➢ Question 2.5.5

Finding

The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No.18-059. 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. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP works with the provider to establish a Client Plan and transition plan for the beneficiary.

Corrective Action Description

Historically, EDCBH has not received requests for continuity of care. To ensure compliance in future cases, EDCBH has developed the following action items to address this finding:

- Review policies and procedures; update as necessary
- Train relevant staff
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated policies, if applicable
- Staff training materials/logs
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; process implementation; and staff training.

➢ Question 3.3.3

Finding

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the MHP Quality Assessment and Performance Improvement 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 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. Per the discussion during the review, the MHP stated the Quality Improvement Committee (QIC) does not have participation from beneficiaries or family members, and it is currently looking at ways to improve participation.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct client/family member recruitment activities (flyers; public announcements)
- Review policies and procedures; update as necessary
- Update rosters when new QIC members are added
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Recruitment materials
- Updated policies, if applicable
- Updated roster, if new members are added during CAP period
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for recruitment materials and needed policy and QIC template updates; and August 20, 2023 (6 months) for updated rosters, if new members are added by such time.

➢ Question 4.2.1

Finding

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(d)(6)(ii). The MHP must provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point. DHCS reviewed the MHP's written informing material and found that several documents had noncompliant font sizes. Per the discussion during the review, the MHP acknowledged the need to update its informing materials. Post review, the MHP provided updated informing material with the correct font size that it will implement moving forward.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Update informing materials
- Review policies and procedures; update as necessary
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated informing materials
- Updated policies, as applicable
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for informing materials and needed policy and QIC template updates.

➢ Question 4.3.2

Finding

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

1. The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2. The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3. The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4. The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Train relevant staff
- Review call scripts and update as necessary
- Conduct regular test calls with various scenarios
- Review policies and procedures; update as necessary
- Add monthly review to the standing QIC agenda and minutes templates
- Review and document monthly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Staff training materials/logs
- Updated call scripts, as applicable
- Test call results
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least monthly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for script and template updates; and August 20, 2023 (6 months) for staff training.

➢ Question 4.3.4

Finding

The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request. While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged on the MHP's written log of initial request.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Implement a new Access Log
- Implement a new intake process
- Review policies and procedures; update as necessary
- Train relevant staff
- Conduct test calls
- Add monthly review of Access Log data and timeliness compliance to the standing QIC agenda and minutes templates
- Review and document monthly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Access Log template
- Updated policies, if applicable
- Staff training materials/logs
- Test call results
- Updated standing QIC agenda and minutes template

Ongoing Monitoring

The QIC will review compliance with these requirements at least monthly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template and policy updates; and August 20, 2023 (6 months) for process implementation and staff training.

➢ Question 4.4.2

Finding

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410. The MHP must have a Cultural Competence Committee or other group that addresses cultural issues and has participation from cultural groups that is reflective of the community. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a Cultural Competence Committee (CCC) or other group that has participation from cultural groups that is reflective of the community. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that its CCC does not include community involvement; however, this is a goal moving forward.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Conduct community recruitment activities (flyers; public announcements)
- Review policies and procedures; update as necessary
- Update rosters when new CCC members are added
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Recruitment materials
- Updated policies, if applicable
- Updated roster, if new members are added during CAP period
- Updated QIC agenda and minutes templates

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for recruitment materials and needed policy and QIC template updates; and August 20, 2023 (6 months) for updated rosters, if new members are added by such time.

➢ Question 5.4.1

Finding

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

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of a payment for service.
4. The failure to provide services in a timely manner.
5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides beneficiaries with a Notice of Adverse Beneficiary Determination (NOABD) upon failure to provide services in a timely manner or failure to act within timeframes regarding the standard resolution of grievances and appeals. The Service Request Log provided did not delineate if NOABDs were sent to beneficiaries when timeliness standards are not met. One (1) grievance was not resolved within the 90-day timeframe and it was not evident that a NOABD was sent to the beneficiary.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Designate specific staff to conduct NOABD processes
- Update relevant logs
- Train relevant staff
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated logs
- Staff training materials/logs
- Updated standing QIC agenda and minutes template

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template updates; and August 20, 2023 (6 months) for process implementation and staff training.

➢ Question 6.2.1

Finding

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains a grievance and appeal log and records grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. Of the 10 grievances reviewed by DHCS, five (5) grievance were not logged within one working day of receipt. Per the discussion during the review, the MHP stated that it is aware of this compliance issue and it may have been due to the staff transition to telework.

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Update relevant log
- Train relevant staff
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated log
- Staff training materials/logs
- Updated standing QIC agenda and minutes template

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title
Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:
Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template updates; and August 20, 2023 (6 months) for process implementation and staff training.

➢ Question 6.3.2

Finding
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). 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 as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day it receives the grievance. Of the 10 grievances reviewed by DHCS, one (1) grievance was not resolved within 90 calendar days of receipt. Per the discussion during the review, the MHP stated it would look into whether a NOABD was sent for not meeting timeliness. No additional evidence was submitted post review.

Corrective Action Description
EDCBH has developed the following action items to address this finding:
- Update relevant log
- Train relevant staff
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction
The following documentation will be submitted to DHCS as evidence of the corrective actions:
- Updated log
- Staff training materials/logs
- Updated standing QIC agenda and minutes template

Ongoing Monitoring
The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title
Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template updates; and August 20, 2023 (6 months) for process implementation and staff training.

➢ Question 7.6.3

Finding

The MHP did not furnish evidence to demonstrate compliance with United States Code, title 42, section 1396u-2(d)(6), Federal Code of Regulations, title 42, section 438, subdivision 602, and BHIN No. 20-071. 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 that 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).

Corrective Action Description

EDCBH has developed the following action items to address this finding:

- Review policies; and update as necessary
- Train relevant staff
- Collect PAVE enrollment information
- Add review to the standing QIC agenda and minutes templates
- Review and document quarterly at the QIC

Proposed Evidence/Documentation of Correction

The following documentation will be submitted to DHCS as evidence of the corrective actions:

- Updated policies, if applicable
- Staff training materials/logs
- PAVE enrollment information
- Updated standing QIC agenda and minutes template

Ongoing Monitoring

The QIC will review compliance with these requirements at least quarterly to ensure that these standards are met. Evidence of each review will be documented in the QIC minutes.

Person Responsible and Job Title

Justine Collinsworth, LMFT, Manager of Mental Health Programs - QA/UR and MHSA

Implementation Timeline:

Implementation and evidence submission anticipated by May 20, 2023 (3 months) for template updates; and August 20, 2023 (6 months) for process implementation and staff training.