County of Fresno Department of Behavioral Health

Fiscal Year 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

Categories 1, 4, 5, 6

System Review

Category 1 –Network Adequacy and Availability of Services – Question 1.1.3

Requirement

The MHP shall 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. (42 C.F.R. § 438.206(c)(1)(i),CCR, tit. 28 § 1300.67.2.2 (c)(5)(D))

DHCS Finding 1.1.3

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. Emergent care appointments for services that require prior authorization: within 96 hours of the request for appointment The MHP submitted the following documentation as evidence of compliance with this requirement: • Service Request Data • 009 Jan-Mar 2020 Service Requests • 2018 Implementation Plan • 2019 Implementation Plan • Timeliness Policy Individual & Group Providers • Timeliness Policy Org • Network Adequacy Timeliness and Access to Care Letter • 19-277 Master Agreement Child Welfare Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has implemented monitoring and tracking of emergent care appointments for services that require prior authorization within the 96-hour period. Per discussions prior to and during the review, the MHP stated it had focused on complying with the ongoing requirements for the Network Adequacy timeliness standards including routine service requests, urgent care requests that do not require prior authorization within the 48-hour period, and psychiatric appointment requests. The MHP stated that moving forward, it will have a mechanism in place to track and monitor all required timeliness standards

Corrective Action Description

DCHS deems the MHP out of compliance with Federal Code Of Regulations Title 42, Section 438, Subdivision 206 (c)(1)(i).

Proposed Evidence

The MHP Quality Improvement (QI) Program met collectively with Managed Care on January 10, 2022 in a Collaborative Kick Off meeting to address the Corrective Action Plan, Category 1 –Network Adequacy and Availability of Services – Question 1.1.3. The MHP understands there is no current mechanism to monitor and track emergent conditions which requires prior authorization within the 96-hour period. As a result of the Collaborative Kick Off meeting, the development of a workgroup will be created to help define what is emergent care which requires prior authorization within the 96-hour period, and to develop of a mechanism to track and monitor timeliness for emergent services.

The workgroup will be comprised of members from the MHP QI Program, Managed Care, Medical Records/Information Technology (IT) Division Services, and Clinical Staff (Utilization Review Specialist (URS)/Senior Clinician). The workgroup will review current clinical workflows to help determine whether new or current electronic forms will need to be develop or modified. Currently in the MHP Electronic Health Record (EHR) Avatar, the MHP is utilizing the Mental Health Access form to track non-urgent and urgent request for services. The MHP will explore mechanisms to track timeliness for emergent services through the use of DOMO, the MHP data dashboard software system.

Frequency of the workgroup meeting will be discussed at the first brainstorming meeting tentatively set for February 2, 2022.

Upon completion of established workflow for emergent condition and the development of a mechanism to track and monitor emergent timeliness, data will be shared at the Quality Improvement Committee (QIC) or subcommittee and Managed Care.

Ongoing Monitoring (if included)

The frequency of ongoing monitoring once a mechanism is in place will be both monthly and quarterly after implementation.

Person Responsible (job title)

Jeff Elliott, Quality Improvement Coordinator, QI Program

Implementation Timeline:

Implementation timeline for the workgroup and development of the tracking mechanism is as followed:

- Collaborative Kick-Off Meeting **1-10-2022**
- Project Plan presented to QIC **1-12-2022**

- Workgroup Brainstorming Session – February 2, 2022 (tentative, dependent on team members' availability)
    - Discuss the goals/objective of the workgroup
    - Develop action items/milestones/deliverables
    - Discuss the frequency of ongoing meetings
- Updates will be presented at QIC (Milestones/Deliverables) and Access subcommittee meetings (Small action items)
- Test monitoring and tracking mechanism (dependent on IT) - **June/July 2022**
- Implement data monitoring mechanism - **October/December 2022**
- Ongoing data timeliness review will be completed monthly and quarterly after implementation

Category 4 – Access and Information Requirements – 24/7 Access Line - 4.3.2

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:
1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

TEST CALL #2 Test call was placed on Monday, November 2, 2020, at 3:39 p.m. The call was answered after one (1) ring via phone tree directing the caller to select a language option, which included the MHP's threshold languages. A recorded greeting provided instructions to hang up and dial 911 if experiencing a life-threatening emergency. The phone tree offered the caller multiple service options that included substance use disorder and other county-provided services. The caller selected mental health services, however, the call immediately disconnected. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

TEST CALL #3 Test call was placed on Friday, March 5, 2021, at 8:08 a.m. The call was immediately answered via phone tree. A recorded greeting provided instructions to hang up and dial 911 if experiencing a life-threatening emergency. The phone tree provided language options for English and the county's threshold languages. After

selecting the appropriate language option, the phone tree menu provided service type options from which the caller selected mental health services. Upon this selection, the call disconnected. The caller attempted to reach the MHP two (2) additional times at 8:09 a.m. and 8:11 a.m., but these attempts were also disconnected. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information on how to treat an urgent condition.

TEST CALL #4 Test call was placed on Monday, May 17, 2021, at 3:07 p.m. The call was immediately answered via phone tree. A recorded greeting provided instructions to hang up and dial Fresno County Mental Health Plan FY 2020/2021 Medi-Cal SMHS Triennial Review Systems Review Findings Report 7 | Page 911 if experiencing a life-threatening emergency. The phone tree offered the information in English and the county's threshold languages. When prompted, the caller selected English and then chose the mental health services option from the phone tree menu. After making the service selection, there was a brief pause and then the call disconnected. The caller attempted to call back two (2) additional times at 3:09 p.m. and 3:15 p.m., but these attempts were also disconnected. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information on how to treat an urgent condition.

TEST CALL #5 Test call was placed on Tuesday, June 1, 2021, at 5:33 p.m. The call was answered after one (1) ring via phone tree providing language capabilities in English and the county's threshold languages. A recorded greeting provided instructions to hang up and dial 911 experiencing a life-threatening emergency. After selecting the appropriate language option, the caller selected mental health services to speak with someone about obtaining a refill for anxiety medication. When the caller selected the service type option, the call ended abruptly. The caller attempted two (2) additional times, once at 5:34 and again at 5:39 p.m. On one attempt, the caller selected zero (0) for operator. On the other, the caller did not make any selections in an effort to reach the operator. Both additional calls were unsuccessful and were disconnected. The caller was not provided information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information on how to treat an urgent condition.

TEST CALL #6 Test call was placed on Tuesday, June 1, 2021, at 5:12 p.m. The call was answered after one (1) ring via phone tree providing language capabilities in English and the county's threshold languages. The phone tree greeting identified that the caller had reached Fresno County Behavioral Health Access Line. The phone tree menu provided the caller with a list services from which to select, including mental health and substance use disorder services. The caller selected mental health services to obtain information regarding the beneficiary grievance process. After the caller selected the service type option, the call was disconnected. The caller attempted the call two (2) additional times at 5:25 p.m. and 5:27 p.m. On one attempt, the caller

selected zero (0) Fresno County Mental Health Plan FY 2020/2021 Medi-Cal SMHS Triennial Review Systems Review Findings Report 8 | Page for operator. On the other, the caller did not make any selections in an effort to reach the operator. Both additional calls were unsuccessful and were disconnected. The caller was unable to obtain information about how to use the beneficiary problem resolution and fair hearing process.

TEST CALL #7 Test call was placed on Wednesday, March 17, 2021, at 3:36 p.m. The call was answered after more than six (6) rings via phone tree providing language capabilities in English and the county's threshold languages. After selecting the appropriate language and mental health services options, the call disconnected. The caller made an additional attempt to reach the MHP by telephone again at 3:37 p.m. This call disconnected after selecting the option for mental health services. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process.

DHCS Finding 4.3.2

The call is deemed in partial compliance with the regulatory requirements with CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Corrective Action Description

Fresno County DBH is aware of the existence of a technical issue with the automated phone system that routes calls to the contracted program that provides the Access Line services. Fresno County IT has investigated the possibility of the technical issue and determined that the issue may be occurring on the contracted program's phone system. Fresno County DBH instructed the contracted program to submit a plan of correction in November of 2021. Currently, the IT group for the contracted program is working to solve the technical issue. The contracted program has submitted a Plan of Correction to the County as of January 2022. The program has begun investigating alternate phone software providers to ensure that they are receiving adequate services.

The County is currently awaiting the 24/7 Access Line RFP deadline. The contracted provider has stated that they will wait to make any software provider changes until the County has selected a provider for ongoing Access Line services.

Proposed Evidence/Documentation of Correction

- Plan of correction
- Test call log

Ongoing Monitoring (if included)

The phone line will be monitored through the test call log to ensure that it functions properly and that calls are no longer being dropped.

Person Responsible (job title)

Jeff Elliott Quality Improvement Coordinator, QI Program

Implementation Timeline:

Q3 FY2021-2022

Category 5 – Coverage and Authorization 5.2.3

Requirement

MHPs are required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services.

a. MHPs shall conduct concurrent review of treatment authorizations following the first day of admission.
b. MHPs may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria. (MHSUDS IN 19-026)

DHCS Finding 5.2.3

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026 (MHSUDS 19-026). The MHP is required to conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services for the below:

1. MHPs shall conduct concurrent review of treatment authorizations following the first day of admission.
2. MHPs may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its policies and procedures to comply with MHSUDS 19-026. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026

Corrective Action Description

The DHCS, *Fresno County, Fiscal Year (FY) 2020-21 MHP Compliance Review Audit, August 10th -12th*, identified the County was out of compliance for Category 5 – Authorizations and Coverage, Section 5.2.3; 5.2.4; 5.2.5; and 5.2.6. Although these items can be summarized into one response, the MHP will address each Category 5 section corrective action plans separately.

To ensure the requirement to conduct concurrent review and authorization for inpatient psychiatric inpatient hospital (PIH) services and psychiatric facilities (PHF) is met, the MHP is seeking to develop and implement a new Policy and Procedure Guideline (PPG) for concurrent review for both PIH and PHF services utilizing language to reflect IN 19-026 – Authorization for Specialty Mental Health Services, beginning on page 6 attached and highlighted in yellow. The *Parity Final Rule* (March 2016) was established to strengthen access to mental health (MH) and substance use disorders (SUD) services and prohibit Mental Health Plans (MHP) from applying a non-quantitate treatment limitation that limits the scope or duration of benefits. In May 2016, the Centers for Medicare and Medicaid Services (CMS) established the *Managed Care Final Rule* and classified MHPs as Prepaid Inpatient Health Plans and therefore must comply with applicable Federal Managed Care requirements for coverage and authorization. To demonstrate compliance with the Parity Rule, the Department of Health Care Services (DHCS) submitted its *Parity Compliance Plan* (October 2017) which outlines the findings from the DHCS parity assessment. Assessment of the State's authorization policies across delivery systems identified inconsistencies in the application of standards and policies for authorization of both inpatient and outpatient services by MHPs. To address these inconsistencies, DHCS released Information Notice (IN)19-026 – Authorization of Specialty Mental Health Services (SMHS) to ensure compliance with parity in MH and SUD services *Final Parity Rule* (May 31, 2019). Furthermore, IN 19-026 communicates new policy changes related to authorizations and concurrent review for Psychiatric Inpatient Hospital and Psychiatric Health Facilities (PHF).

In addition to the development of the new PPG for authorizations, the MHP is in review and will update all Department PPGs related to authorizations and concurrent review such as PPG 4.3.1 – Concurrent Review and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services attached hereto. The County will be requesting proposals from qualified vendors to provide deliverable services to review and authorize inpatient treatment episodes, ensure that medical necessity criteria are met, and concurrent reviews of mental health inpatient treatment authorizations as required by IN 19-026. The release of *Request For Proposal* and closing date have yet to be determined and it is anticipated deliverable services will start July 1, 2022, FY2022-23. A draft overview and scope of services is included as an attachment in this response to State and highlighted to reflect sections related to IN 19-026 - Authorization for SMHS. Once County Agreements are implemented, agreements are assigned and regularly monitored by Department Division Manager and Contract Analyst respectively to ensure fidelity of service deliverables. The Department Executive/Leadership Team continues to monitor and entertain the CalMHSA Psychiatric Inpatient Concurrent Review Multi-County initiative. The MHP is awaiting a Participation Agreement for consideration. The "go-live" date of the CalMHSA project is anticipated by March 31, 2022 and will be open to counties statewide for participation (email to qualified and interested counties attached).

Proposed Evidence/Documentation of Correction

- Attachment A1 - Information Notice 19-026 – Authorization for Specialty Mental Health Services
- Attachment A2 - Policy and Procedure Guide 4.3.1 Concurrent Reviews and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services
- Attachment A3 - Draft Request for Proposal, Overview and Scope of Work
- Attachment A4 - CalMHSA Psychiatric Inpatient Concurrent Review Update – Email

Ongoing Monitoring (if included)

The development/implementation of the new PPG to reflect Information Notice 19-026 – Authorization for Specialty Mental Health Services will be overseen by a Sr. Staff Analyst and processed by a Staff Analyst within the MHP's Managed Care Division. Department PPGs go through a written and review process that involve Human Resource Labor Relations prior to Department final signature and approval which may take 3-4 months to finalize. The existing PPG 4.3.1 Concurrent Reviews and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services is in the revision process and will be overseen by a Sr. Staff Analyst and Staff Analyst within the MHP's Managed Care Division. The County's Purchasing and Behavioral Health Department's Contracts Division will oversee the *Request For Proposal*, selection of vendor and County agreement process. Dependent on the scope of work and deliverable services, development/implementation of County agreement process may take six (6) or more months to completion. The MHP is seeking to implement and begin deliverable services on July 1, 2022, FY 2022-23. Once County Agreements are implemented, agreements are assigned and regularly monitored by Department Division Manager and Contract Analyst respectively to ensure fidelity of service deliverables. By end of FY2021-22, the Department's Executive/Leadership Team anticipates determining a final decision as to whether it will participate in the CalMHSA Psychiatric Inpatient Concurrent Review Agreement.

Person Responsible (job title)

- Jon Rogers, Sr. Staff Analyst, Managed Care Division
- Samantha Wright, Staff Analyst, Managed Care Division
- Shannan Yang, Staff Analyst, Managed Care Division
- Luis Iraheta, Staff Analyst, Contracts Division
- DBH, Executive/Leadership, Marcelia Black, Managed Care Division Manager

Implementation Timeline:

November 2021 – April 2022; Development of new PPG and revision of existing Policy and Procedure Guide 4.3.1 Concurrent Reviews and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services

November 2021 – July 1, 2022; Development/Implementation of deliverable services to review and authorize inpatient treatment episodes, ensure that medical necessity criteria are met, and concurrent reviews of mental health inpatient treatment authorizations.

November 2021 – July 1, 2022; Department of Behavioral Health, Executive/Leadership Team to determine participation in the CalMHSA Psychiatric Inpatient Concurrent Review Participation Agreement.

Category 5 – Coverage and Authorization 5.2.4

Requirement

Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision.

1. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination.
2. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary

DHCS Finding 5.2.4

The MHP did not furnish complete evidence to demonstrate compliance with MHSUDS 19-026. The MHP shall make decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision for the below

1. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination.
2. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures that care continues until a beneficiary's treatment treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. This requirement was not included in any evidence provided by the MHP. Per discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested

additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

Corrective Action Description

To address Category 5, Section 5.2.4, the MHP is seeking to develop and implement a new PPG to ensure the MHP makes decisions to approve, modify or deny provider requests for authorization/concurrent review with the provision of SMHS. The MHP Managed Care Division will communicate decisions to the beneficiary's treating provider, hospital and treating physician in writing within a 24-hour period. PPG language will reflect written policies identified within IN 19-026 – Authorization for SMHS, beginning on page 5 attached and highlighted in green.

The County will be requesting proposals from qualified vendors to provide deliverable services to review and authorize inpatient treatment episodes, ensure that medical necessity criteria are met, and concurrent reviews of mental health inpatient treatment authorizations as required by IN 19-026. The County will ensure language within the RFP and Agreement reflects written policies identified within IN 19-026 – Authorization for SMHS. A draft overview and scope of services is included as an attachment in this response to DHCS and highlighted to reflect sections related to IN 19-026 - Authorization for SMHS. Once County Agreements are implemented, agreements are assigned and regularly monitored by Department Division Manager and Contract Analyst respectively to ensure fidelity of service deliverables. In addition to the RFP, the Department's Executive/Leadership Team is monitoring and entertaining the CalMHSA Psychiatric Inpatient Concurrent Review multi-County initiative. The MHP is awaiting a Participation Agreement for consideration. The "go-live" date of the CalMHSA project is anticipated by March 31, 2022 and will be open to counties statewide for participation (email to qualified and interested counties attached).

Proposed Evidence/Documentation of Correction

- Information Notice 19-026 – Authorization for Specialty Mental Health Services
- Draft Request for Proposal, Overview and Scope of Work
- CalMHSA Psychiatric Inpatient Concurrent Review Update – Email

Ongoing Monitoring (if included)

The development/implementation of the new PPG to reflect Information Notice 19-026 – Authorization for SMHS will be overseen by a Sr. Staff Analyst and processed by a Staff Analyst within the Department's Managed Care Division. Department PPGs go through a written and review process that involve Human Resource Labor Relations prior to Department final signature and approval which may take 3-4 months to finalize. County's Purchasing and Departments Contracts Division will oversee the *RFP*, selection of vendor and County agreement process. Dependent on the scope of work and deliverable services, development/implementation of County agreement process

may take six (6) or more months to completion. The Department is seeking to implement deliverable services no later than July 1, 2022, FY 2022-23. Once County contracts are implemented, agreements are assigned and regularly monitored by Department Division Manager and Contract Analyst respectively to ensure fidelity of service deliverables. By end of FY2021-22, the Department's Executive/Leadership Team anticipates determining a final decision as to whether it will participate in the CalMHSA Psychiatric Inpatient Concurrent Review Agreement.

Person Responsible (job title)

- Jon Rogers, Sr. Staff Analyst, Managed Care Division
- Samantha Wright, Staff Analyst, Managed Care Division
- Luis Iraheta, Staff Analyst, Contracts Division
- DBH, Executive/Leadership, Marcy Black, Managed Care Division Manager

Implementation Timeline:

November 2021 – April 2022; Development of new Policy and Procedure Guide to reflect IN 19-026 – Authorization for SMHS.

November 2021 – July 1, 2022; Development/Implementation of deliverable services Agreement to ensure County meets requirements reflected in IN 19-026 Authorization for SMHS.

November 2021 – July 1, 2022; Department of Behavioral Health, Executive/Leadership Team to determine participation in the CalMHSA Psychiatric Inpatient Concurrent Review Participation Agreement.

Category 5 – Coverage and Authorization 5.2.5

Requirement

In order to conduct concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status.

1) Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.

2) A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.
3) Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented. (MHSUDS IN 19-026)

DHCS Finding 5.2.5

The MHP did not furnish evidence to demonstrate compliance with MHSUDS 19-026. The MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status for the below requirements:

1. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.

2. A hospital may make more than one contact on any given day within the seven consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.

3. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented The MHP submitted the following documentation as evidence of compliance with this requirement:

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its policies and procedures to comply with MHSUDS 19-026. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS

requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

Corrective Action Description

To ensure that the MHP conducts concurrent review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact with a non-acute residential treatment facility per day beginning the day the beneficiary is placed on administrative day status. The MHP seeks to develop a new PPG which include language to reflect policies identified in IN 19-026 – Authorization for SMHS, page 8 attached and highlighted in blue. In addition to the development of the new PPG for authorizations and concurrent review, the County is in review of and will update all Department PPGs related to authorizations and concurrent review such as PPG 4.3.1 – Concurrent Review and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services attached hereto. As mentioned in response to Section 5.2.3 and 5.2.4, the County is seeking to contract for deliverable services to review and authorize inpatient treatment episodes, ensure that medical necessity criteria are met, and concurrent reviews of mental health inpatient treatment authorizations as required by IN 19-026. Draft overview and scope of services is included as an attachment in this response to DHCS and highlighted to reflect sections related to IN 19-026 - Authorization for SMHS. Furthermore, the Department's Executive/Leadership Team continues to monitor and entertain the CalMHSA Psychiatric Inpatient Concurrent Review Multi-County initiative. The MHP is awaiting a Participation Agreement for consideration. The "go-live" date of the CalMHSA project is anticipated by March 31, 2022 and will be open to counties statewide for participation (email to qualified and interested counties attached).

Proposed Evidence/Documentation of Correction

- Attachment A1 - Information Notice 19-026 – Authorization for Specialty Mental Health Services
- Attachment A2 - Policy and Procedure Guide 4.3.1 Concurrent Reviews and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services
- Attachment A3 - Draft Request for Proposal, Overview and Scope of Work
- Attachment A4 - CalMHSA Psychiatric Inpatient Concurrent Review Update – Email

Ongoing Monitoring (if included)

The development/implementation of the new PPG to reflect Information Notice 19-026 – Authorization for Specialty Mental Health Services will be overseen by a Sr. Staff Analyst and processed by a Staff Analyst within the Departments Managed Care Division. Department PPGs go through a written and review process that involve Human Resource Labor Relations prior to Department final signature and approval

which may take 3-4 months to finalize. The existing PPG 4.3.1 Concurrent Reviews and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services is in the revisions process and will be overseen by a Sr. Staff Analyst and Staff Analyst within the Department's Managed Care Division. The County's Purchasing and the Department's Contracts Division will oversee the *Request For Proposal*, selection of vendor and County agreement process. Dependent on the scope of work and deliverable services, development/implementation of County agreement process may take six (6) or more months to completion. The Department is seeking to implement and begin deliverable services on July 1, 2022, FY 2022-23. Once County Agreements are implemented, agreements are assigned and regularly monitored by Department Division Manager and Contract Analyst respectively to ensure fidelity of service deliverables. By end of FY2021-22, the Department's Executive/Leadership Team anticipates determining final decision as to whether it will participate in the CalMHSA Psychiatric Inpatient Concurrent Review Agreement.

Person Responsible (job title)

- Jon Rogers, Sr. Staff Analyst, Managed Care Division
- Samantha Wright, Staff Analyst, Managed Care Division
- Shannan Yang, Staff Analyst, Managed Care Division
- Luis Iraheta, Staff Analyst, Contracts Division
- DBH, Executive/Leadership, Marcy Black, Managed Care Division Manager

Implementation Timeline:

November 2021 – April 2022; Development of new PPG and revision of existing Policy and Procedure Guide 4.3.1 Concurrent Reviews and Claims Processing for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services

November 2021 – July 1, 2022; Development/Implementation of deliverable services to review and authorize inpatient treatment episodes, ensure that medical necessity criteria are met, and concurrent reviews of mental health inpatient treatment authorizations.

November 2021 – July 1, 2022; Department of Behavioral Health, Executive/Leadership Team to determine participation in the CalMHSA Psychiatric Inpatient Concurrent Review Participation Agreement.

Category 5 – Coverage and Authorization 5.2.6

Requirement

MHPs must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization.

1) If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.

2) The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services. (MHSUDS IN 19-026)

DHCS Finding 5.2.6

The MHP did not furnish evidence to demonstrate compliance with MHSUDS 19-026. The MHP must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization for the below:

1. If the MHP refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization as long as the MHP specifies the parameters (e.g., number of days authorized) of the authorization.
2. The MHP must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its policies and procedures to comply with MHSUDS 19-026 related to utilizing referral and/or concurrent review and authorization for all CRTS and ARTS. This requirement was not included in any evidence provided by the MHP. Per discussion during the review, the MHP was informed that the current policies and procedures did not meet the standards outlined in MHSUDS 19-026. DHCS requested additional evidence for this requirement. The MHP provided evidence demonstrating its efforts to contract for concurrent review services; however, it was unable to provide a policy that outlined all requirements specified in MHSUDS 19-026.

Corrective Action Description

To ensure that the MHP meets State requirements for authorization of Crisis Residential Treatment and Adult Residential Treatment Services, the MHP will develop and implement a new PPG as stated in Category 5, Sections 5.2.3, 5.2.4, and 5.2.5 of this response to the State. Furthermore, the new policy will reflect language identified for Crisis Residential Treatment and Adult Residential Treatment Services in Information Notice 19-026 Authorization for Specialty Mental Health Services beginning on page 9 attached and highlighted in pink.

Proposed Evidence/Documentation of Correction

- Attachment A1 - Information Notice 19-026 – Authorization for Specialty Mental Health Services

Ongoing Monitoring (if included)

The development/implementation of the new PPG to include concurrent review of Crisis Residential Treatment Services and Adult Residential Treatment Services and reflective of IN 19-026 – Authorization for SMHS will be overseen by a Sr. Staff Analyst and processed by a Staff Analyst within the Department's Managed Care Division. Department PPGs go through a written and review process that involve Human Resource Labor Relations prior to Department final signature and approval which may take 3-4 months to finalize. As with other PPGs, the Department releases a "News You Can Use" via the Department's PolicyTech application/platform to communicate to team members and contract providers.

Person Responsible (job title)

- Jon Rogers, Sr. Staff Analyst, Managed Care Division
- Samantha Wright, Staff Analyst, Managed Care Division

Implementation Timeline:

November 2021 – April 2022; Development of new Policy and Procedure Guideline

Category 5 – Coverage and Authorization 5.4.1

Requirement

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

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. (42 C.F.R. § 438.400(b)(1))
2. The reduction, suspension, or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2))
3. The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))
4. The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4))
5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5))
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7)) (MHSUDS IN No. 18-010E)

DHCS Finding 5.4.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination (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.
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 issued to each beneficiary, or each beneficiary's representative and provider, the appropriate NOABD. DHCS identified five (5) instances where timely access requirements were not met in which it failed to provide the NOABDs for failure to provide services in a timely manner. Per the discussion during the review, the MHP stated it would research the missing NOABDs. The MHP submitted evidence demonstrating that it had issued two (2) of the five (5) NOABDs when it failed to provide services in a timely manner. The MHP could not substantiate the remaining

three (3) NOABDs in question; therefore, it was unable to demonstrate compliance with this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must comply with CAP requirement addressing this finding of non-compliance. (*Repeated deficiency*).

Corrective Action Description

To ensure the MHP meets compliance with timeliness standards as it relates to "*Notice of Adverse Benefit Determination*" the Department of Behavioral Health, Managed Care Division will conduct review of existing PPG 1.2.12 Notice of Adverse Benefit Determination (NOABD), develop a How To Desk Guide to provide support for staff, and collaborate with the Department's IT division to develop a mechanism to monitor and track NOABDs out of compliance. Furthermore, Managed Care staff will engage with in-house programs and contract providers to share data and identify areas of opportunity to improve and to provide technical support such as training to programs and staff.

Proposed Evidence/Documentation of Correction

- How To Desk Guide, Notice of Adverse Benefit Determination *(in process*)
- Attachment A5 - Policy and Procedure Guide (PPG) 1.2.12 Notice of Adverse Benefit Determination (*Resubmission)*

Ongoing Monitoring (if included)

The "How To Desk Guide - Notice of Adverse Benefit Determination" will be developed/implemented and provided to both in-house and contracted providers via the Department's, *News You Can Use* which informs staff and contractors of PPGs and How To Guides. The How To Desk Guide will be assigned to Bla Fang, Staff Analyst with Managed Care. Although the existing PPG 1.2.12 Notice of Adverse Benefit Determination requires no change, it is currently assigned to Bla Fang, Staff Analyst, Managed Care. Ongoing monitoring of the timeliness of NOABD issuance will be done on a quarterly basis to identify any NOABDs out of compliance and track trends over time. The MHP will provide technical support and training where needed. Monitoring will occur January, April, July, and October of each year.

Person Responsible (job title)

- Meng Moua, Sr. Staff Analyst, Managed Care Division
- Bla Fang, Staff Analyst, Managed Care

Implementation Timeline:

January 2022 – July 1, 2022; Develop/implement a process mechanism to monitor and track NOABDs out of Compliance

January 2022 – March 31, 2022; Develop, distribute and post the How To Desk Guide - Notice of Adverse Benefit Determination via Departments PolicyTech application/platform.

Category 6 – Beneficiary Rights and Protections – Grievances

Requirement

Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1))

DHCS Finding 6.2.1

The Mental Health Plan (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 logged all grievances within one day during the triennial review period. DHCS found one (1) out of thirty-five (35) grievances (3%) that did not meet the 24-hour logging requirement (97% compliance). This grievance was logged three (3) working days after receipt. Per the discussion during the review, the MHP stated it would research the circumstances of this grievance. The MHP submitted evidence that the contracted access line staff delayed forwarding a grievance to its clinic staff for three working days. Upon the MHP receiving the grievance in January 2020, MHP staff addressed the timeliness standard issue with the access line staff, logged the grievance, and mailed the acknowledgement letter. While the additional evidence demonstrated that the MHP responded appropriately to an internal problem with a corrective action, the MHP was unable to demonstrate compliance with the requirement.

DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, Subdivision 416 and California Code of Regulations, title 9, chapter 11, section 1850, subdivision 205. The MHP must comply with Corrective Action Plan (CAP) requirement addressing this finding of non-compliance. (*Repeated Deficiency*)

Corrective Action Description

The Department reviewed previous response to State to confirm corrective action items were followed. In the response to State (*MHP Triennial Compliance Review Fiscal Year (FY) 2017-18*), the Department identified language that both Grievance and Appeals are to be logged within a 24-hour period (one business day). As part of the CAP, the Department reviewed materials such as the Individual/Group Provider Manuals, updated both the Grievance and Appeals Logs within the County's electronic health record, and has confirmed updated language within the Policy and Procedure Guides (PPG); titled, *PPG 1.2.11 Person Served Problem Resolution System -Grievance Process (attachment B1)* and *PPG 1.2.18 Person Served Problem Resolution System - Appeal and Expedited Appeal Process (attachment B2)* to ensure written logs are updated within a 24-hour period (one business day). During reporting period, FY 2020-21, the County contracted Exodus Recovery, Inc to operate its 24/7 Toll-Free Access Line which receives calls for services and works closely with contract provider monthly to review incoming calls, request for services, monitor and track mandated monthly test calls inclusive of grievances and appeals calls log, and to provide technical support and training. In November of 2021, Exodus Recovery, Inc. provided the "Access Line Training" to team members who are responsible to answer incoming access line calls and updated call logs. As evidence, the MHP is including attachments Access Line Training power point *(attachment B3)*, and team member participant attendance sheets *(attachment B4)*. Please note seven mental health and Grievance/Appeals example documentation slides were purposely removed due to protected health information displayed in the presentation. The Department of Behavioral Health has developed and implemented a Strategic Plan which include continuous quality improvement which allows for *performance improvement projects*, *Plan Do Study Act*, and other activities to improve systems within the Department. In December of 2021, Managed Care formed a brainstorm session *(attachment B5)* that was comprised of DBH team members and stakeholders inclusive of Exodus Recovery Inc. who provides the access line and record all incoming calls for services. The brainstorm team identified a variety of areas of focus to improve the Grievance/Appeals process and develop/implement quality improvement activities such as potential *intervention(s)*, *Key performance indicators* and agreed upon the use of the *Plan, Do, Study, Act* process model to test and learn from the selected intervention(s). In mid-December 2021, the Department released the Request for Proposal (RFP) # 22-031 Access Line for Substance Use Disorders and Mental Health Services *(attachment B6)*. The RFP provides an overview, release and closing dates, scope of services and contract start date. The partial RFP attachment highlights areas specific to requirements related to call logs. The MHP can submit the complete RFP upon request should the Department of Health Care Services need as evidence for review and file.

Proposed Evidence/Documentation of Correction

- Attachment B1 – PPG 1.2.11 *Person Served Problem Resolution System - Grievance Process*

- Attachment B2 – PPG 1.2.18 *Person Served Problem Resolution System - Appeal and Expedited Appeal Process*
- Attachment B3 – Access Line Training (Exodus Recovery, Inc.)
- Attachment B4 – Access Line Training Participants Sign-In Sheet
- Attachment B5 – Category 6 – DHCS CAP Grievance Brainstorm Team Meeting
- Attachment B6 – DBH Access Line Request for Proposal (RFP)

Ongoing Monitoring

Fresno County, Department of Behavioral Health (DBH), Managed Care Division, assigns Policy and Procedure Guidelines (PPG) to both Utilization Review Specialist and Staff Analyst. DBH utilizes the PolicyTech platform/application to store, secure, access and review on an annual basis and as needed basis. Currently the Departments Access Line Operation is contracted out for Toll-Free 24/7 Access Line Services and monitored by DBH. Training regarding the Access line is provided by Exodus Recovery, Inc. annually and as part of new staff orientation. DBH, Quality Improvement program, monitors monthly test calls, inclusive of Grievances/Appeals and provides technical support. Data is provided at the Departments monthly Quality Improvement Committee. Ongoing continuous quality improvement of the grievance and appeals process will be a team effort which includes stakeholders and County main IT Communications and DBH staff to manage the Plan, Do, Study, Act (PDSA) to ensure the MHP is meeting compliance standard and streamline existing process where possible. The Departments *Access Line Request for Proposal* has been released in December with a closing date of January 2022. This RFP process is monitored by both County's Purchasing and DBH Contracts Division. Purchasing oversees and monitors RFP while Contracts Division develops and implements the County's contract process via the Board of Supervisors. Contracts along with Managed Care Division will work collaboratively with selected vendor for deliverable Access Line services.

Person Responsible (job title)

- *PPG 1.2.11 Person Served Problem Resolution System -Grievance Process*, Briana Jones, Staff Analyst will oversee the development and implementation process of revised PPG.
- *PPG 1.2.11 Person Served Problem Resolution System - Appeal and Expedited Appeal Process,* Briana Jones, Staff Analyst will oversee the development and implementation process of revised PPG.
- *Access Line Training* is provided by Ana Monreal, Access Line Program Manager, Exodus Recovery, Inc.
- *Grievance/Appeals PDSA Brainstorm Continuous Quality Improvement* will be overseen and facilitated by Francisco Escobedo, Managed Care Coordinator
- *DBH Access Line Request for Proposal (RFP)* is overseen by Fresno County, Purchasing and DBH Contracts Division, Luis Iraheta, Staff Analyst.

Development/Implementation Timeline:

- November 2021 – April 2022 - *PPG 1.2.11 Person Served Problem Resolution System -Grievance Process* and *PPG 1.2.11 Person Served Problem Resolution System - Appeal and Expedited Appeal Process* (in process)
- November 2021 – Exodus Access Line Training (completed)
- December 2021 – June 31, 2022 *Grievances and Appeals PDSA* (in process)
- November 2021 – July 1, 2022 – Access Line delivery service begins (in process)