BEHAVIORAL HEALTH&RECOVERY SERVICES

Kern Behavioral Health & Recovery Services

Fiscal Year (FY) 2021/2022

Specialty Mental Health Triennial Review

Corrective Action Plan

Review Dates: June 21-23, 2022

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KERN COUNTY CALIFORNIA

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NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Protocol Requirement

The MHP shall meet, and require its providers to meet, DHCS 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); WIC, § 14197; MHP Contract, Ex. A, Att. 8, sec. 4(A)(1); see CCR, tit. 28, § 1300.67.2.2(c)(5); BHIN No. 20-012.) NOTE: Non-urgent and non-physician appointments are monitored through the Network Adequacy data submission process. Triennial reviews focus on timeliness of all urgent appointments and physician appointments.
Except as provided in CCR, title 9, section 1300.67.2.2(c)(5)(G),

- Urgent care appointments for services that do not require prior authorization must be provided within 48 hours of the request for appointment.
- Urgent care appointments for services that require prior authorization must be provided within 96 hours of the request for appointment.

DHCS Finding: Question 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.

- Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
- Urgent 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:

- 7. Service Request Log 7.1.21 – 9.30.21
- Policy 10.1.9 Notice of Adverse Benefit Determination with Templates
- Service Request Log Associated NOABDs
- 5.4.1 Line 54 – Service Request Log NOABD_1of4

- 5.4.1 Line 55 – Service Request Log NOABD_2of4
- 5.4.1 Line 60 – Service Request Log NOABD_3of4
- 5.4.1 Line 61 – Service Request Log NOABD_4of4
- Service Request log 7.1.21 – 9.30.21 updated

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP meets the Department standards for timely access to care for physician and urgent care services. Of the 100 appointments reviewed by DHCS, seven (7) of the 50 physician appointments and four (4) of the 50 urgent appointments did not meet timeliness standards. Per the discussion during the review, the MHP stated that it began a new process for logging urgent and physician appointments in July 2021 and has faced challenges documenting these requests. The MHP was provided the opportunity to submit additional evidence to demonstrate compliance with this requirement, including Notice of Adverse Beneficiary Determinations (NOABD) for appointments that did not meet timeliness standards, however, no additional evidence was provided.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

Corrective Action Description

- Quality Improvement Division (QID) Determining Action Through Analytics (DATA) team will update the current training to include an emphasis on the importance of the issuance of the Timely Access Notice of Adverse Benefit Determinations (NOABD)
- QID DATA team will develop a report for the team supervisors to utilize to monitor NOABD issuance

Proposed Evidence/Documentation of Correction

- NOABD Training materials
- Sample NOABD team supervisor reports

Ongoing Monitoring

- Quarterly reporting at the Regulatory Compliance Committee (RCC), a sub-committee of the Quality Improvement Committee (QIC)
- Quarterly reporting to the team supervisors/administrators

Person Responsible

Heather Williams, BH Program Supervisor
Quality Improvement Division (QID)

Implementation Timeline

- NOABD training will be developed and presented by March 2023
- Reports will be developed by January 2023

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Protocol Requirement

The QAPI work plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for:

1) Responsiveness for the Contractor's 24-hour toll-free telephone number.
2) Timeliness for scheduling of routine appointments.
3) Timeliness of services for urgent conditions.
4) Access to after-hours care.
   (MHP Contract, Ex. A, Att. 5)

DHCS Finding: Question 3.2.5

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

- Responsiveness for the Contractor's 24-hour toll-free telephone number.
- Timeliness for scheduling of routine appointments.
- Timeliness of services for urgent conditions.
- Access to after-hours care.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- 3.2.5 Test Call Process
- 4. 21-22 Kern County Work Plan.Final
- 4. QAPI Work Plan Evaluations FY1819 FY1920 FY2021
- 3.2.6 21-22 Kern County Work Plan.Final- Cultural Competence information highlighted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures the QAPI Work Plan includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP acknowledged these specific requirements were missing from its QAPI Work Plan. The MHP stated that these requirements are monitored in different committees throughout its service delivery system. The MHP was given the opportunity to provide additional evidence post review to demonstrate these elements are tracked as part of the QAPI work plan, however, no additional evidence was provided.

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

Corrective Action Description

The following goals have been added to the FY22-23 Kern QAPI Work Plan to be able to assess the accessibility of services within our service delivery area:

- Responsiveness for the Contractor's 24-hour toll-free telephone number:
  24/7 Hotline Test Calls:100% of Access Line initial request for services test calls will be logged correctly
- Timeliness for scheduling of routine appointments:
  80% of routine initial request will receive an assessment within 10 business days of the request
- Timeliness of services for urgent conditions:
  80% of urgent requests will receive an assessment within 48 hours of the initial request
- Access to after-hours care:
  90% of service providers will have service available outside of typical service hours (8-5, Mon-Fri)

Proposed Evidence/Documentation of Correction

- FY22-23 Kern QAPI Work Plan

Ongoing Monitoring

Progress toward the annual goals identified above will be monitored through:

- Monthly Key Performance Indicators (KPI) Dashboards
- Bi-monthly Key Performance Indicators Committee (KPIC) meetings with division supervisors
- Quarterly KPIC meetings
- Quarterly QIC meetings

Person Responsible

Lesleigh Davis, Recovery System Administrator
Quality Improvement Division (QID)

Implementation Timeline

The FY22-23 Kern QAPI Work Plan will be finalized by December 1, 2022

Protocol Requirement

The QAPI work plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. (MHP Contract, Ex. A, Att. 5)

DHCS Finding: Question 3.2.6

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence.
The MHP submitted the following documentation as evidence of compliance with this requirement:

- 4. 21-22 Kern County Work Plan.Final
- 4. QAPI Work Plan Evaluations FY1819 FY1920 FY2021
- 2. Cultural Competence Annual Plan FY 21-22
- 3.2.6 21-22 Kern County Work Plan.Final- Cultural Competence information highlighted
- 3.2.6 CC Annual Plan FY 21-22 FINAL

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures the QAPI Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that cultural and linguistic competence is tracked in the cultural competence plan and in various Quality Improvement Committee subcommittees. The MHP was given the opportunity to provide additional evidence post review to demonstrate these elements are tracked as part of the QAPI Work Plan, however, no additional evidence was provided.

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

Corrective Action Description

The following goal has been added to the FY22-23 Kern QAPI Work Plan to be able to demonstrate compliance with the requirements for cultural competence and linguistic competence:

- Outcomes Measurement Penetration Rate: Increase penetration rate of the Asian Pacific Islander population into MH treatment from 1.00% to 1.25% by implementing culturally sensitive outreach and engagement strategies

Proposed Evidence/Documentation of Correction

- FY22-23 Kern QAPI Work Plan

Ongoing Monitoring

Progress toward the annual goals identified above will be monitored through:

- Monthly KPI Dashboards
- Bi-monthly KPI meetings with division supervisors
- Quarterly KPIC meetings
- Quarterly QIC meetings

Person Responsible

Lesleigh Davis, Recovery System Administrator
Quality Improvement Division (QID)

Implementation Timeline:

- The FY22-23 Kern QAPI Work Plan will be finalized by December 1, 2022

ACCESS AND INFORMATION REQUIREMENTS

Protocol 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).)

DHCS Finding: Question 4.3.2

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

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

The seven (7) test calls are summarized below.

TEST CALL #1
Test call was placed on Friday, December 10, 2021, at 7:34 a.m. The caller received a busy signal. The caller attempted the call again five (5) additional times over a span of three (3) minutes and continued to receive a busy signal. The caller was unable to determine the reason for the technical difficulty and concluded the test call attempt.

The caller was not provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met.

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

TEST CALL #2
Test call was placed on Tuesday, December 22, 2021, at 11:12 a.m. The caller received a busy signal. The caller attempted the call again four (4) additional times over a span of two (2) hours and continued to receive a busy signal. The caller was unable to determine the reason for the technical difficulty and concluded the test call attempt.

The caller was not provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #3
Test call was placed on Thursday, March 24, 2022, at 7:28 a.m. The call was answered after four (4) rings via a live operator. The caller requested information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling overwhelmed, isolated, and hopeless. The operator verified the caller's county of residence and proceeded to provide the caller with information regarding the clinic location and hours of operation to receive walk-in services. The operator explained the screening and assessment process to determine medical necessity. The operator assessed the caller's need for urgent services, which the caller responded in the negative.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #4
Test call was placed on Thursday, March 24, 2022, at 2:31 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services and how to refill his/her medication. The operator explained the process for how to access mental health services including walk-in services for crisis and routine services, and provided clinic locations and hours of operation. The operator informed the caller the 24/7 crisis line is available if he/she needed to speak with staff for psychiatric assistance. The operator assessed the caller's need for urgent services, which the caller responded in the negative. The operator provided the office locations and hours of operation for clinics where he/she may be able to receive an immediate medication refill.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #5
Test call was placed on Friday, March 25, 2022, at 1:33 p.m. The call was answered after one (1) ring via a live operator. The caller requested assistance with what he/she described as feeling depressed, unable to sleep, and bouts of crying. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator requested personally identifying information, which the caller provided. The operator provided the clinic location and hours of operation where he/she could be assessed for services. The operator explained the assessment process and gave the caller several options for crisis services as well as reaffirming the 24/7 line is available for any urgent requests.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

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

TEST CALL #6
Test c aced on Monday, February 28, 2022, at 12:34 pm. The call was answered after one (1) ring via a live operator. The caller asked for assistance with filing a complaint about a county therapist that he/she had been seeing. The operator inquired about the type of complaint, which the caller declined to share. The operator provided the contact information for the Patients' Right's Office. No additional information was provided.

The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process.

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

TEST CALL #7
Test call was placed on Friday, March 25, 2022, at 5:18 p.m. The call was answered after six (6) rings via a live operator. The caller asked for assistance with filing a complaint about a county therapist that he/she had been seeing. The operator informed the caller that he/she reached the MHP's after-hours crisis line and stated

that he/she would need to call the Patients' Right's Advocate regarding filing a complaint, a grievance, or to request a new provider. The operator provided the contact information for the Patients' Right's Office. No additional information was provided.

The caller was not provided information about how to use the beneficiary problem resolution and fair hearing process.

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

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	OOC	OOC	IN	IN	IN	N/A	N/A	60%
3	N/A	OOC	IN	IN	IN	N/A	N/A	75%
4	N/A	N/A	N/A	N/A	N/A	OOC	OOC	0%

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). Repeat deficiency Yes

Corrective Action Description

- Beneficiary Problem Resolution and Fair Hearing Process:
  - All KernBHRS 24/7 Hotline staff will:
    - Be trained to inform beneficiaries on usage of the Problem Resolution and Fair Hearing process
    - Utilize a written script when callers express dissatisfaction and ask about the process for filing a complaint

- Failed Calls Due to Busy Signal:
  - KernBHRS is in the process of negotiating a new phone system that is expected to provide higher quality and more reliable service.

Proposed Evidence/Documentation of Correction

- Beneficiary Problem Resolution and Fair Hearing Process:
  - Problem Resolution and Fair Hearing Process for 24/7 Hotline written script

- Problem Resolution and Fair Hearing Process usage training materials and sign-in sheet

Ongoing Monitoring

- QID completes quarterly test calls in accordance with DHCS 24/7 Access Hotline Test Call process and submits the report form to DHCS
  - Any deficiencies are reported to the Hotline Supervisor to address accordingly with staff

Persons Responsible

Ellen Eggert, Program Support Supervisor
Access to Care Hotline

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline:

- All KernBHRS 24/7 Hotline staff will be fully trained and implement the Problem Resolution and Fair Hearing Process call script by the end of December 2022.
- KernBHRS 24/7 Hotline team is in the early stages of negotiating a new phone system. The California Office of Emergency Services is working on choosing a new united platform for 13 call centers, which includes Kern. Once that decision is made, Kern will implement a new phone system that is compatible with the new platform. The timeline for completion is not known at this time. These upgrades are expected to provide higher quality and more reliable service.

Protocol Requirement

The written log(s) contain the following required elements:
a) Name of the beneficiary.
b) Date of the request.
c) Initial disposition of the request.
(CCR, title 9, chapter 11, section 1810.405(f).)

DHCS Finding: Question 4.3.4

The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request.

The MHP submitted the following documentation as evidence of compliance with this

requirement:

- 4.3.4 First Quarter 2020-2021 MHP Test Call Analysis
- 4.3.4 First Quarter 2021-2022 MHP Test Call Analysis
- 4.4.3 Fourth Quarter 2020-2021 MHP Test Call Analysis
- 4.3.4 MHP 24-7 Hotline Call Logs – 03242022
- 4.3.4 MHP 24-7 Hotline Call Logs – 03252022
- 4.3.4 MHP 24-7 Hotline Call Logs – 12102021
- 4.3.4 MHP 24-7 Hotline Call Logs – 12222021
- 4.3.4 Policy 5.5.2 – Initial Request for Services Log
- 4.3.4 Policy 5.5.3 – 24-7 Toll-Free Telephone Access
- 4.3.4 Policy 5.5.3 – Attachment A – Call Script
- 4.3.4 SilentMonitoringDATA March 3. 2022
- 4.3.4 Third Quarter 24_7 Access Line Form Report FY 20_21
- 4.3.4 Hotline Call Log 12.10.21 1of3
- 4.3.4 Hotline Call Log 12.10.21 2of3
- 4.3.4 Hotline Call Log 12.10.21 3of3
- 4.3.4 Hotline Call Log 12.22.21

While the MHP submitted evidence to demonstrate compliance with this requirement, two (2) of the five (5) required DHCS test calls were not logged on the MHP's written log of initial request. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	12/10/2021	7:34 a.m.	OOC	OOC	OOC
2	12/22/2021	11:12 a.m.	OOC	OOC	OOC
3	3/24/2022	7:28 a.m.	IN	IN	IN
4	3/24/2022	2:31 p.m.	IN	IN	IN
5	3/25/2022	1:33 p.m.	IN	IN	IN
Compliance Percentage			**60%**	**60%**	**60%**

Note: Only calls requesting information about SMHS, including services needed to treat a beneficiary's urgent condition, are required to be logged.

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, *section 1810, subdivision 405(f).*

Corrective Action Description

- KernBHRS 24/7 Hotline team is in the process of relocating and negotiating a new phone system that is expected to provide higher quality and more reliable service, allowing for all calls to be answered and logged accordingly. Until then, monitoring through test calls will continue.

Proposed Evidence/Documentation of Correction

- DHCS 24-7 Access Line Test Call Report Form (submitted quarterly to DHCS)

Ongoing Monitoring

- QID will monitor the implementation of corrections through the quarterly test call process and submission of the DHCS 24/7 Access Line Test Call Report Form
- The quarterly report will be provided to the hotline supervisor and correction plan required when deficiencies are identified

Persons Responsible

Ellen Eggert, Program Support Supervisor
Access to Care Hotline

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

The test call monitoring and reporting has been in place for several years and will continue on the current fiscal year quarterly schedule as required by DHCS.

COVERAGE AND AUTHORIZATION OF SERVICES

Protocol Requirement

MHPs must comply with the following communication requirements:

1) Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2) Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization.
3) A physician shall be available for consultation and for resolving disputed requests for authorizations;
4) Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting these online;
5) Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
6) MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.
7) (MHSUDS IN 19-026).

DHCS Finding: Question 5.2.2

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must comply with the following communication requirements:

1. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;
2. Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization.
3. A physician shall be available for consultation and for resolving disputed requests for authorizations;
4. Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting these online;

5. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,
6. MHPs must provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- 5.2.2 Blank Inpatient UR Concurrent Review Tool
- 5.2.2 Good Sam-Concurrent Review Notification Letter
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.2 Provider Notification

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensures that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services; or discloses to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP uses to authorize, modify, or deny SMHS. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. No additional evidence of practice was submitted for this requirement.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- The Authorizations staff will follow the procedures outlined in policy 5.1.19 Treatment Authorization Requests.
- Authorizations team will publish all policies and procedures related to service authorization criteria and guidelines on KernBHRS.org

Proposed Evidence/Documentation of Correction

- To demonstrate the procedures in the policy were in effect prior to the triennial review, the following evidence will be submitted:
  1. Sample executed facility contract from FY21-22 with authorizations requirements highlighted
  2. Sample of the reply to an inpatient hospitalization notification from FY21-22 that demonstrates the written instructions regarding requirements and timeframes for concurrent review authorizations were included

3. Sample minutes from meetings with contracted facilities in FY21-22, highlighting where education and feedback regarding service authorization was provided

- KernBHRS website links and screen shots demonstrating service authorization criteria / guidelines have been posted

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

- Service authorization criteria / guidelines policies will be posted to the public website by the end of December 2022.

Protocol 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: Question 5.2.5

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 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:

- Policy 5.1.19 Treatment Authorization Requests
- 5.2.5 Administrative Days Calculation Form
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.5 Admin Day TAR Allen, D – 6.25.21
- 5.2.5 Admin Day TAR Hernandez, V – 11.11.21
- 5.2.5 Admin Day TAR Johnson Jr., V – 7.22.21

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews 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. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. Post review, the MHP provided Treatment Authorization Requests (TARs), however the TARs did not demonstrate the administrative day contact requirements.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- The Authorizations staff will follow the procedures outlined in policy 5.1.19 Treatment Authorization Requests.

- The Authorizations team will utilize the already developed UR tool and process for reviewing that a hospital makes the required contacts needed for administrative days.

Proposed Evidence/Documentation of Correction

To demonstrate the policy was in effect prior to the triennial review, the following evidence will be submitted:

- Sample TAR packets from FY21-22 with the completed Administrative Day UR tool included and clearly identified

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline
The UR tool and process for reviewing administrative day contact requirements was implemented in 2019.

Protocol 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: Question 5.2.6

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 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.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- 5.2.6 Blank Authorization Request Form
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP utilizes referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. No additional evidence of practice was submitted for this requirement.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- The Authorizations staff will follow the procedures outlined in policy 5.1.19 Treatment Authorization Requests.

- The Authorizations team will utilize the already developed process for authorizing CRTS and ARTS within the electronic health record that includes concurrent review of the documentation to determine appropriateness of the referral and/or reauthorization.

Proposed Evidence/Documentation of Correction

To demonstrate the policy was in effect prior to the triennial review, the following evidence will be submitted:

- Sample completed Authorization Request forms for CRTS and ARTS referrals from FY21-22

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

The CRTS and ARTS authorization process was implemented in 2019.

Protocol Requirement

MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS

a. MHPs may not require prior authorization for the following services/service activities:
    i. Crisis Intervention;
    ii. Crisis Stabilization;
    iii. Mental Health Services -;
    iv. Targeted Case Management;
    v. Intensive Care Coordination; and,
    vi. Medication Support Services.
b. Prior authorization or MHP referral is required for the following services:
    i. Intensive Home-Based Services
    ii. Day Treatment Intensive
    iii. Day Rehabilitation
    iv. Therapeutic Behavioral Services
    v. Therapeutic Foster Care (MHSUDS IN 19-026)

DHCS Finding: Question 5.2.7

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS:

a. MHPs may not require prior authorization for the following services/service activities:
    i. Crisis Intervention;
    ii. Crisis Stabilization;
    iii. Mental Health Services;
    iv. Targeted Case Management;
    v. Intensive Care Coordination; and,
    vi. Medication Support Services.
b. Prior authorization or MHP referral is required for the following services:
    i. Intensive Home-Based Services
    ii. Day Treatment Intensive
    iii. Day Rehabilitation
    iv. Therapeutic Behavioral Services
    v. Therapeutic Foster Care

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- Policy 5.1.26 Out of Plan OutPt Auth and Out of Network Access to Serv
- 5.2.7 2nd Bridge Request
- 5.2.7 Example TBS Assessment-Plan
- 5.2.7 IHBS Request
- 5.2.7 Non-Formulary Request
- 5.2.7 TBS Request
- 5.2.7 TFC Request
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established and implements policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS that may not require prior authorization. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- KernBHRS has implemented and is following these policies to address prior authorization and/or MHP referral requirements for outpatient SMHS:
    - Policy 5.1.19 Treatment Authorization Requests
    - Policy 5.1.26 Out of Plan OutPt Auth and Out of Network Access to Serv
    - Policy 5.4.3 Therapeutic Behavioral Services (TBS)
    - Policy 5.4.7 ICC-IHBS-TFC Services

- Policy 5.1.7 Realignment-Funded and Outpatient Specialty Mental Health Service Authorization Process

Proposed Evidence/Documentation of Correction

To demonstrate the policies were in effect prior to the triennial review, the following evidence will be submitted:

- Sample authorization requests for TBS, ICC, IHBS, and TFC from FY21-22

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

The KernBHRS policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS were implemented in 2019.

Protocol Requirement

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

DHCS Finding: Question 5.2.8

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

this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- SAR Packet_12of14
- SAR Packet_13of14
- SAR Packet_14of14
- 5.1.1 SARs Explanation
- 5.1.1 SARs Sample_1of14
- 5.1.1 SARs Sample_2of14
- 5.1.1 SARs Sample_3of14
- 5.1.1 SARs Sample_4of14
- 5.1.1 SARs Sample_5of14
- 5.1.1 SARs Sample_6of14
- 5.1.1 SARs Sample_7of14
- 5.1.1 SARs Sample_8of14
- 5.1.1 SARs Sample_9of14
- 5.1.1 SARs Sample_10of14
- 5.1.1 SARs Sample_11of14
- 5.1.1 SARs Sample_12of14
- 5.1.1 SARs Sample_13of14
- 5.1.1 SARs Sample_14of14
- External Kern Additional Evidence
- DD SARs Receipt
- EW SARs Receipt 2.16.22

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

Requirement	# of Services Authorizations in compliance	# of Service Authorizations out of compliance	Compliance Percentage
Regular Authorization: The MHP makes a decision regarding a provider's request for prior authorization not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.	5	7	42%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of

the information. Per the discussion during the review, the MHP stated that this is the practice of the MHP. Of the 12 service authorization requests (SARs), eight (8) exceeded the five (5) business day requirement. Post review, the MHP submitted additional evidence for this requirement; however, seven (7) SARs remained out of compliance.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- Authorizations team will develop a process to ensure that all decisions are made within 5 business days or an Authorization Delay Notice (NOABD) is issued when the decision exceeds 5 business days.

Proposed Evidence/Documentation of Correction

- Authorizations decision timeliness written monitoring process

Ongoing Monitoring

- Authorization team's timeliness monitoring process
- QID DATA provide quarterly reporting at Regulatory Compliance Committee (RCC), a sub-committee of QIC

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Heather Williams, BH Program Supervisor
Quality Improvement Division (QID)

Implementation Timeline

The Authorizations team will develop and implement the monitoring process by the end of December 2022.

Protocol Requirement

For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.210(d)(2)).

DHCS Finding: Question 5.2.9

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2). The MHP must for cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.
The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. No additional evidence of practice was submitted for this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2).

Corrective Action Description

- KernBHRS policy 5.1.19 Treatment Authorization Requests will be updated to include a specific process for providers to request an expedited authorization
- The Authorization Request form will be updated for the providers to identify whether it is a standard or expedited request
- Authorizations team will implement a tracking system for expedited authorization requests to ensure providers are notified no later than 72 hours after the receipt of request

Proposed Evidence/Documentation of Correction

- Updated KernBHRS policy 5.1.19 Treatment Authorization Requests
- Sample of the updated Authorization Request form
- Evidence of the expedited authorization tracking log/system

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline:

The KernBHRS policy, Authorization form, and tracking system regarding expedited authorization decisions will be implemented the end of January 2023

Protocol Requirement

MHPs must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

(MHSUDS IN 19-026)

DHCS Finding: Question 5.2.11

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. The MHP must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:

1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually-eligible beneficiaries; and/or,
4. Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.11 Retro Auth CR
- 5.2.11 Retro Auth DP
- 5.2.11 Retro Auth PC
- 5.2.11 Retro Auth WT
- 5.2.11 Retro Auth AZ

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. The MHP submitted additional TARs post review; however, these TARs do not satisfy the requirement of having an established policy and procedure as outlined in the MHSUDS IN 19-026.

DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- The Authorizations staff will follow the procedures outlined in policy 5.1.19 Treatment Authorization Requests.

Proposed Evidence/Documentation of Correction

To demonstrate the policy was in effect prior to the triennial review, the following evidence will be submitted:

- Sample retrospective authorizations from FY21-22

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline:

The KernBHRS policy regarding retrospective authorizations was implemented in 2019.

Protocol Requirement

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements. (MHSUDS IN 19-026)

DHCS Finding: Question 5.2.12

The MHP did not furnish evidence to demonstrate compliance with MHSUDS IN 19-026. In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.1.19 Treatment Authorization Requests
- External Kern Additional Evidence
- Policy 5.01.19 Treatment Authorization Requests
- 5.2.11 Retro Auth CR
- 5.2.11 Retro Auth DP
- 5.2.11 Retro Auth PC
- 5.2.11 Retro Auth WT
- 5.2.11 Retro Auth AZ

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's retrospective authorization decision is communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information and is communicated to the provider in a manner that is consistent with state requirements. Per the discussion during the review, the MHP stated this process is in place but it has a purposely vague policy as it is awaiting further direction from DHCS. Post review, the MHP submitted a compliant policy dated prior to the start of the review, however, it was not evident this policy was implemented during the review period per email communications with the MHP and discussions during the review. The MHP submitted additional TARs post review; however, it was not evident the MHP's authorization decision was communicated to the individual, the individual's

designee, or the provider as required in MHSUDS IN 19-026.

The evidence of practice submitted post review does not meet the requirement. DHCS deems the MHP out of compliance with MHSUDS 19-026.

Corrective Action Description

- The Authorizations staff will follow the procedures outlined in policy 5.1.19 Treatment Authorization Requests for retrospective authorization decision notifications

Proposed Evidence/Documentation of Correction

- To demonstrate the procedures in the policy for notifying individuals of denials/modifications and treatment providers (all outcomes) were in effect prior to the triennial review, the following evidence will be submitted:
    - Sample of retrospective authorization decision notification sent to providers
    - Sample of retrospective authorization decision notification sent to individuals – NOABDs provided for denials/modifications

- Sample of retrospective authorization decision notification sent to individuals for approved stays

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline:

- Retrospective authorization decision notifications to providers and to individuals (when a stay was denied or modified) were implemented in 2019
- Retrospective authorization decision notifications to individuals when a stay is approved will be implemented by the end of December 2022

Protocol Requirement

If the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP in the county in which the foster child resides shall accept that assessment. (Welf. & Inst. Code § 14717.1(f).)

DHCS Finding: Question 5.3.3

The MHP did not furnish evidence to demonstrate compliance with California Welfare and Institution Code, section 14717, subdivision 1(f). The MHP must ensure if the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP in the county in which the foster child resides shall accept that assessment.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 5.4.5 Presumptive Transfer
- 5.3.3 Policy Presumptive Transfer – County of Jurisdiction Assessment
- 5.3.3 Policy 5.4.5 Presumptive Transfer

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures when the MHP in the county of original jurisdiction has completed an assessment of needed services for the foster child, the MHP will accept that assessment. Per the discussion during the review, the MHP stated that its draft policy and procedure would be approved soon and includes this requirement. Post review, the MHP submitted a compliant policy that was dated prior to the review that it will implement moving forward, however it was not evident this policy was in place during the review period.

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

Corrective Action Description

- The Care Coordination Unit (CCU) staff will follow the procedures outlined in policy 5.4.5 Presumptive Transfer: Provision of Services for Out of County Foster Youth

Proposed Evidence/Documentation of Correction

To demonstrate the policy was in effect prior to the triennial review, the following evidence will be submitted:

- Sample of clients from FY21-22 showing client transfers from other counties with an assessment

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Person Responsible

Jeffery Kaya, BH Unit Supervisor II
Care Coordination Unit

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

This process has been in place since the inception of Presumptive Transfer in 2018.

Protocol Requirement

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

DHCS Finding: Question 5.3.8

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

- Policy 5.4.5 Presumptive Transfer
- 5.3.5 Presumptive Transfer Timeliness Tracking Log
- 5.3.7 Expedited Presumptive Transfer Notices
- 5.3.8 Policy 5.4.5 Presumptive Transfer – Expedited Transfers
- 5.3.8 Policy 5.4.5 Presumptive Transfer

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction. Per the discussion during the review, the MHP stated that its draft policy and procedure would be approved soon and includes this language. Post review, the MHP

submitted a compliant policy that was dated prior to the review that it will implement moving forward, however it was not evident this policy was in place during the review period.

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

Corrective Action Description

- The Care Coordination Unit (CCU) staff will follow the procedures outlined in policy 5.4.5 Presumptive Transfer: Provision of Services for Out of County Foster Youth

Proposed Evidence/Documentation of Correction

To demonstrate the policy was in effect prior to the triennial review, the following evidence will be submitted:

- Presumptive Transfer Spreadsheet May 2021 with expedited transfers identified
- Presumptive Transfer Notifications received that were identified as expedited on the May 2021 spreadsheet

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Jeffery Kaya, BH Unit Supervisor II
Care Coordination Unit

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

This process has been in place since the inception of Presumptive Transfer in 2018.

Protocol 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: Question 5.4.1

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

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

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 10.1.9 Notice of Adverse Benefit Determination with Templates
- Service Request Log Associated NOABDs
- TARs-SARs NOABD Tracking w NOABDs 2-1-21 to 3-31-22
- 5.4.1 Line 54 – Service Request Log NOABD_1of4
- 5.4.1 Line 55 – Service Request Log NOABD_2of4
- 5.4.1 Line 60 – Service Request Log NOABD_3of4
- 5.4.1 Line 61 – Service Request Log NOABD_4of4

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides NOABDs to beneficiaries for the failure to provide services in a timely manner. This requirement was not included in any evidence

provided by the MHP. Of the 50 physician appointments reviewed by DHCS, seven (7) beneficiaries did not receive a NOABD. Of the 50 urgent appointments reviewed by DHCS, four (4) beneficiaries did not receive a NOABD. Per the discussion during the review, the MHP stated that it has experienced challenges in providing the required NOABDs and hopes to improve this process moving forward. The MHP was given the opportunity to submit the NOABDs for these appointments requests, however, no additional evidence was submitted.

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

Corrective Action Description

- QID DATA team will update the current training to include an emphasis on the importance of the issuance of the Timely Access NOABDs
- QID DATA team will develop a report for the team supervisors to utilize to monitor NOABD issuance

Proposed Evidence/Documentation of Correction

- NOABD Training materials
- Sample NOABD team supervisor reports

Ongoing Monitoring

- Quarterly reporting at Regulatory Compliance Committee (RCC), a sub-committee of QIC
- Quarterly reporting to the team supervisors/administrators

Person Responsible

Heather Williams, BH Program Supervisor
Quality Improvement Division (QID)

Implementation Timeline:

- NOABD training will be developed and presented by March 2023
- Reports will be developed by January 2023

BENEFICIARY RIGHTS AND PROTECTIONS

Protocol Requirement

The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).)

DHCS Finding: Question 6.1.13

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a). The MHP must ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 10.1.3 Grievance & Appeal System
- Policy 11.1.13 Beneficiary Informing Materials
- Beneficiary Handbook
- Policy 10.1.03 Grievance & Appeal System

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures that decision makers for grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. Per the discussion during the review, the MHP stated that it reviews all information submitted by beneficiaries and beneficiary's representative for grievances and appeals. The MHP was provided the opportunity to submit additional evidence to demonstrate this process was in place. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, it is not evident this policy was in place during the triennial review period.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 406(b)(2)(iii) and 228(a).

Corrective Action Description

- Patients' Rights Office will update the Grievance and Appeals training to include this requirement
- Patients' Rights Office will provide updated Grievance and Appeals training to all KernBHRS teams and contract providers

Proposed Evidence/Documentation of Correction

- Grievance and Appeal Training material
- Schedule of update trainings

Ongoing Monitoring (if included)

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Rachel Mehia, BH Therapist II
Acting Patients' Rights Supervisor

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

- The Grievance and Appeal training materials were updated on 11.10.22
- The update Grievance and Appeal trainings will be completed by the end of February 2023

Protocol Requirement

Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (42 C.F.R. § 438.410(b); MHP Contract, Ex. A, Att. 12, sec. 5(B)(3).)

DHCS Finding: Question 6.4.13

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 410(b). The MHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this

requirement:

- Policy 10.1.3 Grievance & Appeal System
- Policy 11.1.13 Beneficiary Informing Materials
- Beneficiary Handbook
- Policy 10.1.03 Grievance & Appeal System

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. Per the discussion during the review, the MHP stated it would review its policy to see if this requirement was included. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, however, it is not evident this policy was in place during the triennial review period.
DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 410(b).

Corrective Action Description

- Patients' Rights Office will update the Grievance and Appeals training to include this requirement
- Patients' Rights Office will provide updated Grievance and Appeals training to all KernBHRS teams and contract providers

Proposed Evidence/Documentation of Correction

- Grievance and Appeal Training material
- Schedule of update trainings

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Rachel Mehia, BH Therapist II
Acting Patients' Rights Supervisor

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

- The Grievance and Appeal training materials were updated on 11.10.22

- The update Grievance and Appeal trainings will be completed by the end of February 2023

Protocol Requirement

Inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal.
(42 CFR § 438.406(b)(4); 42 CFR § 438.408(b)-(c); MHP Contract, Ex. A, Att. 12, sec. 5(B)(4).)

DHCS Finding: Question 6.4.14

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c). The MHP must inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 10.1.3 Grievance & Appeal System
- 6.4.14 Beneficiary's right template_English_YOUR RIGHTS UNDER MEDI-CAL
- Problem Resolution Informing posters
- Policy 10.1.03 Grievance & Appeal System

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident the MHP informs beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. Per the discussion during the review, the MHP stated that the grievance and appeal posters it has posted throughout the MHP have general information about this requirement and that it would look for evidence to demonstrate this practice. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, it is not evident this policy was in place during the triennial review period.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c).

Corrective Action Description

- Patients' Rights Office will add this information to the Grievance and Appeal Process correspondence provided to the beneficiary

Proposed Evidence/Documentation of Correction

- Sample Grievance and Appeal Process beneficiary correspondence

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Rachel Mehia, BH Therapist II
Acting Patients' Rights Supervisor

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

The Grievance and Appeal Process beneficiary correspondence was updated 11.10.22

PROGRAM INTEGRITY

Protocol Requirement

If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. §438.608(a)(2), (4).

DHCS Finding: Question 7.5.3

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4). The MHP promptly notify DHCS if the MHP finds a party that is excluded.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy 3.1.15 Screen for Ineligible – Susp Employees & Entities
- Policy 3.1.15 AttB Exclusion Attestation
- 7.5.3 KernBHRS Letter regarding Exclusions 6.28.22
- 7.5.3 Policy 3.1.15 Screen Inelig and Susp Empl

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded. Per the discussion during the review, the MHP stated that it reviews exclusion lists monthly, however, it would have to review its policy to identify if the practice of notifying DHCS is in place. Post review, the MHP submitted an updated compliant policy that it will implement moving forward; however, it was not in place during the triennial review period.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4).

Corrective Action Description

- A process will be developed and added to the KernBHRS policy 3.1.15 Screening for Ineligible and Suspended Employees and Entities policy to promptly notify DHCS if an excluded employee/provider is found

Proposed Evidence/Documentation of Correction

- Updated KernBHRS policy 3.1.15 Screening for Ineligible and Suspended Employees and Entities

Ongoing Monitoring

- QID will monitor the initial development and scheduled biennial reviews of the policy to ensure all DHCS requirements are included
- QID will monitor compliance with the process outlined in the policy/procedure annually

Persons Responsible

Liz Brown, Privacy and Corporate Compliance Officer

Donna Robinson, BH Unit Supervisor
Quality Improvement Division (QID)

Implementation Timeline

The DHCS reporting process will be developed and implemented by the end of March 2023.

Chart Review

Protocol Requirement

The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A, Att. 9, Sec. 1(D)(4)).

DHCS Finding: Question 8.3.1

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:

1) **Line number 7 and 17**: There was no written medication consent form found in the medical record. *During the review, MHP staff were given the opportunity to locate the missing medication consent forms but were unable to locate it in the medical records.*

- **Line number 7.** There was no written medication consent form found in the medical record for Asenapine, Buspirone, Paroxetine, and Quetiapine that covered the review period.
- **Line number 17.** There was no written medication consent form found in the medical record for Depakote that covered the review period.

2) **Line number 10**: The written medication consent form in the medical record was not current per the MHP's written documentation standards. *The MHP was able to locate evidence in the medical record; however, the medication consent in question was not completed until well after the beneficiary was prescribed the medications in question. Per Medication Support Progress Note dated 8/17/2021, the beneficiary was prescribed Cogentin, Lorazepam, Sertraline, and Buspirone; however, there was not a medication consent completed for these specific medications until 9/21/2021.*

CORRECTIVE ACTION PLAN 8.3.1:

The 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

- Provide training to Medical Services staff on the procedures outlined in KernBHRS policy 5.2.1 Informed Consent to Administer Or Prescribe Psychotropic Drugs

Proposed Evidence/Documentation of Correction

- Medical Staff Meeting minutes where training on the policy was conducted

Ongoing Monitoring

- QID Documentation Compliance team's quarterly chart reviews
- Medical Services Division monthly medication monitoring reviews

Person Responsible

Ashley Jones, Unit Supervisor II
Authorizations

Karina Leonzo, BH Unit Supervisor II
Quality Improvement Division (QID)

Implementation Timeline

- Medical Services staff training will be completed by 12.12.22
- QID Documentation Compliance team and Medical Services Division medication monitoring reviews are processes that have been implemented