Tehama County Mental Health Services

Fiscal Year (FY) 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

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.

DHCS Finding 1.1.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP met and requires its providers to meet department standards for timely access to care and services, taking into account the urgency of need for services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that the system doesn't make distinction between urgent and emergent appointments. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 03-01-1008, "Access and Availability of Specialty Mental Health Services" to include the definition of urgent care appointments as within 48 hours if no pre-auth required and within 96 hours if pre-auth required.

2. Update policy, "Access and Availability of Specialty Mental Health Services" to include providers update their appointment classification to include "urgent" and to comply with the timelines standard.

3. Train staff and relevant providers on policy updates and changes.

Proposed Evidence/Documentation of Correction

1. Revised policy 03-01-1008, "Access and Availability of Specialty Mental Health Services"

2. Attestations signed by providers within 30 days of receipt

Ongoing Monitoring (if included)

1. Chart audits from selected providers completed quarterly for four (4) quarters to identify appointments classified as urgent were completed within the designated timeframes.

Person Responsible (job title)

1. Quality Assurance Manager

2. Assistant Director Behavioral Health

3. Director of Behavior Health

Implementation Timeline:

1. Policy 03-01-1008, "Access and Availability of Specialty Mental Health Services revisions completed by 6/30/2022.

2. Training for staff and relevant providers on policy changes completed by 7/31/2022.

Requirement

Demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(ii). The MHP must require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves MediCal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP.

DHCS Finding 1.1.5

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation provided hat the MHP requires hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. In addition, if the provider only serves Medi-Cal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP access to after-hours care. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(ii). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 03-01-1008, "Access and Availability of Specialty Mental Health Services"" to include the requirement of subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries.

2. Update policy 03-01-1008, "Access and Availability of Specialty Mental Health Services" to include providers update their hours of operation to reflect services provided are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries.

3. Train staff and relevant providers on policy updates and changes.

Proposed Evidence/Documentation of Correction

1. Revised policy 03-01-1008, "Access and Availability of Specialty Mental Health Services"
2. Attestations signed by providers within 30 days of receipt

Ongoing Monitoring (if included)

1. Chart audits from selected providers completed quarterly for four (4) quarters to identify appointments classified as urgent were completed within the designated timeframes.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy 03-01-1008, "Access and Availability of Specialty Mental Health Services revisions completed by 6/30/2022.
2. Training for staff and relevant providers on policy changes completed by 7/31/2022.

Requirement

Demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 214(a), (b), (c), (d) and 12(a)(2), and (1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18- 019. The MHP must comply with following: The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

DHCS Finding 1.4.3

While the MHP submitted evidence to demonstrate compliance with this requirement, there was no language contained in the submitted policy to reflect that the MHP provides practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 214(a), (b), (c), (d) and 12(a)(2), and (1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-019. The MHP must comply with CAP requirement addressing this finding of noncompliance.]

Corrective Action Description

1. Update policy 03-01-1125, "Provider Selection, Retention, and or Termination" to include language about the requirement to notify, in writing, the reason of a decision to not contract with applying contractor as applicable.
2. Train applicable staff on process for giving practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

Proposed Evidence/Documentation of Correction

1. Revised policy 03-01-1125, "Provider Selection, Retention, and or Termination"
2. Training materials and staff sign in sheets.

Ongoing Monitoring (if included)

1. Audit all denied contract applications packets monthly for six (6) months to check for notification stating the reason for the decision.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy revisions completed by 6/30/2022.
2. Training of applicable staff completed by 07/31/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

DHCS Finding 1.4.4

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certifies or uses another MHP's certification documents to certify the organizational providers that subcontracts with the MHP to provide SMHS. Specifically, one (1) of 23 providers was overdue (96% compliance). DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 8. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review all Site Certification Tracking Log to determine entities that are out of compliance with certification timeline.
2. Schedule sites that are out of compliance for site reviews.
3. Send required documentation requests and protocols for site review timely to out of compliance sites for completion.
4. Complete site reviews and update tracking log to reflect completion.

Proposed Evidence/Documentation of Correction

1. Revised policy 03-01-1125, "Provider Selection, Retention, and or Termination"
2. Training materials and staff sign in sheets.

Ongoing Monitoring (if included)

1. Audit all denied contract applications packets monthly for six (6) months to check for notification stating the reason for the decision.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy revisions completed by 6/30/2022.
2. Training of applicable staff completed by 07/31/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP and the subcontractor shall take corrective action if the MHP identifies deficiencies or areas of improvement.

DHCS Finding 1.4.6

While the MHP submitted evidence to demonstrate compliance with this requirement, there was no documentation submitted by the MHP that indicates that if the MHP identifies deficiencies or areas of improvement that the MHP and the subcontractor take corrective action. Per the discussion during the review, the MHP stated that they don't have a QA Manager and when a review is conducted and deficiencies are determined, the MHP gives the contractor the opportunity to explain how it will be fixed. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review all current Site Certification CAP's received and determine which timelines for completion have passed.
2. Complete follow-up/site reviews to ensure CAP objectives were completed by requesting proof/evidence of completion.
3. Request new timeline for any CAP items that have not been completed.
4. Schedule follow up/site review for uncompleted items.
5. Update Site Certification Tracking Log to include CAP's required per entity and follow-up timeline.

Proposed Evidence/Documentation of Correction

1. Updated Tracking Log with CAP's required per entity and follow-up timeline completed.
2. Completed CAP documentation on file with Compliance Office/Quality Assurance.

Ongoing Monitoring (if included)

1. Audit Site Certification Tracking Log monthly for twelve (12) months to ensure all applicable sites have updated CAP's in place with completion timelines.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Review of current Site Certification CAP's received completed by 4/30/2022.
2. Complete follow-up with noncompliant entities by 5/31/2022.
3. Scheduling of on site reviews completed by 7/31/2022.

Requirement

Demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 415(d). The MHP must, when the MHP determines that the beneficiary's diagnosis is not an included diagnosis for SMHS, or is included but would be responsive to physical health care-based treatment; the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations.

DHCS Finding 2.3.2

While the MHP submitted evidence to demonstrate compliance with this requirement, the policy and procedure and the form submitted did not contain language to reflect that when the MHP determines that the beneficiary's diagnosis is not an included diagnosis for SMHS, or is included but would be responsive to physical health care based on treatment, the MHP of the beneficiary refers the beneficiary in accordance with state regulations. Per discussion during the review, the MHP stated that they would provide additional evidence to support the requirement however, the MHP did not provide the additional evidence as requested. DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 415(d). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy draft, "Transitioning Med Support clients to Primary Care Providers" to include language that states when the MHP determines that the beneficiary's diagnosis is not an included diagnosis for SMHS, or is included but would be responsive to physical health care based treatment; the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations.
2. Update any procedure/forms to include language that reflects when the MHP determines that the beneficiary's diagnosis is not an included diagnosis for SMHS, or is included but would be responsive to physical health care based treatment; the MHP of the beneficiary shall refer the beneficiary in accordance with state regulations.
3. Train applicable staff/providers on language added to policy, procedure, and correct form usage.
4. Submit attestations to applicable staff to sign agreeing they have received training and materials related to the added language, procedures, and forms.

Proposed Evidence/Documentation of Correction

1. Updated and final policy, "Transitioning Med Support clients to Primary Care Providers".
2. Updated procedure/forms that support final policy "Transitioning Med Support clients to Primary Care Providers".

3. Training materials that support final policy "Transitioning Med Support clients to Primary Care Providers".
4. Signed attestations from staff attending training on final policy "Transitioning Med Support clients to Primary Care Providers".

Ongoing Monitoring (if included)

1. Audit Triage notes monthly for three (3) months to determine clients referred to PCP, forms completed, and appointment was coordinated.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy revisions completed by 6/30/2022.
2. Policy, "Transitioning Med Support clients to Primary Care Providers" in effect 7/1/2022.
3. Training applicable staff/providers completed by 9/30/2022.

Requirement

Demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care.

DHCS Finding 2.5.8

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies the beneficiary and/or the beneficiary's authorized representative 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care as this language was not included in the policy and procedure provided by the MHP. DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-059. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 03-01-1062 "Continuity of Care" to ensure the appropriate language is included to notify beneficiaries and/or their representative(s) 30 days before the end of the continuity of care period and the steps of the process that will occur.
2. Create notification letter template with transition plan/process information to be sent to a client when the continuity of care period ends.
3. Train applicable staff on timelines and usage requirements for the letter template.

Proposed Evidence/Documentation of Correction

1. Updated policy 03-01-1062 "Continuity of Care".
2. Notification letter template.
3. Staff training materials/sign in sheets.

Ongoing Monitoring (if included)

1. Audit charts of clients that are in a continuity of care plan monthly for six (6) months to ensure notification is sent 30 days prior to the end of the continuity of care period with steps that will occur for the transition to a new provider.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Update/Review policy 03-01-1062 "Continuity of Care" to ensure the appropriate language is included to notify beneficiaries and/or their representative(s) 30 days before the end of the continuity of care period and the process that will occur by 06/30/2022.

2. Create notification letter template with transition plan/process information to be sent to a client when the continuity of care period ends by 06/30/2022.

3. Complete applicable staff training by 07/31/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP shall inform providers of the beneficiary/family satisfaction activities.

DHCS Finding 3.1.7

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP informs their providers of the beneficiary/family satisfaction activities. This requirement was not included in any evidence provided by the MHP. Specifically, the MHP's evidence stated that the MHP had significant losses in staff during the last fiscal year which included the MHP's Business Operations Supervisor position who historically had the responsibility to oversee the distribution and completion of the consumer satisfaction surveys. The MHP does have any information on the report. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Create timeline and policy/procedure for administering the satisfaction surveys to beneficiaries and families at least annually.
2. Review satisfaction survey activities annually to ensure providers are evaluated appropriately by beneficiaries and families in accordance to state regulations.
3. Send satisfaction survey results specific to the provider completing services.

Proposed Evidence/Documentation of Correction

1. Updated Beneficiary/Family Satisfaction Survey form.
2. Updated Beneficiary/Family Satisfaction Survey Policy/Procedure.
3. Spreadsheet of demographics, distribution, and survey return tracking.
4. Provider Notification Letter template for Survey Results.

Ongoing Monitoring (if included)

1. Audit tracking spreadsheet monthly for 12 (12) months to ensure inclusion from each demographic, survey distribution, receipt, and provider notification of results.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Review of beneficiary satisfaction survey activities to ensure capturing all applicable demographics and topics regarding satisfaction with services provided by 6/30/2022.
2. Complete final satisfaction survey forms/timelines/processes for distribution, submission, and data collection by 9/30/2022.
3. Begin distributing satisfaction surveys to individual demographics by 10/15/2022.
4. Complete compilation of data from received surveys by 2/1/2023.
5. Distribute results of surveys to applicable providers by 3/1/2023.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must implement mechanisms to monitor the safety and effectiveness of medication practices meeting the below listed requirements: 1. Under the supervision of a person licensed to prescribe or dispense medication. 2. Performed at least annually. 3. Inclusive of medications prescribed to adults and youth.

DHCS Finding 3.1.8

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a mechanism to monitor the safety and effectiveness of medication practices and that the monitoring mechanism is under the supervision of a person licensed to prescribe or dispense medication; performed at least annually; and inclusive of medications prescribed to adults and youth. This requirement was not included in any evidence provided by the MHP. Specifically, the evidence stated that during the last fiscal year the MHP has continued to try and recruit a psychiatrist or a pharmacist that would be able to perform medication monitoring. The MHP is currently in the process of entering into a contract with a psychiatrist that will be providing this service. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Finalize contract with a psychiatrist to perform medication management for the MHP.
2. Review current policies and procedures for Medication Management and revise/update to ensure MHP is meeting current requirements from the state.
3. Review/develop monitoring documentation and review forms that meet the requirements of the state for medication management program.
4. Complete necessary trainings with psychiatrist to provide medication management chart audits for adults and youth on an established monthly schedule.
5. Review psychiatrist audits monthly during Quality Assurance Committee/Peer Review Meetings to ensure medication management program is safe and effective.
5. Evaluate the Medication Management Program annually to ensure program is safe and effective.

Proposed Evidence/Documentation of Correction

1. Completed and executed Psychiatrist contract.
2. Updated/revised policy and procedure for Medication Management Program.
3. Chart audit training materials

4. QIC/Peer Review Agenda templates
5. Updated QAPI Workplan

Ongoing Monitoring (if included)

1. Audit psychiatrist chart reviews monthly for twelve (12) months for completion and accuracy.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete contract with psychiatrist for medication management by 6/30/2022.
2. Medication Management policy/procedure review and documentation/forms completed by 04/30/2022.
3. Complete Medication Management trainings with psychiatrist by 7/15/2022.
4. Add Medication Management to Quality Committee/Peer Review agendas to begin review by 8/31/2022.
5. Add Medication Management to QAPI workplan for 2023 for continuous annual review and evaluation by 12/31/2022.

Requirement

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.

DHCS Finding 3.2.6

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP QAPI work plan included cultural competence and linguistic competence requirements. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review and update QAPI workplan and add language that states evaluation of the requirements for cultural and linguistic competence is being met by the MHP per state requirements.

Proposed Evidence/Documentation of Correction

1. Updated QAPI Workplan FY 2022-2023.

Ongoing Monitoring (if included)

1. Evaluate QAPI workplan annually to ensure cultural and Linguistic competence requirements are included and have been met by the MHP.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete QAPI workplan with cultural and linguistic competence requirements included for FY 2022-2023 by 6/30/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 5, that the MHP must ensure the MHP's Utilization Management Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively. During the desk review and the post-WebEx evidence request, the Chart Audit Tool was requested because the files provided were password protected. However, DHCS never received a copy of the unprotected files for review.

DHCS Finding 3.4.1

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's Utilization Management Program evaluates medical necessity, appropriateness and efficiency of services provided to the Medi-Cal beneficiaries prospectively or retrospectively. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review the current Utilization Management Program to ensure the program evaluates medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
2. Develop standardized policies and procedures and audit tools that meet the states requirement for an effective utilization review program outlined in MHP Contract, Exhibit A, Attachment 5.
3. Train applicable staff/providers on policy and procedures and required elements of the Utilization Management Program.
4. Incorporate the Utilization Management Program elements into the Annual QAPI Workplan to evaluate effectiveness of the program.

Proposed Evidence/Documentation of Correction

1. Revised/updated policies and procedures and audit tools for the Utilization Management Program.
2. Training materials for staff and providers for the Utilization Management Program.
3. QAPI FY 2022-2023.

Ongoing Monitoring (if included)

1. Audit chart documentation and billing utilizing developed tools monthly for twelve (12) months to ensure the MHP is providing medically necessary, appropriate and efficient services to Medi-Cal beneficiaries.

2. Review the effectiveness of the program through the QAPI workplan evaluation annually.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete review of the Utilization Management Program by 4/30/2022.
2. Complete development/revision of policies and procedures and audit tools for the Utilization Management Program by 6/30/2022.
3. Complete training for applicable staff/providers on the Utilization Management Program elements and documentation by 8/31/2022.
4. Incorporate the Utilization Management Program into the QAPI FY 2022-2023 by 06/30/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

DHCS Finding 3.5.2

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident how the MHP disseminates the guidelines to all affected providers and upon request to the beneficiaries and potential beneficiaries. This requirement was not included in any evidence provided by the MHP. While during the review the MHP stated that it is disseminated via provider's preference and is available in lobbies of facilities, there was no documented evidence provided to show how the guidelines are disseminated to all affected providers and upon request to the beneficiaries and potential beneficiaries. For example, for providers, evidence could include sample emails to providers with the guidelines attached, provider meeting minutes indicating the providers in attendance and that the guidelines were discussed and disseminated to the providers during the meeting. For beneficiaries and potential beneficiaries, there could be a posting in the lobby letting the beneficiaries or potential beneficiaries know that the guidelines are available to them upon request and a copy of the posting could be provided as evidence; or this could be covered with beneficiaries / potential beneficiaries during intake and the intake form could have a check box indicating the guidelines were provided or the beneficiary was informed they would be provided upon their request, with a sample of a completed form provided as evidence. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review current practice guidelines to ensure they meet all the required elements of title 42, section 438, subdivision 236(b).
2. Develop policy and procedures on the method of dissemination to be utilized for all affected providers and, upon request, to enrollees and potential enrollees.
3. Incorporate annual practice guideline review into provider meetings annually with final approved guidelines sent to all providers electronically.
4. Develop/create signage for provider offices to inform enrollees and potential enrollees of how the MHP practices dissemination of the practice guidelines.

Proposed Evidence/Documentation of Correction

1. Update MHP Practice Guidelines
2. Completed policies and procedures for dissemination of the MHP Practice Guidelines.
3. Final approved signage for providers offices for enrollees/potential enrollees.

Ongoing Monitoring (if included)

1. Complete random site visits quarterly for four (4) quarters to provider offices to ensure signage for enrollees and potential enrollees is visibly prominent and accessible within the lobby/office.
2. Audit provider meeting minutes annually to ensure Practice Guidelines were reviewed, approved, and received by providers.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete review of the MHP's practice guidelines by 5/31/2022.
2. Complete policies and procedure development by 6/30/2022.
3. Complete applicable signage for information in dissemination of the practice guidelines to enrollees/potential enrollees for provider offices by 7/31/2022.

Requirement

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 tollfree 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.

DHCS Finding 4.3.2.3 – Test Call 3

Test call was placed on Monday, March 15, 2021, at 5:05 p.m. The call was answered after two (2) rings via live operator. The caller requested information about accessing mental health services in the county for his/her son who was having problems at school and being disruptive. The operator provided the caller with information regarding the walk-in process. The operator provided the walk-in hours and clinic location. The caller was provided information on how to access SMHS including SMHS required to assess whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in partial compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

Corrective Action Description

1. Retrain applicable staff on the elements required by the state, including information about services needed to treat a beneficiary's urgent condition, and location/address of where services can be obtained, through 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. Review/develop script for test call to ensure continuous quality assurance with 24/7 toll free line.

Proposed Evidence/Documentation of Correction

1. Training materials and applicable staff sign in sheets

Ongoing Monitoring (if included)

1. Test calls will be performed two (2) times a quarter to ensure all elements of the state requirement are met.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Training/script developed and completed by 4/30/2022.

Requirement

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 tollfree 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.

DHCS Finding 4.3.2.3 – Test Call 5

Test call was placed on Wednesday, May 19, 2021, at 7:16 a.m. The call was answered after two (2) rings via live operator. The caller requested information about how to refill his/her anxiety medication as a new resident to Tehama County. The operator asked the caller if he/she was an established client. The caller replied in the negative. The operator asked the caller if he/she had transferred his/her Medi-Cal to Tehama County. The caller replied that it was in process. The operator informed the caller that he/she would need to complete an assessment to see what type of services the caller needs. The operator informed the caller that he/she could walk in to obtain an assessment and provided the hours of operation however did not provide the address. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met but was not provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in partial compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

Corrective Action Description

1. Retrain applicable staff on the elements required by the state, including information about services needed to treat a beneficiary's urgent condition, and location/address of where services can be obtained, through 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. Review/develop script for test call to ensure continuous quality assurance with 24/7 toll free line.

Proposed Evidence/Documentation of Correction

1. Training materials and applicable staff sign in sheets

Ongoing Monitoring (if included)

1. Test calls will be performed two (2) times a quarter to ensure all elements of the state requirement are met.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Training/script developed and completed by 4/30/2022.

Requirement

Demonstrate compliance with California Code of 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.

DHCS Finding 4.3.4

While the MHP submitted evidence to demonstrate compliance with this requirement, two (2) of five (5) required DHCS test calls were not logged on the MHP's written log of initial request. DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f). The MHP must comply with CAP requirement addressing this finding of partial compliance.

Corrective Action Description

1. Retrain applicable staff on maintaining a written log of the initial requests for specialty mental health services from beneficiaries of the MHP, requests shall be recorded whether they are made via telephone, in writing, or in person, and the log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

Proposed Evidence/Documentation of Correction

1. Training materials and applicable staff sign in sheets

Ongoing Monitoring (if included)

1. Audit of the call log performed monthly for twelve (12) months to ensure all elements of the requirement are recorded.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Training developed and completed by 4/30/2022.

Requirement

Demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4). The MHP must have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers.

DHCS Finding 4.4.6

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP had implementation of training programs to improve the cultural competence skills of staff and contract providers. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that this would have been tracked by Quality Assurance Management however this has not occurred. DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review/develop training program to improve the cultural competence skills of staff and contract providers.
2. Develop tracking mechanism to determine completion of training by staff and contract providers.
3. Train staff on cultural competence initially, and annually thereafter.

Proposed Evidence/Documentation of Correction

1. Training materials and applicable staff sign in sheets.
2. Cultural competence tracking log

Ongoing Monitoring (if included)

1. Audit tracking log monthly to ensure all new staff and contracted providers have received initial cultural competence training, and all staff and contact providers have received cultural competence training annually thereafter.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Training program review/development completed by 5/31/2022.
2. Tracking mechanism for training completed by 5/31/2022.
3. Training competed by 7/31/2022.

Requirement

Demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410(e)(2)(B). The MHP must have evidence of referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

DHCS Finding 4.4.8

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provided referrals for beneficiaries who preferred to receive services in a threshold language, but who initially accessed services outside the specified geographic area to a key point of contact that did not have interpreter services in that threshold language. This requirement was not included in any evidence provided by the MHP. Specifically, the documented evidence provided by the MHP states “We do not have samples of this.” DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410(e)(2)(B). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Develop policy and procedure to define the process to identify key points of contact for referrals for beneficiaries who prefer to receive services in a threshold language, but who initially access services outside the specified geographic area that did not have interpreter services in that threshold language.
2. Train staff/providers on the policy procedure for referral for these services for beneficiaries preferring to use a threshold language.
3. Develop tracking mechanism/log to track referrals that require a key point of contact for referrals for beneficiaries who prefer to receive services in a threshold language, but who initially access services outside the specified geographic area that did not have interpreter services in that threshold language.

Proposed Evidence/Documentation of Correction

1. Training materials and applicable staff sign in sheets.
2. Referral tracking log.

Ongoing Monitoring (if included)

1. Audit tracking log monthly to ensure all referrals that require a key point of contact for referrals for beneficiaries who prefer to receive services in a threshold language, but who initially access services outside the specified geographic area that did not have interpreter services in that threshold language are recorded.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy and procedure development completed by 6/30/2022.
2. Training of staff/providers on policy and procedure completed by 7/31/2022.
3. Tracking mechanism/log completed by 5/31/2022.

Requirement

demonstrate compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c). The MHP must notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

DHCS Finding 5.1.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notified the requesting provider and gives the beneficiary written notice of any decision by the contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that was less than requested. Specifically, for nine (9) denied/modified TARs there was no evidence submitted to show that a NOABD was issued. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with MHP contract; exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review and update current policy and procedure for notification of provider and beneficiary of adverse benefit decisions.
2. Create a tracking mechanism to determine if providers and beneficiaries were sent notifications regarding any adverse benefit decisions.
3. Train staff on updated processes for notifications and tracking of adverse benefit decisions to beneficiaries and providers.

Proposed Evidence/Documentation of Correction

1. Updated policy and procedure for notification of adverse benefit decisions.
2. Materials used for staff training on notifications of adverse benefit decisions.
3. Tracking log for notifications of adverse benefit decisions.

Ongoing Monitoring (if included)

1. Audit tracking log monthly for twelve (12) months to ensure required notifications of adverse benefit decisions have been sent to applicable beneficiaries and corresponding providers.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete review/updates to policy and procedure by 6/30/2022.
2. Complete tracking mechanism/log for notifications by 5/31/2022.
3. Complete training of staff on policy and procedure updates and processes by 7/31/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(e). The MHP must ensure compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

DHCS Finding 5.1.4

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that compensation to individuals or entities that conduct utilization management activities is not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. Per the discussion during the review, the MHP stated that the Personnel Rules Manual discusses about receiving gifts, however the evidence and manual does not specifically document that UM activities are not being structured so as to provide incentives to individuals or entities to deny, limit, or discontinue medical necessary services to any beneficiary. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(e). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review the current Utilization Management Program to ensure the program evaluates its policy to ensure compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.
2. Develop standardized policies and procedures that meet the states requirements and includes language that ensures compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.
3. Train applicable staff/providers on policy and procedures and required elements of the Utilization Management Program.
4. Incorporate the Utilization Management Program elements into the Annual QAPI Workplan to evaluate effectiveness of the program.

Proposed Evidence/Documentation of Correction

1. Revised/updated policies and procedures for the Utilization Management Program.
2. Training materials for staff and providers for the Utilization Management Program.
3. QAPI Work Plan FY 2022-2023.

Ongoing Monitoring (if included)

1. Review the effectiveness of the program through the QAPI workplan evaluation annually.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete review of the Utilization Management Program by 4/30/2022.
2. Complete development/revision of policies and procedures for the Utilization Management Program by 6/30/2022.
3. Complete training for applicable staff/providers on the Utilization Management Program elements and documentation by 8/31/2022.
4. Incorporate the Utilization Management Program into the QAPI FY 2022-2023 by 06/30/2022.

Requirement

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.

DHCS Finding 5.2.5

While the MHP submitted evidence to demonstrate compliance with this requirement, 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. It is not evident that the MHP has a procedure to review and ensure a hospital has made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays) starting with the day the beneficiary was 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. DHCS deems the MHP out of compliance with MHSUDS 19-026. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Review and update policy 03-01-1165 "TR Authorization Requests for Hospital Services" to ensure language includes the requirements of MHSUDS IN 19-026 including:
a. 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.
b. 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.
c. 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.
2. Develop a procedure that allows for tracking and follow up to ensure a hospital has made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays) starting with the day the beneficiary was placed on administrative day status for the above requirements.
3. Train applicable staff on updated policy and procedures for compliance with MHSUDS IN 19-026 requirements.

Proposed Evidence/Documentation of Correction

1. Updated policy 03-01-1165 "TR Authorization Requests for Hospital Services".
2. Procedure for Follow up and tracking.
3. Training materials used and sign in sheets for applicable staff.

Ongoing Monitoring (if included)

1. Audit follow up and tracking documentation monthly for twelve (12) months to ensure compliance with MHSUDS IN 19-026.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete review/updates to policy 03-01-1165 "TR Authorization Requests for Hospital Services" by 6/30/2022.
2. Complete procedure for follow up and tracking by 6/30/2022.
3. Complete training of staff on policy 03-01-1165 "TR Authorization Requests for Hospital Services" and procedure updates and processes by 7/31/2022.

Requirement

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.

DHCS Finding 5.2.9

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the Implementation Plan provided by the MHP that 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. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 210(d)(2). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 03-01-1005 "Authorization of Outpatient Services" to include more specific language regarding title 42, section 438, subdivision 210(d)(2) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.
2. Train applicable staff on the updated policy and requirements of FCR title 42, section 438, subdivision 210(d)(2).

Proposed Evidence/Documentation of Correction

1. Updated policy 03-01-1005 "Authorization of Outpatient Services".
2. Training materials and sign in sheets for applicable staff on policy and procedure updates.

Ongoing Monitoring (if included)

1. Audit treatment authorizations monthly for twelve (12) months to ensure timeframes for expedited authorization requests are being met per FCR title 42, section 438, subdivision 210(d)(2).

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete policy 03-01-1005 "Authorization of Outpatient Services "update by 6/30/2022.
2. Complete staff training on policy 03-01-1005 "Authorization of Outpatient Services" by 07/31/2022.

Requirement

Demonstrate compliance with this requirement, it is not evident that 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. 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 Finding 5.2.12

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 retrospective review. 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 deems the MHP out of compliance with MHSUDS 19-026. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 03-01-1005 "Authorization of Outpatient Services" to include more specific language regarding MHSUDS 19-026 requirements 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.
2. Train applicable staff on the updated policy and requirements of MHSUDS 19-026 Retrospective Authorizations.

Proposed Evidence/Documentation of Correction

1. Updated policy 03-01-1005 "Authorization of Outpatient Services".
2. Training materials and sign in sheets for applicable staff on policy and procedure updates.

Ongoing Monitoring (if included)

1. Audit retrospective treatment authorizations monthly for twelve (12) months to ensure timeframes are being met per requirements of MHSUDS 19-026 Retrospective Authorizations.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Complete policy 03-01-1005 "Authorization of Outpatient Services" update by 6/30/2022.
2. Complete staff training on policy 03-01-1005 "Authorization of Outpatient Services" by 07/31/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements: 1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. 2. The acknowledgment letter shall include the following: a. Date of receipt b. Name of representative to contact c. Telephone number of contact representative d. Address of Contractor 3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

DHCS Finding 6.1.5

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP acknowledged receipt of each grievance, appeal, or request for expedited appeal of adverse benefit determinations to the beneficiary in writing and the written acknowledgement to the beneficiary was postmarked within five (5) calendar days of receipt of the grievance. In addition, DHCS reviewed grievance, appeals, and expedited appeals samples to verify compliance with this requirement. DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18- 010E. The MHP must comply with CAP requirement addressing this finding of partial compliance.

Corrective Action Description

1. Update policy "Grievance Process Medical Beneficiaries 2019-08-19" and policy "Grievance Process non-Medical Beneficiaries 2019-08-19" to ensure current language on the timeframes for written acknowledgement of receipt of grievances and appeals is accurate with current standards and regulations.
2. Restructure the tracking log for grievances and appeals to make processes more efficient and complete.
3. Retrain applicable staff on policy and process changes to ensure compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E.

Proposed Evidence/Documentation of Correction

1. Updated policy "Grievance Process Medical Beneficiaries 2019-08-19" and updated policy "Grievance Process non-Medical Beneficiaries 2019-08-19".
2. Updated tracking log for grievances and appeals.
3. Training materials and sign in sheets for staff training.

Ongoing Monitoring (if included)

1. Audit grievance and appeals tracking log monthly for twelve (12) months to ensure timeframe requirements for written acknowledgement of receipt of grievances and appeals is accurate with current standards and regulations.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy updates completed by 6/30/2022.
2. Tracking log updates completed by 6/30/2022.
3. Training for staff on policy and procedure changes completed by 07/31/2022.

Requirement

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.

DHCS Finding 6.2.1

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP recorded grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. Specifically, the grievance and appeal log did not contain a date the grievance and or appeal was entered to determine if the grievance and appeal were logged within one working day of the receipt of the grievance, appeal, or expedited appeal. This requirement was not included in any evidence provided by the MHP. In addition, DHCS reviewed grievance, appeals, and expedited appeals samples to verify compliance with this requirement. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy "Grievance Process Medical Beneficiaries 2019-08-19" and policy "Grievance Process non-Medical Beneficiaries 2019-08-19" to ensure language reflects the requirements of timely documentation of grievances and appeals received is noted and aligns with current standards and regulations.
2. Restructure the tracking log for grievances and appeals to make processes more efficient and complete.
3. Retrain applicable staff on policy and process changes to ensure compliance with the Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

Proposed Evidence/Documentation of Correction

1. Updated policy "Grievance Process Medical Beneficiaries 2019-08-19" and updated policy "Grievance Process non-Medical Beneficiaries 2019-08-19".
2. Updated tracking log for grievances and appeals.
3. Training materials and sign in sheets for staff training.

Ongoing Monitoring (if included)

1. Audit grievance and appeals tracking log monthly for twelve (12) months to ensure timely documentation of grievances and appeals received is noted and aligns with current standards and regulations.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy updates completed by 6/30/2022.
2. Tracking log updates completed by 6/30/2022.
3. Training for staff on policy and procedure changes completed by 07/31/2022.

Requirement

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

DHCS Finding 6.2.6

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provided notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy "Grievance Process Medical Beneficiaries 2019-08-19" and policy "Grievance Process non-Medical Beneficiaries 2019-08-19" to ensure language reflects the requirements of timely notification of any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal and aligns with current standards and regulations.
2. Restructure the tracking log for grievances and appeals to make processes more efficient and complete.
3. Retrain applicable staff on policy and process changes to ensure compliance with California Code of Regulations, title 9, section 1850, subdivision 205.

Proposed Evidence/Documentation of Correction

1. Updated policy "Grievance Process Medical Beneficiaries 2019-08-19" and updated policy "Grievance Process non-Medical Beneficiaries 2019-08-19".
2. Updated tracking log for grievances and appeals.
3. Training materials and sign in sheets for staff training.

Ongoing Monitoring (if included)

1. Audit grievance and appeals tracking log monthly for twelve (12) months to ensure timely notification of any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's

grievance, appeal, or expedited appeal and aligns with current standards and regulations.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy updates completed by 6/30/2022.
2. Tracking log updates completed by 6/30/2022.
3. Training for staff on policy and procedure changes completed by 07/31/2022.

Requirement

Demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance.

DHCS Finding 6.3.2

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolved each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the contractor receives the grievance. Specifically, five (5) of 36 grievances were not resolved within the 90 calendar day timeframe. In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must comply with CAP requirement addressing this finding of partial compliance.

Corrective Action Description

1. Update policy "Grievance Process Medical Beneficiaries 2019-08-19" and policy "Grievance Process non-Medical Beneficiaries 2019-08-19" to ensure language reflects the requirements of resolution of each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance.
2. Restructure the tracking log for grievances and appeals to make processes more efficient and complete.
3. Retrain applicable staff on policy and process changes to ensure compliance with the Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1).

Proposed Evidence/Documentation of Correction

1. Updated policy "Grievance Process Medical Beneficiaries 2019-08-19" and updated policy "Grievance Process non-Medical Beneficiaries 2019-08-19".
2. Updated tracking log for grievances and appeals.
3. Training materials and sign in sheets for staff training.

Ongoing Monitoring (if included)

1. Audit grievance and appeals tracking log monthly for twelve (12) months to ensure resolution of each grievance is completed as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy updates completed by 6/30/2022.
2. Tracking log updates completed by 6/30/2022.
3. Training for staff on policy and procedure changes completed by 07/31/2022.

Requirement

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

DHCS Finding 6.3.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provided written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted. Specifically, three (3) of 36 written notification of a grievance were not provided to the beneficiary. In addition, DHCS reviews grievances samples to verify compliance with standards. DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1850, subdivision 206(c). The MHP must comply with CAP requirement addressing this finding of partial compliance.

Corrective Action Description

1. Update policy "Grievance Process Medical Beneficiaries 2019-08-19" and policy "Grievance Process non-Medical Beneficiaries 2019-08-19" to ensure language reflects the requirements of providing written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.
2. Restructure the tracking log for grievances and appeals to make processes more efficient and complete.
3. Retrain applicable staff on policy and process changes to ensure compliance with the California Code of Regulations, title 9, section 1850, subdivision 206(c).

Proposed Evidence/Documentation of Correction

1. Updated policy "Grievance Process Medical Beneficiaries 2019-08-19" and updated policy "Grievance Process non-Medical Beneficiaries 2019-08-19".
2. Updated tracking log for grievances and appeals.
3. Training materials and sign in sheets for staff training.

Ongoing Monitoring (if included)

1. Audit grievance and appeals tracking log monthly for twelve (12) months to ensure written notification to the beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted has been completed.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy updates completed by 6/30/2022.
2. Tracking log updates completed by 6/30/2022.
3. Training for staff on policy and procedure changes completed by 07/31/2022.

Requirement

Demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a); 408(b)(2). The MHP must resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.

DHCS Finding 6.4.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolved each appeal and provided notice, as expeditiously as the beneficiary's health condition required, within 30 calendar days from the day the MHP received the appeal. Specifically, one (1) of three (3) appeals were not resolved within 30 calendar day from the day the MHP received the appeal. In addition, DHCS reviews appeal samples to verify compliance with standards. DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408. The MHP must comply with CAP requirement addressing this finding of partial compliance.

Corrective Action Description

1. Update policy "Grievance Process Medical Beneficiaries 2019-08-19" and policy "Grievance Process non-Medical Beneficiaries 2019-08-19" to ensure language reflects the requirements of resolving each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.
2. Restructure the tracking log for grievances and appeals to make processes more efficient and complete.
3. Retrain applicable staff on policy and process changes to ensure compliance with the Federal Code of Regulations, title 42, section 438, subdivision 408(a); 408(b)(2).

Proposed Evidence/Documentation of Correction

1. Updated policy "Grievance Process Medical Beneficiaries 2019-08-19" and updated policy "Grievance Process non-Medical Beneficiaries 2019-08-19".
2. Updated tracking log for grievances and appeals.
3. Training materials and sign in sheets for staff training.

Ongoing Monitoring (if included)

1. Audit grievance and appeals tracking log monthly for twelve (12) months to ensure resolution of each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy updates completed by 6/30/2022.
2. Tracking log updates completed by 6/30/2022.
3. Training for staff on policy and procedure changes completed by 07/31/2022.

Requirement

Demonstrate compliance with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(6). The MHP must implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers.

DHCS Finding 7.2.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implemented and maintained written policies for all employees of the MHP, and of any contractor or agent, that provided detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(6). The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update behavioral health compliance plan to include detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers for all employees of the MHP, and of any contractor or agent.
2. Create attestation to be presented with a copy of the plan initially and annually thereafter to be signed by all employees of the MHP, and of any contractor or agent, to acknowledge receipt, understanding, and will abide the compliance plan and policies.
3. Provide training for all employees of the MHP, and of any contractor or agent, of behavioral health compliance plan updates including details of the False Claims Act and whistleblower protections.
4. Add behavioral health compliance plan training to training tracking log for annual review.

Proposed Evidence/Documentation of Correction

1. Updated behavioral health compliance plan with attestation form attached.
2. Signed attestations from all employees of the MHP, and of any contractor or agent.

Ongoing Monitoring (if included)

1. Audit training log annually to ensure all employees of the MHP, and of any contractor or agent, have completed training and attestations of behavioral health compliance plan receipt.
2. Evaluate/update behavioral health compliance plan annually

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Updated behavioral health compliance plan completed by 6/30/2022.
2. Attestation form completed by 6/30/2022.
3. Training of all employees of the MHP, and of any contractor or agent completed by 9/30/2022.

Requirement

Demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106. The MHP must submit disclosure to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

DHCS Finding 7.4.6

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP had a system in place to submit disclosures to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 8-02-3018 "Exclusions Lists" to include language that the MHP must submit disclosure to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.
2. Update procedure to define roles and processes for reporting to meet the requirements of Federal Code of Regulations, title 42, section 455, subdivision 101 and 106.
3. Create tracking mechanism or log to ensure timely and accurate reporting to DHCS is completed.

Proposed Evidence/Documentation of Correction

1. Completed policy 8-02-3018 "Exclusions Lists".
2. Completed procedure to define roles and processes for reporting.

Ongoing Monitoring (if included)

1. Audit reporting tracking log monthly for twelve (12) months to ensure timely disclosure to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and

identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Updated policy 8-02-3018 "Exclusions Lists" completed by 6/30/2022.
2. Updated procedure to define roles and processes for reporting completed by 6/30/2022.
3. Reporting tracking log completed by 6/30/2022.

Chart Review

Requirement

Medical Necessity

DHCS Finding 8.1.1.3b1

The intervention(s) documented on the progress note(s) for the following Line number(s) did not meet medical necessity since the service provided did not specifically address the mental health condition or impairment identified in the assessment and was solely: • Clerical: Line number 10. RR11f, refer to Recoupment Summary for details. The service claimed as a Collateral service on 3/24/20 (20 Units of Time) describes the provider leaving a voicemail message only with the provider's availability for return call. The MHP shall submit a CAP that describes how the MHP will ensure that services provided and claimed are not solely clerical.

Corrective Action Description

1. Review and update documentation standards for clinicians to ensure documentation of services is being delivered and is accurate to the beneficiary's mental health condition.
2. Train staff/providers on updated documentation standards for clinicians and educate on expectations.

Proposed Evidence/Documentation of Correction

1. Updated documentation standards
2. Training materials for updated documentation standards
3. Staff/provider training sign in sheets

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure documentation of services is being delivered and is accurate to the beneficiary's mental health condition.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Documentation Standards review and update completed by 6/30/2022.
2. Training for staff and providers on updated documentation standard completed by 07/31/2022.

Requirement

Medication Consent

DHCS Finding 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 1 and 10: There was no written medication consent form found in the medical record. During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record. • Line number 1. During the review period, the client was prescribed Clozaril, Paxil, Abilify, Ativan, and Propranalol, but the MHP was unable to locate Medication Consent(s) for these medications. • Line number 10. During the review period, the client was prescribed Methylphenidate ER, but the MHP was unable to locate a Medication Consent for these medications. 2) Line numbers 2, 3, and 5: Although there was a written medication consent form in the medical record, there was no medication consent for each of the medications prescribed. The MHP was given the opportunity to locate the medication consent(s) in question but was unable to locate it/them in the medical record. Line number 2. Although medication consent forms were provided for the majority of prescribed medications, a medication consent form could not be located for Prozac. • Line number 3. Although medication consent forms were provided for the majority of prescribed medications, medication consent form(s) could not be located for Topamax and Imitrex. • Line number 5. Although medication consent forms were provided for the majority of prescribed medications, medication consent form(s) could not be located for Clonidine, Wellbutrin, and Pramipexole. 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

1. Review and update written medication consent form procedure to ensure that a consent form is completed for each medication prescribed and administered as well as completed in accordance with current documentation standards.
2. Train staff/providers on current documentation standards and updated medication consent form procedures.

Proposed Evidence/Documentation of Correction

1. Updated medication consent form procedure
2. Training materials for staff/providers on updated medication consent form procedures
3. Staff/provider training sign in sheets

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure each medication has the correct consent with the correct information noted per documentation standards and state requirements.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Medication Consent form procedure review and update completed by 6/30/2022.
2. Training for staff and providers on Medication Consent form procedure updated completed by 07/31/2022.

Requirement

Written Medication Consents

DHCS Finding 8.3.2

Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent form, and/or documented to have been reviewed with the beneficiary, and/or provided in accompanying written materials to the beneficiary: 1) Type of medication: Line number 3. • Line number 3. The Medication Consent form for Sertraline (unknown completion date) did not contain information about the type of medication. 2) Range of Frequency (of administration): Line numbers 2 (see summary note regarding older Medication Consent form) and 3. • Line number 3. The Medication Consent forms for Cymbalta, Prazosin, and Guanfacine (completed 1/17/19, 5/17/19, and 2/5/20 respectively) did not contain information about the range of frequency. • Line number 3. The Medication Consent form for Sertraline (unknown completion date) did not contain information about the range of frequency. 3) Dosage: Line numbers 2 (see summary note regarding older Medication Consent form) and 3. Line number 3. The Medication Consent form for Cymbalta, Prazosin, and Guanfacine (completed 1/17/19, 5/17/19, and 2/5/20 respectively) did not contain information about the dosage. 4) Method of administration: Line numbers 2 (see summary note regarding older Medication Consent form) and 3. • Line number 2. The Medication Consent form for Topomax (completed 5/15/18) did not contain information about the route of administration. • Line number 3. The Medication Consent form for Sertraline (unknown completion date) did not contain information about the route of administration. 5) Duration of taking the medication: Line numbers 2 (see summary note regarding older Medication Consent form), 3, and 5. • Line number 2. The Medication Consent form for Gabapentin (completed 8/14/18) indicated the expected duration was “ongoing”, which is insufficient detail for fully informing the beneficiary of the length of time they would be taking the medication. • Line number 2. The Medication Consent form for Topomax (completed 5/15/18) did not contain information about the expected duration. • Line number 3. The Medication Consent form for Sertraline (unknown completion date) did not contain information about the expected duration. • Line number 3. The Medication Consent form for Cymbalta, Prazosin, and Guanfacine (completed 1/17/19, 5/17/19, and 2/5/20 respectively) indicated the expected duration was “ongoing”, which is insufficient detail for fully informing the beneficiary of the length of time they would be taking the medication. • Line number 5. The Medication Consent form for Latuda, Lamictal, and Ativan (unknown completion date) indicated the expected duration was “ongoing”, which is insufficient detail for fully informing the beneficiary of the length of time they would be taking the medication. 6) Possible side effects if taken longer than 3 months: Line number 2 (see summary note regarding older Medication Consent form).

The older version of the Medication Consent form was missing elements including range of frequency (of administration), dosage, method of administration, duration of taking the medication, and possible side effects if taken longer than 3 months. Subsequent to the last Triennial Review, the MHP made changes to their standard medication consent form in order to meet compliance standards and address required elements. During the on-site review, MHP staff indicated that the new medication form has been in use for any newly prescribed medications (as well as other circumstances that require a new medication consent), but MHP providers did not complete a new medication consent form for medications that clients may have been prescribed on a long-term basis (i.e. prescribed prior to last Triennial Review). For example, with Line number 2, the MHP provided a medication consent form (Celexa, Abilify, Trazadone, Klonopin, Buspar, and Gabapentin, completed on 1/2/14) that was in use prior to the last Triennial Review. The MHP shall submit a CAP that describes how the MHP will ensure that every medication consent process addresses all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description

1. Review and update written medication consent form procedure to ensure that a consent form is completed for each medication prescribed and administered as well as completed in accordance with current documentation standards to include documentation of review with the beneficiary about information about the type of medication prescribed, range of frequency, dosage, method of administration, duration of taking the medication, and possible side effects if taking longer than 3 months.
2. Train staff/providers on current documentation standards and updated medication consent form procedures.

Proposed Evidence/Documentation of Correction

1. Updated medication consent form procedure
2. Training materials for staff/providers on updated medication consent form procedures
3. Staff/provider training sign in sheets

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure each medication has the correct consent with the correct information reviewed with the beneficiary noted per documentation standards and state requirements.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Medication Consent form procedure review and update completed by 6/30/2022.
2. Training for staff and providers on Medication Consent form procedure updated completed by 07/31/2022.

Requirement

Medication Consent in the Chart

DHCS Finding 8.3.3

Medication Consent(s) in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, job title, and/or the date the provider completed and entered the document into the medical record. Specifically: • The signature of the person providing the service (or electronic equivalent) • Line numbers 3 and 5. • Line number 3. The Medication Consent form for Sertraline (unknown completion date) did not contain the signature of the person providing the service. • Line number 5. The Medication Consent form for Latuda, Lamictal, and Ativan (unknown completion date) did not contain the signature of the person providing the service. • The type of professional degree, licensure, or job title of person providing the service: • Line numbers 2, 3, and 9. • Line number 2. The provided Medication Consent Forms for Topomax and Gabapentin (completed 5/15/28 and 8/14/18 respectively) did not include the professional degree, licensure, or job title of person providing the service. • Line number 3. The provided Medication Consent form for Cymbalta, Prazosin, and Guanfacine (completed 1/17/19, 5/17/19, and 2/5/20 respectively) did not include the professional degree, licensure, or job title of person providing the service. • Line number 9. The provided Medication Consent form for Guanfacine and Clonidine (completed 3/6/20) did not include the professional degree, licensure, or job title of person providing the service. • The date the documentation was completed, signed (or electronic equivalent) and entered into the medical record: • Line numbers 3 and 5. • Line number 3. The Medication Consent form for Sertraline did not contain the date the documentation was completed, signed (or electronic equivalent) and entered into the medical record. • Line number 5. The Medication Consent form for Latuda, Lamictal, and Ativan did not contain the date the documentation was completed, signed (or electronic equivalent) and entered into the medical record. The MHP shall submit a CAP that describes how the MHP will ensure that all Medication Consents include the: 1) Provider's signature (or electronic equivalent). 2) Provider's signature (or electronic equivalent) that includes professional degree, licensure or title. 3) Date the signature was completed and the document was entered into the medical record.

Corrective Action Description

1. Review and update written medication consent form procedure to ensure that a consent form is completed for each medication prescribed and administered as well as completed in accordance with current documentation standards to include the signature of the provider of service (or electronic equivalent) that includes the provider's

professional degree, licensure, job title, and/or the date the provider completed and entered the document into the medical record.
2. Train staff/providers on current documentation standards and updated medication consent form procedures.

Proposed Evidence/Documentation of Correction

1. Updated medication consent form procedure
2. Training materials for staff/providers on updated medication consent form procedures
3. Staff/provider training sign in sheets.

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure each medication has the correct consent with the correct information reviewed with the provider signatures elements per documentation standards and state requirements.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Medication Consent form procedure review and update completed by 6/30/2022.
2. Training for staff and providers on Medication Consent form procedure updated completed by 07/31/2022.

Requirement

Client Plans

DHCS Finding 8.4.4

Client Plans did not include all of the required elements identified in the MHP Contract. Specifically: • One or more goal/treatment objective was not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments. Line number 2. On the "Annual Mental Health Medication Support Service Plan" completed as signed on 6/28/19, the objective is indicated by a checkbox for the client to their level of Physical Activity, and shows their objective as an "increase in frequency of physical activity from 1 days a week to 2 days a week…" This objective was not related to the beneficiary's identified functional impairments in that the described functional impairments were related to Activities of Daily Living. • One or more proposed intervention did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded. Line number 2. On the "Mental Health Recovery Plan" completed as signed on 1/13/20, the Therapy intervention content section states, "Clinician will continue to collaborate with client and CRS staff to coordinate care and will meet with client at least once per 6 month authorization period to assess progress and functioning and revise treatment goals." This content is not a detailed description consistent with planned therapy intervention. The MHP shall submit a CAP that describes how the MHP will ensure that: 1) Client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis. 2) Mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).

Corrective Action Description

1. Review and update documentation standards for clinicians to ensure documentation is specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments.
2. Train staff/providers on updated documentation standards for clinicians and educate on expectations

Proposed Evidence/Documentation of Correction

1. Updated documentation standards
2. Training materials for updated documentation standards
3. Staff/provider training sign in sheets

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure documentation of services being delivered includes specific, observable and/or quantifiable objectives and detailed description of the interventions to be provided related to the beneficiary's mental health condition.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Documentation Standards review and update completed by 6/30/2022.
2. Training for staff and providers on updated documentation standard completed by 07/31/2022.

Requirement

Progress Notes

DHCS Finding 8.5.2

Progress notes did not include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically: • Line numbers 2, 4, and 8. One or more progress note was not completed within the MHP's written timeliness standard of 1 day after provision of service. MHP's timeliness policy describes that progress notes should be completed concurrently with service or on the same day. Eight (6 percent) of all progress notes reviewed were completed late (94% compliance). • Line numbers 1, 3, and 5. Progress note "Completion Timeliness" could not be determined because the provider signed, but did not date the note. Therefore, the note was considered late. Twelve (8 percent) of all progress notes reviewed did not include provider signature completion date (or electronic equivalent).(92% compliance). The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document: • Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards. • Date the progress note was completed and entered into the medical record in order to determine completion timeliness, as specified in the MHP Contract with the Department.

Corrective Action Description

1. Review and update documentation standards for clinicians to ensure documentation of services is being completed timely within one day after provision of services and contains the date when the note was completed and entered into the medical record.
2. Train staff/providers on updated documentation standards for clinicians and educate on expectations.

Proposed Evidence/Documentation of Correction

1. Updated documentation standards
2. Training materials for updated documentation standards
3. Staff/provider training sign in sheets

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure documentation of services is being completed and dated within one day after provision of services.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Documentation Standards review and update completed by 6/30/2022.
2. Training for staff and providers on updated documentation standard completed by 07/31/2022.

Requirement

Progress Note Frequency

DHCS Finding 8.5.4

Progress notes were not documented according to the frequency requirements specified in the MHP Contract. Specifically: • Line number 1: There was no progress note in the medical record for the service claimed on 3/10/20; Service Function 60; Units of Time 6). RR8a, refer to Recoupment Summary for details. The MHP was given the opportunity to locate the document(s) in question but did not provide written evidence of the document(s) in the medical record. The MHP shall submit a CAP that describes how the MHP will ensure that all Specialty Mental Health Services claimed are documented in the medical record.

Corrective Action Description

1. Review and update documentation standards for clinicians to ensure timely documentation of a progress note is being completed for each date of service claimed per documentation standards.
2. Train staff/providers on updated documentation standards for clinicians and educate on expectations.

Proposed Evidence/Documentation of Correction

1. Updated documentation standards
2. Training materials for updated documentation standards
3. Staff/provider training sign in sheets.

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure documentation of services includes a progress note completed for each date of service claimed.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Documentation Standards review and update completed by 6/30/2022.
2. Training for staff and providers on updated documentation standard completed by 07/31/2022.

Requirement

Provision of ICC Services and IHBS for Children and Youth

DHCS Finding 8.6.1

1) The MHP did not furnish evidence that it has a standard procedure for providing and documenting individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs. • For this review, the MHP submitted a Policy and Procedure document (Policy Number 03-01-1135; Dated May 13, 2021) regarding Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC) and the Child and Family Team. This document describes the MHP's policies regarding ICC, IHBS, and TFC, including procedures on the provision of said services. As noted, this is a recent document, and evidence from this review and the review sample, indicate that the MHP is in a state of transition regarding the determination and provision of ICC and IHBS services. During the on-site review, MHP staff discussed that previously the MHP conducted CFT meetings but currently these responsibilities are primarily performed by a contracted provider, specifically for those youth referred by County Welfare Services. At time of this review, the MHP is also in the process of developing additional contracts with providers who will be providing ICC and IHBS services on behalf of the MHP. 2) The medical record associated with the following Line number(s) did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS, and that if appropriate, such services were included in their Client Plan: • Line numbers 6, 7, and 8. o Line number 6. Client is a child in foster care and presenting with behavioral issues. Though there was a notation on the MHP's authorization for services form (ASR Worksheet) that client is "non Katie A – High Needs", there was no further evidence that a determination was made on client's eligibility or need for ICC services and/or IHBS. o Line number 7. Client is a child in foster care and previously in an intensive group home situation, but there is was no evidence that a determination was made on client's eligibility or need for ICC services and/or IHBS. o Line number 8. Client is a child in foster care and with history of trauma exposure, but there was no evidence that a determination was made on client's eligibility or need for ICC services and/or IHBS. The MHP shall submit a CAP that describes how it will ensure that: 1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS. 2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS. 3) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

Corrective Action Description

1. Review and update policy 03-01-1135 "Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC) and the Child and Family Team" to include language referring to usage of the Child and Adolescent Needs and Strengths (CANS) assessment to provide individual determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs.
2. Train staff on the updated policy, usage of the CANS assessment, and documentation process per the documentation standards.

Proposed Evidence/Documentation of Correction

1. Updated policy 03-01-1135 "Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC) and the Child and Family Team" and procedure.
2. Training materials for staff/providers on updated policy and procedures.
3. Staff/provider training sign in sheets

Ongoing Monitoring (if included)

1. Audit charts monthly for 12 (12) months to ensure documentation of (CANS) assessment for beneficiaries under age 22 is completed as necessary.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Policy 03-01-1135 "Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC) and the Child and Family Team" and procedure review and update completed by 6/30/2022.
2. Training for staff/providers on updated policy and procedure completed by 7/31/2022.

Requirement

Demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4). The MHP promptly notifies DHCS if the MHP finds a party that is excluded.

DHCS Finding 7.5.3

While the MHP submitted evidence to demonstrate compliance with this requirement, the policies submitted did not include language to indicate that the MHP had a system in place to promptly notify DHCS if the MHP found an excluded party or how this would be done. This requirement was not included in any evidence provided by the MHP. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608. The MHP must comply with CAP requirement addressing this finding of noncompliance.

Corrective Action Description

1. Update policy 8-02-3018 "Exclusions Lists" to include language that the MHP must promptly notifies DHCS if the MHP finds a party that is excluded.
2. Update procedure to define roles and processes for reporting to meet the requirements of Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4).
3. Create tracking mechanism or log to ensure timely and accurate reporting to DHCS is completed.

Proposed Evidence/Documentation of Correction

1. Completed policy 8-02-3018 "Exclusions Lists".
2. Completed procedure to define roles and processes for reporting.
3. Completed reporting tracking log.

Ongoing Monitoring (if included)

1. Audit reporting tracking log monthly for twelve (12) months to ensure prompt notification to DHCS if the MHP finds a party that is excluded.

Person Responsible (job title)

1. Quality Assurance Manager
2. Assistant Director Behavioral Health
3. Director of Behavior Health

Implementation Timeline:

1. Updated policy 8-02-3018 "Exclusions Lists" completed by 6/30/2022.
2. Updated procedure to define roles and processes for reporting completed by 6/30/2022.
3. Reporting tracking log completed by 6/30/2022.