Lake County Behavioral Health Services

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

Corrective Action Plan

Contents

System Review

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Finding 1.1.3

Requirement

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services.

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

2. Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment

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

- 101-Medi-Cal Array of Services
- Service Request Log
- 161 Network Adequacy
- 274-Out-of-Network Access and Single Case Agreements
- 103-Intake Process for Outpatient Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP meets and requires its providers to meet Department standards for timely access to care and services. Per the discussion during the review, the MHP reported issues tracking timeliness standards with the existing tracking system and Electronic Health Records (EHR) which has caused several urgent care requests that do not require prior authorization to be out of compliance with timeliness standards.

The MHP is currently working with Kings View to modify its current EHR system and has developed a request for proposal for a new EHR system. In the interim, the MHP is manually tracking timelines for 48 and 96 hour urgent care appointments. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

Corrective Action Description

Policies #103 (Intake Process for Outpatient SMHS) and #102 (Access Line and Log; Availability of 24/7 Services) will be updated to include these timeliness standards. The Access Log/EHR will be modified, as feasible, to include these data elements. At least annually, LCBHS will train relevant staff to accurately document these types of service requests. Access Log review will be conducted semi-annually by the Compliance team to ensure ongoing compliance. Activities and findings will be summarized quarterly for the QIC.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; log or EHR template with updates; sample requests, if any; QIC Committee minutes.

Ongoing Monitoring (if included)
LCBHS will provide annual training to relevant staff and will conduct semi-annual Compliance team reviews to ensure compliance. Activities and findings will be summarized quarterly for the QIC.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.1.6

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi). The MHP shall establish mechanisms to ensure that network providers comply with the below timely access requirements:

1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements.
2. The MHP shall take corrective action if there is a failure to comply with timely access requirements.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established mechanisms to ensure that network providers comply with timely access standards. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that timely access standards were built into provider contracts and reinforced through the provider service data uploaded to the provider portal and via monthly submission to the MHP. DHCS requested provider contracts and corrective action documentation, however; the contract boilerplate and additional evidence submitted did not indicate timely access requirements and was insufficient in demonstrating a corrective action process.

DHCS deems the MHP out of compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi).

Corrective Action Description
LCBHS staff will ensure that policy #127 includes these standards, including CAP process, update if necessary; update Provider Manual with these standards; ensure that provider manual is given to providers upon contract (or when updated); update

boilerplate language to reference provider manual, if necessary; periodic chart reviews; summarize findings for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy and provider manual; updated boilerplate contract, if applicable; chart reviews; Compliance Committee minutes
Ongoing Monitoring (if included)
10% of caseload periodic provider chart/data reviews; summarized for Compliance committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager/Privacy Officer

Implementation Timeline
Submit updated policies and provider manual by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.2.1
Requirement
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to all children and youth who meet medical necessity criteria for those services. Membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides ICC and IHBS to all qualified children and youth. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that ICC and IHBS services are provided by the MHP or are referred to its contracted service provider, Redwood Community Services (RCS). DHCS requested evidence of the referrals and a tracking process for these referral; however, no further evidence was submitted. DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
LCBHS staff ensures that policies #101, 108, and 147 include these standards; obtain service data; conduct periodic chart reviews; summarize findings for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; service data; chart review results; Compliance Committee minutes.

Ongoing Monitoring (if included)

10% of caseload regular chart reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and data by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.2.2
Requirement
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth meet medical necessity criteria need ICC and IHBS.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth for ICC and IHBS services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that the Child and Adolescent Needs and Strengths (CANS) assessment, Pediatric Symptom Checklist (PSC-35), and the Addiction Severity Index (ASI) risk assessment are used are its standard assessment and screening tools for ICC and IHBS. The MHP also stated that it evaluates the Child Family Team (CFT) process to determine if there is a need for ICC and IHBS. DHCS requested evidence of this assessment process; however, no further evidence was submitted.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
LCBHS staff ensures that policies #101, 108, 142, & 147 include these standards; train relevant staff; obtain relevant data from LCBHS and RCS; conduct chart reviews; summarize for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; data; chart reviews; Compliance Committee minutes.

Ongoing Monitoring (if included)
10% of caseload regular chart reviews; summarized for Compliance Committee.

Person Responsible (job title)

Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and data by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.2.5
Requirement
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must convene a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP conducts CFT meetings for all children and youth receiving ICC, IHBs, or TFC regardless of child welfare or juvenile probation involvement. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that all children and youth receiving ICC and IHBS services should be receiving CFT. DHCS requested samples of CFT meeting minutes and other evidence of this practice; however no further evidence was submitted.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
LCBHS staff ensure that policies #101, 108, & 147 include these standards; update if necessary; train relevant staff; conduct regular chart reviews and summarize findings for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; evidence of CFTs; chart reviews; Compliance Commitee minutes.

Ongoing Monitoring (if included)
10% of caseload regular chart reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and CFT evidence by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.2.6

Requirement

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an established ICC Coordinator, as appropriate, who serves as the single point of accountability.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established an ICC Coordinator who serves as the single point of accountability. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that the contracted provider, RCS, has an ICC Coordinator who provides these services for the MHP. DHCS requested evidence demonstrating an ICC Coordinator has been established; however, no further evidence was submitted.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description

LCBHS staff ensures that policies #101 and 108 include these standards; update if necessary; identify an ICC Coordinator.

Proposed Evidence/Documentation of Correction

Updated policies; evidence of ICC Coordinator assignment, proof of training for ICC Coordinator.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Vanessa Mayer, Compliance Program Manager

Implementation Timeline

Submit policies and ICC Coordinator assignment/training evidence by January 31, 2023

Finding 1.2.7

Requirement

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

While the MHP submitted evidence to demonstrate compliance with this requirement, it

is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that eligible children and youth are receiving TFC services through its contracted provider RCS, which operates a foster care agency. DHCS requested evidence of the TFC services provided by this subcontractor; however, no further evidence was submitted.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
LCBHS staff ensures that policies #101 & 108 include these standards; update if necessary; obtain service data; conduct periodic chart reviews and/or data checks; summarize for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; TFC service data; chart reviews; Compliance Committee minutes.

Ongoing Monitoring (if included)
10% of caseload regular chart reviews/data checks; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and RCS evidence by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.2.8

Requirement
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all eligible children and youth for the need for TFC services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that RCS assesses all eligible children and youth for the need for TFC services. DHCS requested evidence of this assessment process and assessment criteria; however, no further evidence was submitted.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care

Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
LCBHS staff will ensure that policies #101, 108, 142, & 147 include these standards; train relevant staff; obtain relevant data on TFC screening; conduct chart reviews; summarize for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; data; chart reviews; Compliance Committee minutes.

Ongoing Monitoring (if included)
10% of caseload regular chart reviews; summarized for QIC.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and data by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.3.1

Requirement
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institution Code, section 5600, subdivision (a), 4(f), 5(e), 6(e) and 7(e). The MHP must use its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP used its 1991 Realignment funding to provide an array of community mental health services, including acute psychiatric inpatient hospital services provided in Institutions for Mental Disease (IMD), to target populations. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it used its 1991 Realignment funding to provide these services for the target populations. DHCS requested evidence of these services. The MHP submitted a spreadsheet noting the IMD entity name, invoice number, payment amount, and billing source; however, it was unclear if the target population was served as information such as length of stay, type of service, patient age, and other care specific details was absent. The documentation the MHP submitted does not provide the detail needed to verify IMD services were provided to the target ages in Lake County.

DHCS deems the MHP out of compliance with Mental Health and Substance Use

Disorder Services, Information Notice, No. 18-008, California Welfare and Institution Code, section 5600, subdivision (a), 4(f), 5(e), 6(e) and 7(e).

Corrective Action Description
LCBHS staff ensure that policy #101 includes these standards, update as necessary; obtain relevant service data; conduct periodic chart/data reviews; summarize findings for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; service data with requested elements; chart/data review results; Compliance Committee minutes.

Ongoing Monitoring (if included)
10% of caseload regular chart/data reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and data by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.3.2

Requirement
The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institutions Code, section 14053, subdivision (a) and (b)(3), and Federal Code of Regulations, title 42, section 1396, subdivision d(a)(29)(B), (a)(16), (h)(1)(c), and Federal Code of Regulations, title 42, section 441.subdivision 13 and section 435, subdivision 1009. The MHP must cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP covered acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it used its 1991 Realignment funding to provide an array of community health services to all eligible residents in the MHP. DHCS requested IMD provider contracts and payment invoices for acute psychiatric inpatient hospital services provided to Medi-Cal beneficiaries under the age of 21, or 65 years or older. The MHP provided valid contracts; however, the invoices spreadsheet provided did not specify patients served or type of treatment provided.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institutions Code, section 14053, subdivision (a) and (b)(3), and Federal Code of Regulations, title 42, section 1396, subdivision d(a)(29)(B), (a)(16), (h)(1)(c), and Federal Code of Regulations, title 42, section 441, subdivision 13, and section 435, subdivision 1009.

Corrective Action Description
LCBHS staff ensures that policy #101 includes these standards, update as necessary; obtain service data from LCBHS and RCS; conduct periodic chart/data reviews; summarize findings for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy; service data with the requested elements; chart/data review results; Compliance Committee minutes.

Ongoing Monitoring (if included)
10% of caseload regular chart/data reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and data by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.4.3

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a) (1). 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.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident 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. Per the discussion during the review, the MHP stated it would provide a copy of the written notice of denial it had issued for a contract provider that had applied to provide substance abuse disorder services, but with whom the MHP chose not to contract. DHCS requested evidence of a written notice or

template written notice of the reason for a decision not to contract; however, no further evidence was submitted.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a)(1).

Corrective Action Description
LCBHS staff will ensure that policy #127 includes these standards, update if necessary; update Provider Manual with these standards; ensure that provider manual is going to providers upon contract (or when updated); update boilerplate language to reference PM, if necessary; train relevant staff; create template for notification letter; supply evidence to DHCS, if available; summarize for Compliance Committee.

Proposed Evidence/Documentation of Correction
Updated policy and provider manual; updated boilerplate contract, if applicable; letter template; evidence of notification, if any; Compliance Committee minutes.

Ongoing Monitoring (if included)
Semi-Annual reports as summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies, letter template, and PM by January 31, 2023; submit additional evidence by April 30, 2023

Finding 1.4.4
Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors and updates the certification documents of its contracted SMHS organizational providers. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it was unaware it had three (3) providers overdue for certification and was unsure why two of the providers were categorized as providing SMHS. The MHP stated it would work to resolve these issues and provide DHCS updated information. No additional evidence or updated information was provided to demonstrate compliance for this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

Corrective Action Description
LCBHS will ensure that policy #138 includes these standards; conduct any overdue certifications; assign to specific staff; add to calendar for ongoing certifications & share this information with DHCS.

Proposed Evidence/Documentation of Correction
Updated policy; certification activity evidence, certification calendar.

Ongoing Monitoring (if included)
LCBHS will assign certification verifications to specific staff; add to calendar for ongoing certifications.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy and certification activities by January 31, 2023

Finding 1.4.5

Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must monitor the performance of its subcontractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the subcontractors' performance to periodic formal review.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors the performance of its subcontractors and network providers on an ongoing basis for compliance with the terms of the MHP contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated its process could be improved but consisted of reviewing submitted Treatment Authorization Requests, Service Authorization Requests, and quarterly service verifications. The MHP acknowledged it had not conducted regular chart reviews but had resumed this analysis in October 2021. DHCS requested evidence of the contractor monitoring process, however the evidence submitted did not demonstrate compliance.

Corrective Action Description
LCBHS will ensure that policy #127 include these standards, including CAP process, update if necessary; update Provider Manual with these standards; ensure that provider manual is given to providers upon contract (or when updated); update boilerplate language to reference provider manual, if necessary; conduct periodic provider data reviews; summarize findings for Compliance Committee; add to standardized Compliance Committee agenda.

Proposed Evidence/Documentation of Correction

Updated policy and provider manual; updated boilerplate contract, if applicable; chart/data reviews; Compliance Committee agenda & minutes.

Ongoing Monitoring (if included)
10% of caseload periodic provider chart/data reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies and PM by January 31, 2023; submit updated contract boilerplate, chart/data review evidence, and QIC minutes by April 30, 2023

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Finding 3.1.4

Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3). The MHP must have mechanisms to detect both underutilization and overutilization of services.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has mechanisms in place to detect underutilization and overutilization of services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it had struggled to conduct utilization management activities such as quarterly clinical chart reviews for inpatient services.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3).

Corrective Action Description
LCBHS will ensure that policies #131 & 140, and Compliance Plan, include these standards, update if necessary; obtain service data on over-utilization/under-utilization; conduct periodic data/chart reviews; summarize findings for Compliance Committee; add to standardized Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policies; Compliance Plan update; service data; chart review results; Compliance Committee agenda & minutes.

Ongoing Monitoring (if included)

LCBHS will complete Compliance Plan updates; regular chart/data reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies, QI Work Plan, and data by January 31, 2023; submit additional evidence by April 30, 2023

Finding 3.3.3

Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the MHP Quality Assessment and Performance Improvement program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the Quality Improvement Program (QIP).

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP includes active participation of required stakeholders in the planning, design, and execution of the QIP. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP described its efforts in reaching out and including community stakeholders such as beneficiaries and their families, practitioners and providers, and MHP staff. The MHP has made meeting attendance easier by adding webinar options, installing Smart Boards at peer support centers, and rotating meeting location sites at various peer center sites. The MHP did not provide evidence of these processes.

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

Corrective Action Description
LCBHS will ensure that policy #131 and QI Work Plan include these standards, update if necessary; gather evidence of engagement efforts; engage QIC Committee, provide evidence of QIC involvement by MHP practitioners/providers as well as beneficiaries and their family members.

Proposed Evidence/Documentation of Correction
Updated policies; QI Work Plan update; engagement activities; QIC minutes.

Ongoing Monitoring (if included)
QIC discussion/action items.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies, QI Work Plan, and engagement evidence by January 31, 2023; submit additional evidence by April 30, 2023

Finding 3.3.5

Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must obtain input from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP obtained input from all required stakeholders in identifying barriers to its delivery of clinical care and administrative services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it had challenges involving beneficiaries and their family members, but attempt to gain more attendees by holding meetings at different peer support locations. The MHP has also installed Smart Boards at peer support centers so beneficiaries and families can connect using Zoom. The MHP did not provide evidence of these processes.

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

Corrective Action Description
LCBHS will ensure that policy #131 and QI Work Plan include these standards, update if necessary; gather evidence of discussions with providers, beneficiaries, and family members; engage QIC Committee, evidence with action items; add to standardized QIC agenda.

Proposed Evidence/Documentation of Correction
Updated policies; QI Work Plan update; relevant activities; QIC agenda & minutes.

Ongoing Monitoring (if included)
QIC discussion/action items.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies, QI Work Plan, and engagement evidence by January 31, 2023; submit additional evidence by April 30, 2023

Finding 3.4.1
Requirement

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. 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.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP Utilization Management Program is effective in evaluating medical necessity and efficiency of services prospectively or retrospectively. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP indicated that it had struggled with medication monitoring and chart audit reviews but it had developed a schedule that includes pharmacist-led quarterly medication monitoring reviews and a plan for consistent chart audits with newly developed audit tools. However, the MHP was unable to provide evidence that it conducted chart audit reviews during the triennial review period.

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

Corrective Action Description
LCBHS will ensure that policies #131 & 140, and Compliance Plan, include these standards, update if necessary; obtain utilization review service; conduct periodic data/chart reviews; summarize findings for Compliance Committee; add to standardized Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policies; Compliance Plan update; service data; chart review results; Compliance Committee agenda & minutes.

Ongoing Monitoring (if included)
Compliance Plan updates; regular chart/data reviews; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies, Compliance Plan, and data by January 31, 2023; submit additional evidence by April 30, 2023

ACCESS AND INFORMATION REQUIREMENTS

Finding 4.3.2

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:

- 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.
- 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.
- The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
- The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

The test call(s) deemed out of compliance are summarized below.

TEST CALL #4
Test call was placed on Thursday, November 19, 2020, at 11:38 a.m. The call was answered after one (1) ring via a live operator. The caller requested information about refilling his/her anxiety medication. The operator asked the caller for personally identifying information. The caller provided his/her full name and DOB, but declined to provide his/her SSN. The operator stated that he/she would need that information before the caller could speak to a clinician, otherwise there was not much assistance he/she could offer. The caller informed the operator that he/she was requesting some general information on how to refill his/her anxiety medication. The operator said the clinician would need the same information in order to help. The operator transferred the caller to a clinician at which point the caller ended the call.
The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was not provided information about services needed to treat a beneficiary's urgent condition.
FINDING
The call is deemed *out of compliance* with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

TEST CALL #5
Test call was placed on Thursday, March 18, 2021, at 7:52 a.m. The call was answered after one (1) ring by an automated system. A recorded message instructed the caller to hold for the next operator. The automated system did not provide options to immediately speak with an operator nor did it provide any information regarding services. After holding for 10 minutes, the caller disconnected the call without speaking to an operator or counselor.
The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was not

provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

Corrective Action Description

LCBHS will ensure that policy #102 includes these standards, update as necessary; train day and night staff/answering service; conduct test calls; initiate CAPs and additional training (if appropriate); summarize findings for Compliance Committee; add to standing Compliance Committee agenda.

Proposed Evidence/Documentation of Correction

Updated policy; training evidence; test call results; Compliance Committee agenda & minutes.

Ongoing Monitoring (if included)

Regular test calls; regular training; summarized for Compliance Committee.

Person Responsible (job title)

Vanessa Mayer, Compliance Program Manager

Implementation Timeline

Submit policies and training evidence by January 31, 2023; submit additional evidence by April 30, 2023

Finding 4.3.4

Requirement

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

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

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	12/3/2020	5:22 p.m.	IN	IN	IN
2	12/3/2020	2:54 p.m.	OOC	OOC	OOC
3	7/9/2021	11:37 a.m.	OOC	OOC	OOC
4	11/19/2020	11:38 a.m.	OOC	OOC	OOC
5	3/18/2021	7:52 a.m.	OOC	OOC	OOC
Compliance Percentage			**20%**	**20%**	**20%**

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

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

The MHP must comply with CAP requirement addressing this finding of partial compliance.

Repeat deficiency: Yes

Corrective Action Description
LCBHS will ensure that policy #102 includes these standards, update as necessary; train day and night staff/answering service; conduct test calls; CAPs and additional training; summarize findings for Compliance Committee; add to standing Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; training evidence; test call results; Compliance Committee agenda & minutes.

Ongoing Monitoring (if included)
Regular test calls; regular training; summarized for Compliance Committee

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit policies and training evidence by January 31, 2023; submit additional evidence by April 30, 2023

COVERAGE AND AUTHORIZATION OF SERVICES

Finding 5.4.1

Requirement

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

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

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides beneficiaries with a NOABD under each circumstance as required. DHCS reviewed service request data and found the MHP failed to provide NOABDs wherein the beneficiary was denied services due to not meeting medical necessity requirement and failure to meet timely access requirements.

Per the discussion during the review, the MHP stated that the access team issues NOABDs when a beneficiary does not meet medical necessity criteria, psychiatry services, and for timeliness. DHCS requested evidence the MHP sent notification to beneficiaries. While the MHP provided additional evidence, including an explanation for its failure to provide specific NOABDs, it is not evident beneficiaries are provided NOABDs as required.

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

Corrective Action Description
LCBHS will ensure that policy #118 and NOABD Log template includes these standards, update as necessary; train relevant staff; conduct and log NOABD activities; summarize for QIC; add to standing QIC Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; NOABD activities; QIC agenda & minutes.

Ongoing Monitoring (if included)
NOABD activities; summarized for QIC

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

BENEFICIARY RIGHTS AND PROTECTIONS

Finding 6.2.6

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.

It is not evident that the MHP provides written notice to any beneficiary identified provider or provider 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. Per the discussion during the review, the MHP stated that to ensure the beneficiaries privacy, it does not directly notify the provider with a copy of the disposition letter. Instead, the MHP notifies the provider's supervisor in a separate notification, either by email or case notes of the grievance, appeal, or expedited appeal disposition. DHCS requested evidence of this communication, however, none was provided.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1850, subdivision 205.

Corrective Action Description
LCBHS will ensure that policy #121 includes these standards; train relevant staff; conduct grievance/appeal activities, including notification requirements; summarize for QIC; add to standing QIC Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; notification activities; QIC agenda & minutes.

Ongoing Monitoring (if included)
notification activities; summarized for QIC

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 6.3.2
Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each grievance within timeliness standards. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that untimely grievance resolutions were a result of tracking issues and NOABDs had been sent to notify the beneficiaries of the delays. DHCS requested additional documentation to provide evidence of this communication but the evidence was not sufficient to demonstrate compliance.

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below:

	RESOLVED WITHIN TIMEFRAMES			REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
	# OF SAMPLE REVIEWED	# IN COMPLIANCE	# OOC		
GRIEVANCES	8	6	2	N/A	75%
APPEALS	0	N/A	N/A	N/A	N/A
EXPEDITED APPEALS	0	N/A	N/A	N/A	N/A

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1).

Corrective Action Description
LCBHS will ensure that policy #121 includes these standards; train relevant staff; conduct grievance/appeal activities; summarize for QIC Committee; add to standing QIC Committee agenda

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; grievance/appeal activities; QIC Committee agenda & minutes.

Ongoing Monitoring (if included)
grievance/appeal activities; summarized for QIC Committee

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline

Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 6.4.7
Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(6). The MHP must allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP allows a beneficiary appointed representative or legal representative of a deceased beneficiary's estate to be included as parties to an appeal. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that the required language is included in its grievance and appeals brochure; however the submitted brochure as well as the policies and procedures did not included language stating the legal representative of a deceased beneficiary's estate can be included as a party to the appeal.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(6).

Corrective Action Description
LCBHS ensure that policy #121 includes these standards; train relevant staff; conduct grievance/appeal activities; summarize for QIC; add to standing QIC Committee agenda

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; grievance/appeal activities; QIC Committee agenda & minutes.

Ongoing Monitoring (if included)
grievance/appeal activities; summarized for QIC Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

Finding 6.4.14
Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 406(b)(4) and 408(b)-(c). The MHP must inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal.

The Contractor must inform beneficiaries of this sufficiently in advance of the resolution timeframe for the expedited appeal.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP informs beneficiaries of the limited time available to present evidence and testimony for an expedited appeal. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated this notification was on the grievance form, the appeal brochure, and the NAR template. Upon review of these documents, the required language was absent from all informing materials.

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

Corrective Action Description
LCBHS will ensure that policy #121 includes these standards; train relevant staff; conduct grievance/appeal activities; summarize for QIC Committee; add to standing QIC Committee agenda

Proposed Evidence/Documentation of Correction
Updated policies; evidence of training; grievance/appeal activities; QIC Committee agenda & minutes

Ongoing Monitoring (if included)
grievance/appeal activities; summarized for QIC Committee

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy by January 31, 2023; submit additional evidence by April 30, 2023

PROGRAM INTEGRITY

Finding 7.1.5

Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attached 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(1). The MHP system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a system in place for training and education for the Compliance Officer, the organization's senior management, and the organization's

employees for the federal and state standards and requirements under the contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that MHP staff complete an annual compliance training in addition to regular trainings at staff meetings. The MHP maintains a tracking mechanism for compliance trainings but does not track contracted providers staff for this requirement. DHCS requested additional evidence for this requirement, however the evidence did not demonstrate compliance to the contract.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attached 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(1).

Corrective Action Description
LCBHS will ensure that policies #149 & 152 and the Compliance Plan include these standards; train relevant staff; add to training plan for recurrence; gather provider training info; summarize for Compliance Committee; add to standing Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated documents; evidence of trainings; training plan; Compliance Committee agenda and minutes.

Ongoing Monitoring (if included)
Monitor training plan; reporting from staff and providers; summarized for Compliance Committee.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated documents by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.4.1

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 101 and 104. The MHP must ensures collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's (disclosing entities) ownership and control.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP ensures collection of information pertaining to ownership or control interest in the MHP and ensures its subcontractors and network providers submit disclosures to the MHP regarding the network provider's ownership and control. Per the discussion during the review, the MHP stated that while there is a policy in

place, it has not been tracking this requirement during the triennial review period due to the vacant Compliance Officer position. The MHP stated it attends to develop this process moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 101 and 104.

Corrective Action Description
LCBHS will ensure that policies #127 and #129, Compliance Plan, and disclosure log template includes these standards, update if necessary; train relevant staff; conduct update to completed disclosure log, including providers; report findings to DHCS; add to Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; disclosure updates; Compliance Committee agenda and minutes.

Ongoing Monitoring (if included)
Ongoing activities; summarized for Compliance Committee; report to DHCS

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy, Compliance Plan, and log template by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.4.2

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a). As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by the MHP that the MHP requires providers to consent to criminal background checks as a condition of enrollment. Per the discussion during the review, the MHP stated that while there is a policy in place, it has not been tracking this requirement during the triennial review period due to the vacant Compliance Officer position. The MHP stated it intends to develop this process moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a).

Corrective Action Description

LCBHS will ensure that policy #151 and the Compliance Plan includes these standards, update as necessary; train designated staff on recurring process; add to Provider Manual; add to Compliance Committee agenda; conduct update to disclosure log, including providers; get fingerprints if necessary; report findings to DHCS.

Proposed Evidence/Documentation of Correction
Updated policy; disclosure updates; Compliance Committee agenda and minutes.

Ongoing Monitoring (if included)
Ongoing activities; summarized for Compliance Committee; report to DHCS

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy and Compliance Plan by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.4.3

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13. The MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/ network provider's ownership, annually and upon request during the revalidation of enrollment process under 42 Code of Federal Regulations part 455.104.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires providers or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. Per the discussion during the review, the MHP stated that while there is a policy in place, it has not been tracking this requirement during the triennial review period due to the vacant Compliance Officer position. The MHP stated it intends to develop this process moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13.

Corrective Action Description
LCBHS will ensure that policies #127, #129, and #151 and the Compliance Plan include these standards; update if necessary; train relevant staff for ongoing activities; conduct

update to disclosure log, including providers; get fingerprints if necessary; report findings to DHCS; add to Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; disclosure updates; Compliance Committee agenda and minutes.

Ongoing Monitoring (if included)
Ongoing activities; summarized for Compliance Committee; report to DHCS

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy and Compliance Plan by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.4.4

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13. The MHP's network providers must be required to submit updated disclosures. Disclosure must include all aspects listed below:

1. The name and address of any person (individual or corporation) with an ownership or control interest in the network provider.
2. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
3. Date of birth and Social Security Number (in the case of an individual);
4. Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);
5. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;
6. The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and
7. The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.
8. The MHP shall provide DHCS with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from DHCS during the re-validation of enrollment process.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires network providers to submit updated disclosure forms as outlined in regulations. Per the discussion during the review, the MHP stated that while there is a policy in place, it has not been tracking this requirement during the triennial review period due to the vacant Compliance Officer position. The MHP stated it intends to develop this process moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104 MHP contract, exhibit A, attachment 13.

Corrective Action Description
LCBHS will ensure that policies #127 and #129, Compliance Plan, and disclosure log template include these standards, update if necessary; train relevant staff; conduct update to completed disclosure log, including providers; report findings to DHCS; add to Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; disclosure updates; Compliance Committee agenda and minutes.

Ongoing Monitoring (if included)
Ongoing activities; summarized for Compliance Committee; report to DHCS

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy, Compliance Plan, and log template by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.4.5

Requirement
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosures and updated disclosures to the DHCS

as required per regulations. Per the discussion during the review, the MHP stated that while there is a policy in place, it has not been tracking this requirement during the triennial review period due to the vacant Compliance Officer position. The MHP stated it intends to develop this process moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Corrective Action Description
LCBHS will ensure that policies #127 and #129, Compliance Plan, and disclosure log template include these standards, update if necessary; train relevant staff; conduct update to completed disclosure log, including providers; report findings to DHCS; add to Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; disclosure updates; Compliance Committee agenda and minutes.

Ongoing Monitoring (if included)
Ongoing activities; summarized for Compliance Committee; report to DHCS

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policy, Compliance Plan, and log template by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.4.6

Requirement
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2). The MHP must submit disclosure to DHCS of 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.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosure forms 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. Per the discussion during the review, the MHP stated that while there is a policy in place, it has not been tracking this requirement during the triennial review period due to the vacant Compliance Officer position. The MHP stated it intends to develop this process moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2).

Corrective Action Description
LCBHS will ensure that policies #127, 130, 151, and the Compliance Plan include these standards, update if necessary; conduct monthly checks; report adverse findings to DHCS, if any; add to standing Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; monthly check results; reports of adverse findings, if any.

Ongoing Monitoring (if included)
Ongoing activities; summarized for Compliance Committee; report to DHCS.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies, Compliance Plan, and sample monthly checks by January 31, 2023; submit additional evidence by April 30, 2023

Finding 7.5.3

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

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a process in place to promptly notify DHCS if the MHP finds a party that is on an exclusion list. This requirement was not included in any evidence provided by the MHP. Per the facilitated discussion, the MHP stated its staff and provider exclusion verification policy demonstrated adherence to his requirement. Upon review of this policy, as well as other compliance policies submitted by the MHP, it was not evident there was a process in place to notify DHCS regarding excluded providers.

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

Corrective Action Description
LCBHS will ensure that policies #127, 130, 151, and the Compliance Plan include these standards, update if necessary; conduct monthly checks; report adverse findings to DHCS, if any; add to standing Compliance Committee agenda.

Proposed Evidence/Documentation of Correction
Updated policy; monthly check results; reports of adverse findings, if any.

Ongoing Monitoring (if included)

Ongoing activities; summarized for Compliance Committee; report to DHCS.

Person Responsible (job title)
Vanessa Mayer, Compliance Program Manager

Implementation Timeline
Submit updated policies, Compliance Plan, and sample monthly checks by January 31, 2023; submit additional evidence by April 30, 2023