County of San Mateo

Fiscal Year 2022/2023 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

#1 Question 1.2.7

Requirement

Compliance with BHIN No. 21-073 and 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.

DHCS Finding 1.2.7

The MHP did not furnish evidence to demonstrate compliance with the BHIN No. 21-073 and 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 beneficiary access criteria for SMHS as medically necessary.

Corrective Action Description

1. Identify & Contract with RFP agency to establish TFC services that will also include ICC and IHBS.

Proposed Evidence/Documentation of Correction

1. Create a new policy that underline ICC, IHBS, & TFC services for all youth beneficiaries and identify clear criteria to receive services.
2. Create workflows with the new contractor.
3. Update P&P's
4. Disseminate information to staff & contractors that includes training.

Ongoing Monitoring (if included)

A workgroup has been identified to support the efforts of this CAP that will meet on a bi-weekly basis.

Person Responsible (job title)

Deputy Director of Youth & Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#2 Question 1.2.8

Requirement

Compliance with BHIN No. 21-073 and 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.

DHCS Finding 1.2.8

The MHP did not furnish evidence to demonstrate compliance with the BHIN No. 21-073 and 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 beneficiary access criteria for SMHS need TFC..

Corrective Action Description

1. Identify & Contract with RFP agency to establish TFC services that will also include ICC and IHBS.
2. Identify a clear workflow to screen all youth for ICC, IHBS & TFC services.

Proposed Evidence/Documentation of Correction

5. Create a new policy that underline ICC, IHBS, & TFC services for all youth beneficiaries and identify clear criteria to receive services.
6. Create workflows with the new contractor, including a screening for all youth.
7. Update P&P's
8. Disseminate information to staff & contractors that includes training.

Ongoing Monitoring (if included)

A workgroup has been identified to support the efforts of this CAP that will meet on a bi-weekly basis.

Person Responsible (job title)

Deputy Director of Youth & Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#3 Question 3.5.1

Requirement

MHP contract, exhibit A, attachment 5, section 6(A); Code of Federal Regulations, title 42, section 438, subdivision 236(b); and California Code of Regulations, title 9, section 1810, subdivision 326.

DHCS Finding 3.5.1

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 6(A); Code of Federal Regulations, title 42, section 438, subdivision 236(b); and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must have practice guidelines, which meet the requirements of the MHP Contract.

Corrective Action Description

1. Update our Practice Guidelines

Proposed Evidence/Documentation of Correction

1. Practice Guidelines will be updated.
2. Policy 18-03 will be updated.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Assistant Director & Quality Assurance Manager

Implementation Timeline: Complete by end of FY 23/24

#4 Question 3.5.2

Requirement

MHP contract, exhibit A, attachment 5, section 6(c); Code of Federal Regulations, title 42, section 438, subdivision 236(c); and California Code of Regulations, title 9, section 1810, subdivision 326.

DHCS Finding 3.5.2

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, section 6(c); Code of Federal Regulations, title 42, section 438, subdivision 236(c); 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.

Corrective Action Description

1. Update our Practice Guidelines
2. Disseminate guideline to all providers, beneficiaries, and potential beneficiaries.

Proposed Evidence/Documentation of Correction

1. Practice Guidelines will be updated.
2. Policy 18-03 will be updated.
3. Once updated, practice guidelines will be shared with all-staff & contractors and will be posted on our website.
4. Beneficiaries will have access to them via our welcome page for beneficiaries and potential beneficiaries.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Assistant Director & Quality Assurance Manager

Implementation Timeline: Completed by end of FY 23/24

#5 Question 4.2.2

Requirement

The MHP must be in 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 4.2.2

Test #1-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). **(Appeal has been sent for this call).**

Test #2-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).

Test #3-The call is deemed **in compliance** with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

Test #4-The call is deemed **in compliance** with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

Test #5-The call is deemed **in compliance** with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

Test #6- 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 #7-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

Appeal:

Will be providing feedback as to why our calls were deemed out of compliance.

#1-Caller hung up before someone was able to pick up the call. The call showed that all 5 access call center staff were on the phone. We will be checking our data to see what the abandonment rate was that day.

#2-After hours call, unclear why the call was disconnected, but it was deemed in partial-compliance, will try to appeal based on information about why the caller didn't call back.

#6-Legitimate finding. Caller was transferred to OCFA and was not answered by anyone. Access has fixed this issue and calls inquiring about a grievance will have a person to answer their call live.

#7-Call was disconnected, deemed out of compliance instead of being in partial compliance like caller #2.

Proposed Evidence/Documentation of Correction:

Phone Tree has been updated, when a beneficiary calls to file a grievance they will speak to a live person. Procedures have been updated.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Quality Manager, Assistant Director & Access Call Center Manager

Implementation Timeline: Completed.

#6 Question 4.2.4

Requirement

MHP to comply with California Code of Regulations, title 9, section 1810, subdivision 405(f).

DHCS Finding 4.2.4

The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, 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.

Corrective Action Description

1. **Appeal:** Based on the callers dropping the call and not calling back, we may be able to appeal one of the logs. The other two calls that are out of compliance, are with after-hours contractor, Optum.

Proposed Evidence/Documentation of Correction

1.Retrain Access Call Center Staff to ensure every call is logged.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Quality Manager, Assistant Director & Access Call Center Manager

Implementation Timeline: Completed

#7 Question 5.2.1

Requirement

BHIN No. 22-017; California Code of Regulations, title 9, section 1810, subdivision 440(b); and Code of Federal Regulations, title 42, section 438, subdivision 210(a)(4), (b)(1),(2).

DHCS Finding 5.2.1

The MHP did not furnish evidence to demonstrate compliance with BHIN No. 22-017; California Code of Regulations, title 9, section 1810, subdivision 440(b); and Code of Federal Regulations, title 42, section 438, subdivision 210(a)(4), (b)(1), (2). The MHPs are required to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to SMHS. The UM program must evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively, such as through prior or concurrent authorization review procedures.

Corrective Action Description

1. UM Program will include concurrent authorizations.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06
3. Create new workflow for CalMHSA contractor.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#8 Question 5.2.2

Requirement

BHIN 22-017; Code of Federal Regulations, title 42, section 438, subdivision 210(b)(1); California Code of Regulations, title 9, section 1810, subdivision 440(b)(2)(i-ii).

DHCS Finding 5.2.2

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Code of Federal Regulations, title 42, section 438, subdivision 210(b)(1); and California Code of Regulations, title 9, section 1810, subdivision 440(b)(2)(i-ii). The MHP must establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Authorization procedures and utilization management criteria shall:

a. Be based on medical necessity and consistent with current evidence- based clinical practice guidelines, principles, and processes;

b. Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their respective scopes of practice;

c. Be evaluated, and updated as necessary, and at least annually, and be disclosed to the MHP's beneficiaries and network providers.

Corrective Action Description

1. Update UM program that will include procedures specific to review criteria for authorization decisions.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#9 Question 5.2.3

Requirement

MHP required to comply with BHIN 22-017.

DHCS Finding 5.2.3

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017. The MHP may manage authorizations directly or delegate authorization functions to an administrative entity, consistent with federal law and the MHP's contract for SMHS.

Corrective Action Description

1. Update UM program that will include procedures with concurrent review during after-hours.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization

2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
4. Ensure Procedures include concurrent review during after-hours.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#10 Question 5.2.4

Requirement

MHP is required to comply with BHIN 22-017 and Code of Federal Regulations, title 42, section 438, subdivision 10(g)(2)(iv).

DHCS Finding 5.2.4

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017 and Code of Federal Regulations, title 42, section 438, subdivision 10(g)(2)(iv). The MHP must comply with the following communication requirements:

1. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services;

2. Disclose to DHCS, the MHP's providers, beneficiaries and members of the public, upon request, the UM or utilization review policies and procedures that the MHP, or any entity that the MHP contracts with, uses to authorize, modify, or deny SMHS. The MHP may make the criteria or guidelines available through electronic communication means by posting them online;

3. Ensure the beneficiary handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS; and,

4. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

Corrective Action Description

1. Update UM program that will include procedures with concurrent review, after-hour procedures, included in the beneficiary handbook.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
4. Ensure all contracting providers are aware of new procedures and timeframes necessary to obtain authorizations for services.
5. Update Procedures to include criteria or guidelines available through electronic communication by posting them online.
6. Update beneficiary handbook to include procedures for obtaining benefits, including any requirements for service authorization and/or referrals to SMHS
7. Update Procedures to ensure written notifications will be sent regarding authorization decisions in accordance with established timeframes.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#11 Question 5.2.5

Requirement

MHP required to comply with BHIN 22-016.

DHCS Finding 5.2.5

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. Concurrent Review: In the absence of an MHP referral, MHPs shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge. MHPs may elect to authorize multiple days, based on the beneficiary's mental health condition, for as long as the services are medically necessary.

Corrective Action Description

1. Update UM program that will include procedures with concurrent review of treatment authorization following the first day of admission to the facility and through discharge.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization

2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
4. Ensure all contracting providers are aware of new procedures and timeframes necessary to obtain authorizations for services starting on the day of admission and through discharge.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#12 Question 5.2.6

Requirement

MHP is required to be in compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; and Health and Safety Code, section 1367.01(i), 1371.4(a).

DHCS Finding 5.2.6

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; and Health and Safety Code, section 1367.01(i), 1371.4(a). The MHPs must maintain telephone access to receive Psychiatric Inpatient Hospital or Psychiatric Health Facility (PHF) admission notifications and initial authorization requests 24-hours a day and 7 days a week.

Corrective Action Description

1. Update UM program that will include procedures for concurrent review with telephone access for inpatient hospital or PHF admission notification and initial authorization requests 24hr-day, 7 days a week.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
4. Ensure UM program P&P’s include telephone access for inpatient hospital or PHF admission notification and initial authorization requests 24hr-day, 7 days a week.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#13 Question 5.2.7

Requirement

MHP required to comply with BHIN 22-017.

DHCS Finding 5.2.7

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017. The MHP must decide whether to grant, modify or deny the hospital or PHFs initial treatment authorization request and communicate the decision to the requesting hospital or PHF per managed care requirements for expedited authorizations following receipt of all information specified in I.a. of BHIN 22-017. The MHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and not later than 72 hours after receipt of the request for services.

Corrective Action Description

1. Update UM program that will include procedures to include how MHP will respond to initial treatment authorizations, such as grand, modify and deny a request and include procedures for an expedited authorizations and respond no later than 72 hours after receipt of request for services.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
2. Ensure UM program P&P's include how the MHP will respond to initial treatment authorization treatment authorizations, such as grand, modify and deny a request and include procedures for an expedited authorizations and respond no later than 72 hours after receipt of request for services.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#14 Question 5.2.8

Requirement

MHP is required to comply with BHIN 22-017; Welfare and Institution Code, section 14197.1; and Health and Safety Code, section 1367.01(h)(2).

DHCS Finding 5.2.8

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; Health and Safety Code, section 1367.01(h)(2). When medically necessary for the beneficiary, before the end of the initial authorization period, or a subsequent authorization period, the hospital or PHF shall submit a continued-stay- authorization request for a specified number of days to the responsible county MHP. The responsible county MHP shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24-hours of receipt of the request and all information reasonably necessary to make a determination.

Corrective Action Description

1. Update UM program that will include procedures to include how MHP will respond to initial treatment authorizations, subsequent authorizations and a continued-stay-authorization requests for a specific number of days and respond with decision within 24-hours of receipt.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
3. Ensure UM program P&Ps include how the MHP will respond within 24-hours of receipt for an initial treatment authorization, subsequent authorizations and a continued-stay-authorization requests for a specific number of days and respond with a determination. All information reasonably necessary shall be included to make a determination.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#15 Question 5.2.9

Requirement

MHP is required to comply with BHIN 22-017; Welfare and Institution Code 14197.1; Health and Safety Code 1367.01(e) & (h)(3-4); Code of Federal Regulations, title 42, section 431, subdivision 213(c); section 438, subdivision 404, section 438, subdivision 210(b)(3) & (c), section 431, subdivision 213(c); and MHSUDS IN 18-010E.

DHCS Finding 5.2.9

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; Welfare and Institution Code 14197.1; Health and Safety Code 1367.01(e) & (h)(3-4); Code of Federal Regulations, title 42, section 431, subdivision 213(c); section 438, subdivision 404, section 438, subdivision 210(b)(3) & (c), section 431, subdivision 213(c), and MHSUDS IN 18-010E.

1. While LMHPs/LPHAs may review authorization requests and issue approvals within their scope of practice, all MHP decisions to modify or deny a treatment request shall be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs. A psychologist may modify or deny a request for authorization for treatment for a patient only if a psychologist admitted the patient to the hospital. A psychologist may modify or deny a request for authorization for treatment consistent with the psychologist's scope of practice.

2. A decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the MHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

3. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.

4. If a MHP modifies or denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.

5. If a MHP denies a hospital's authorization request, the MHP must work with the treating provider to develop a plan of care. Services shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care

plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary.

6. If the MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

Corrective Action Description

1. Update UM program that will include
    a. An professional such as (LMHPs/LPHAs, psychologist or psychiatrist) will review, modify and deny a service request which will be within their scope of practice.
    b. Procedures will include when MHP decides to modify/deny a treatment request. A decision to modify an authorization request shall be provided to the treating provider(s) initially by telephone, fax, and then in writing, and will include a clear and concise explanation of the reasons for the MHPs decision.
    c. The decision will include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.
    d. If MHP modifies or denies an authorization request, the MHP will notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services. The notice to the beneficiary shall meet the requirements pertaining to notices of adverse benefit determinations.
    e. If MHP denies a hospital's authorization request, the MHP will work with the treating provider to develop a plan of care. Services shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical, including behavioral health, needs of the beneficiary.
    f. If MHP and treating hospital provider do not agree on a plan of care, the provider, may, on behalf of the beneficiary and with the beneficiary's written consent, appeal the denial to the MHP, as provided for in the notice of adverse benefit determination. The hospital may provide the adverse benefit determination to the beneficiary after receiving notice from the MHP.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization

2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
4. Ensure UM program P&Ps include a-f specifics as outlined above.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Complete by end of FY 23/24

#16 Question 5.2.10

Requirement

MHP to comply with BHIN 22-017; California Code of Regulations, title 9, section 1820, subdivision 230; and Welfare and Institution Code 14184.402, 14184.102 and 14184.400.

DHCS Finding 5.2.10

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-017; California Code of Regulations, title 9, section 1820, subdivision 230; and Welfare and Institution Code 14184.402, 14184.102 and 14184.400. Authorizing Administrative Days:

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

2. 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.

3. 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.

4. Once the five-contact requirement is met, any remaining days within the sevenday period can be authorized without a contact having been made and documented.

5. MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact. (If an MHP has been granted an exemption to 9 CCR § 1820.220, then the review of the MHP will be based upon the alternate procedure agreed to in the MHP contract.)

Corrective Action Description

1. Update UM program that will include
    a. In order for MHP to conduct concurrent review and authorization for administrative day service claims, the MHP will require the hospital's documentation to ensure they have made contact to at least one non-acute residential treatment facility per day (except on weekends & holidays), starting with the day the beneficiary is placed on administrative day status.
    b. 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.
    c. 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.
    d. 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.
    e. MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.

Proposed Evidence/Documentation of Correction

1. Contract with CalMHSA Concurrent Review Authorization
2. Update Policy 20-06 & 20-04
3. Create new workflow for CalMHSA contractor.
4. Ensure UM program P&Ps include a-e specifics as outlined above.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Completed by end of FY 23/24

#17 Question 5.2.11

Requirement

MHP is required to comply with BHIN 22-016.

DHCS Finding 5.2.11

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHP must utilize referral and/or concurrent review and authorization for all Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS). MHPs may not require prior authorization.

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

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

Corrective Action Description

a. Update UM Program with P&P's to specify the parameters (# of days authorized) when a beneficiary is referred to a CRTS or ARTS facility
b. Update UM Program with P&P's that can re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and need for continued services.

Proposed Evidence/Documentation of Correction

1. Update Policy 20-06 & 20-04

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Completed by end of FY 23/24

#18 Question 5.2.12

Requirement

MHP is required to comply with BHIN 22-016.

DHCS Finding 5.2.12

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHP may extend the timeframe for making an authorization decision for up to 14 additional calendar days, if the following conditions are met:

1. The beneficiary, or the provider, requests an extension; or,

2. The MHP justifies (to the State upon request), and documents, a need for additional information and how the extension is in the beneficiary's interest.

Corrective Action Description

a. Update P&P's to ensure the beneficiary, or provider requests an extension
b. P&P's will include a clear procedure on how to document on how the extension is in the beneficiary interest.

Proposed Evidence/Documentation of Correction

1. Update Policy 20-06 & 20-04
2. Update P&P's to reflect a & b as stated above.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Completed by end of FY 23/24

#19 Question 5.2.13

Requirement

MHP is required to comply with BHIN 22-016.

DHCS Finding 5.2.13

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHPs must establish and implement policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS.

a. MHPs may not require prior authorization for the following services/service activities:
   i. Crisis Intervention;
   ii. Crisis Stabilization;
   iii. Mental Health Services, including initial assessment;
   iv. Targeted Case Management;
   v. Intensive Care Coordination; and,
   vi. Medication Support Services.

b. Prior authorization or MHP referral is required for the following services:
   i. Intensive Home-Based Services
   ii. Day Treatment Intensive
   iii. Day Rehabilitation
   iv. Therapeutic Behavioral Services
   v. Therapeutic Foster Care

Corrective Action Description

1. Update P&P's to ensure beneficiaries and providers are aware of when a authorization and specify what SMHS do not require a prior authorization.

Proposed Evidence/Documentation of Correction

1. Update 20-06 & 20-04 to reflect the changes stated above.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Completed by end of FY 23/24

#20 Question 5.2.14

Requirement

MHP is required to comply with BHIN 22-016.

DHCS Finding 5.2.14

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. The MHPs must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.

Corrective Action Description

1. Upon a provider request for prior authorization, the MHP will make a decision as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the receipt of the information reasonability necessary and requested by MHP to make the determination.

Proposed Evidence/Documentation of Correction

1. Update 20-06 & 20-04 to reflect the changes stated above.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Completed by end of FY 23/24

#21 Question 5.2.15

Requirement

MHP is required to comply with BHIN 22-016 and Code of Federal Regulations, title 42, section 438, subdivision 210(d)(2)(i).

DHCS Finding 5.2.15

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016 and Code of Federal Regulations, title 42, section 438, subdivision 210(d)(2)(i). 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.

Corrective Action Description

1. MHP will update P&P's to reflect how an expedited authorization is needed following the standard timeframe for cases in which a provider indicated that it could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. The MHP will 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.

Proposed Evidence/Documentation of Correction

1. Update 20-06 & 20-04 to reflect the changes stated above.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

Deputy Director of Adult & Older Adult Services & Clinical Services Manager

Implementation Timeline: Completed by end of FY 23/24

#22 Question 6.1.14

Requirement

MHP is required to comply with exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5).

DHCS Finding 6.1.14

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5). The MHP shall provide information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance with:

a) The MHP and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

Corrective Action Description

1. Policy has already been updated, signed, and posted online. CAP has already been fulfilled.

Proposed Evidence/Documentation of Correction

1.

Ongoing Monitoring (if included)

None

Person Responsible (job title)

OCFA Director and Quality Manager

Implementation Timeline: Completed

#23 Question 6.1.15

Requirement

MHP is required to be in compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1).

DHCS Finding 6.1.15

The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(1). The MHP must designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

Corrective Action Description

1. Policy has already been updated, signed, and posted online. CAP has already been fulfilled.

Proposed Evidence/Documentation of Correction

1. 19-01_grievance_and_appeals_policy.pdf (smchealth.org)

Ongoing Monitoring (if included)

None

Person Responsible (job title)

OCFA Director and Quality Manager

Implementation Timeline: Completed

#24 Question 6.1.16

Requirement

MHP is required to be in compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2).

DHCS Finding 6.1.16

The MHP did not furnish evidence to demonstrate compliance with the Welfare and Institution Code, section 14727(a)(4); Code of Federal Regulations, title 45, section 84.7; Code of Federal Regulations, title 34, section 106.8; Code of Federal Regulations, title 28, section 35.107; 42 United States Code, section 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; and MHP Contract, exhibit A, Attachment 12, section 4(A)(2). The MHP shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. The MHP shall not require a beneficiary to file a Discrimination Grievance with the MHP before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

Corrective Action Description

1. Policy has already been updated, signed, and posted online. CAP has already been fulfilled.

Proposed Evidence/Documentation of Correction

1. 19-01_grievance_and_appeals_policy.pdf (smchealth.org)

Ongoing Monitoring (if included)

None

Person Responsible (job title)

OCFA Director and Quality Manager

Implementation Timeline: Completed

#25 Question 6.1.17

Requirement

MHP is required to comply with MHP Contract, exhibit A, Attachment 12, section 4(A)(3) and California Medicaid State Plan, section 7, attachments 7.2-A and 7.2-B.

DHCS Finding 6.1.17

The MHP did not furnish evidence to demonstrate compliance with MHP Contract, exhibit A, Attachment 12, section 4(A)(3) and California Medicaid State Plan, section 7, attachments 7.2-A and 7.2-B. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the MHP must submit the following information regarding the complaint to the DHCS Office of Civil Rights:

a) The original complaint.
b) The provider's or other accused party's response to the complaint.
c) Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the MHP.
d) Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
e) All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.
f) The results of the MHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

Corrective Action Description

1. Policy has already been updated, signed, and posted online. CAP has already been fulfilled.

Proposed Evidence/Documentation of Correction

1. 19-01_grievance_and_appeals_policy.pdf (smchealth.org)

Ongoing Monitoring (if included)

None

Person Responsible (job title)

OCFA Director and Quality Manager

Implementation Timeline: Completed