San Francisco Department of Public Health, Behavioral Health Services

Fiscal Year (FY) 22/23 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

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. *California Code of Regulations, title 9, section 1810, subdivision 435 and MHP contract, exhibit A, attachment 8, section 8(D).*

DHCS Finding 1.4.4

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP certifies, or uses another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS. Of the MHP's 92 providers, 19 provider certifications were overdue. Per the discussion during the review, the MHP stated it would provide evidence of submitted transmittals and actions taken to resolve any overdue certifications. Post review, additional evidence was provided; however, 19 certifications remained overdue.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 435 and MHP contract, exhibit A, attachment 8, section 8(D).

Repeat deficiency: Yes

Corrective Action Description

Background:

Due to staffing transitions since FY21-22, vacancies, and consequent staff shortage at the Department of Public Health's (DPH) Business Office of Contract Compliance (BOCC), the MHP had 19 overdue providers at the time of the audit.

All 19 providers have been followed-up with and all remaining certifications are in process.

At the time of writing this CAP, we have completed 3 certifications. 11 transmissions have been re-submitted to the state.

It should be noted that the state intermittently continues to have difficulty with opening emails with submissions, and that the state liaison denied granting a MOVEit account to BOCC for easier submissions. Jerna Reyes followed up with county and state IT for

removing restrictions for secure transfer to no avail. BOCC sends the completed transmission to DHCS DMH, however we continue to experience delays in processing.

The incoming BOCC director has made it a department goal to clear all the overdue certifications from FY21-22 and FY22-23 by January 31, 2024. By December 31, 2023, the MHP will also have processes in place to prevent any overdue certifications greater than 12 months.

By October 2, 2023, BOCC will resume its workflow to notify programs whose certifications are due in 3 and in 6 months using its internal database. Site visits will be scheduled for programs whose certifications are due in 3 months. Resuming the workflow will prevent additional overdue certifications greater than 12 months. In addition to the current workflow of copying the SOC Managers, BOCC will also copy the MHP's Quality Management (BHS QM) liaison (Regulatory Affairs Coordinator) for certifications in all correspondence with programs, so that BHS QM can escalate any issues for providers that are due for re-certification. In addition, BOCC will forward a monthly list of overdue certifications to BHS QM. BHS QM will escalate outstanding follow-up items with the programs on this list and their MHP SOC managers to render support to the program and facilitate completion of the certifications.

Proposed Evidence/Documentation of Correction

We are proposing to submit the following as evidence of progress or documentation of correction:

- 3 Approved transmittals for Providers 38GS, 38KY,and 8949
    - Re-submitted transmittals for 9 programs
    - Follow up emails with state regarding 2 programs
- Email exchange with DHCS regarding MOVEIt
    - Sample email from the state regarding automatic encryption
- Updated tracking spreadsheet with the current statuses of the 19 deficiencies

Please see folder: **1.4.4 Evidence**

Ongoing Monitoring (if included)

The Business Office (BOCC) utilizes its re-certification database to remind and prompt providers at six (6) months prior to certification expiration and at the three (3) months prior to certification expiration.

Between October 2, 2023, and December 31, 2023, BOCC will increase the frequency from monthly to weekly check within certification database for the organizations with overdue statuses. At the same time, BOCC will increase the frequency of communications to the providers/organizations and SOC managers and update the tracking spreadsheet at this weekly interval.

During the certification and re-certification site visits, the current workflow includes invitations to the SOC managers. In addition, for the visits between now and January 31, 2024, BOCC will also invite the QM liaison.

SOC Managers will also be responsible for high touch follow-up and engagement, including meeting the providers and offering technical assistance, to ensure compliance with certification for the 5 programs that remain overdue.

The Business Office and SOC Manager, however, only can prompt providers; each provider must make their own arrangements to update their NPI registration and meet compliance in whichever county the program is sited. The Business Office is prepared to terminate certification for any provider who fails to meet the minimum requirements.

Person Responsible (job title)

Business Office:
Jerna Reyes, LMFT
Contract Compliance Manager
Business Office of Contract Compliance Manager

Behavioral Health Services:
SOC Managers

Implementation Timeline:

- BOCC will notify all the overdue providers/organizations by September 27, 2023.
- Starting October 2, 2023, BOCC will resume weekly checks on the overdue certifications until 12/31/23.
- By January 31, 2024, all outstanding certifications will be completed.

Requirement

The MHP shall coordinate the services the MHP furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers, and other human services agencies used by its beneficiaries. *MHP Contract, exhibit A, attachment 10, section 1(A)(2); Code of Federal Regulations, title 42, section 438, subdivision 208(b)(2)(i)-(iv); and California Code of Regulations, title 9, section 1810, subdivision 415*

DHCS Finding 2.1.2

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP coordinates the services the MHP furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in Fee-for-service Medi-Cal, from community and social support providers,

and other human services agencies used by its beneficiaries. Per the discussion during the review, the MHP stated it has screening and tracking tools to ensure timeliness and coordination of care its managed care plan (MCP). Post review, the MHP submitted evidence of its tracking mechanism for beneficiaries referred to and from the MCPs; however, it is not evident that it identified and tracked beneficiaries from San Francisco Health Plan (MCP) as the MHPs referral tracking mechanism does not include beneficiaries identified by the MCP.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 10, section 1(A)(2); Code of Federal Regulations, title 42, section 438, subdivision 208(b)(1); and California Code of Regulations, title 9, section 1810, subdivision 415.

Corrective Action Description

MHP established a Screening and Transition Tool Workgroup to create and implement standard care coordination processes between the MHP and MCP utilizing the new DHCS Screening & Transition tools. These processes have created greater coordination of care between the systems.

In coordination with MCP, MHP implemented centralized logging and tracking mechanisms and data sharing procedures for referrals resulting from incoming and outgoing screening and transition tools assessments. These tools tracks where the client is referred as well as their disposition and allow for increased ability to close the loop on shared referrals and individuals for whom MCP and MHP are coordinating care.

MHP has regular meetings with the MCP regarding implementation of screening & transition tool workflows, identification and removal of barriers, and data-sharing procedures. These meetings include our MCP partners San Francisco Health Plan and Carelon Behavioral Health to ensure effective care coordination for individuals with high needs.

Proposed Evidence/Documentation of Correction

2.1.2 S&T Tracking (MCP-MHP)

2.1.2 S&T Tracking (SFHP-MHP)

Personal health information have been deleted from the document.

Ongoing Monitoring (if included)

Screening and Transition Tool Workgroup includes the Office of Coordinated Care and Behavioral Health Access Center leadership who reviews the tool **weekly**, at the minimum, to ensure the information is up to date.

Person Responsible (job title)

Adela Morales, Program Coordinator, Behavioral Health Access Line

Implementation Timeline:

Effective February 2023

Requirement

The MHP did not furnish evidence to demonstrate compliance with the MHSUDS IN No. 18-059; *MHP contract, exhibit A, attachment 10, section 1(F); and Code of Federal Regulations, title 42, section 438, subdivision 62(b)(2)*. The MHP Continuity of Care written notifications to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

- The MHP's denial of the beneficiary's continuity of care request;
- A clear explanation of the reasons for the denial;
- The availability of in-network SMHS;
- How and where to access SMHS from the MHP;
- The beneficiary's right to file an appeal based on the adverse benefit determination; and,
- The MHP's beneficiary handbook and provider directory.

DHCS Finding 2.2.1

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's Continuity of Care written notifications to the beneficiary comply with Title 42 of the Code of Federal Regulations, part 438.10(d). This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it does not usually deny continuity of care requests and it would review its process. Post review, the MHP submitted a revised policy, which includes providing beneficiaries with required informing materials if a request is denied, that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHSUDS IN No. 18-059; MHP contract, exhibit A, attachment 10, section 1(F); and Code of Federal Regulations, title 42, section 438, subdivision 62(b)(2).

Corrective Action Description

San Francisco Behavioral Health Services updated the Continuity of Care policy which includes providing beneficiaries with required informing materials if a request is denied. The policy specifies:

The written notice of denial must contain a clear explanation of the reasons for the denial; the availability of in-network BHS specialty mental health services; how and where to access BHS Specialty Mental Health Services; the beneficiary's right to file an appeal based on the adverse benefit determination, the Beneficiary Handbook, and the Provider Directory.

Proposed Evidence/Documentation of Correction

See highlighted text on page 3 of **2.2.1 3.04-09 San Francisco Continuity of Care Requirements for Medi-Cal Specialty Mental Health Services_highlighted p3.pdf**

Ongoing Monitoring (if included)

BHS Quality Management is required to submit to DHCS a quarterly continuity-of-care report (along with the quarterly Network Adequacy Certification Tool report), MH Access will keep a log of all requests, and approvals, for continuity-of-care, that includes the following information:

Date of the request; Beneficiary's name; Name of beneficiary's pre-existing provider; Address/location of the pre-existing provider's office.

Person Responsible (job title)

Craig Murdock, Director, Behavioral Health Access Programs

Implementation Timeline:

Effective April 25, 2023

Requirement

The MHP must have practice guidelines, which meet the requirements of the MHP Contract. *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

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has practice guidelines, which meet the requirements of the MHP Contract. Per the discussion during the review, the MHP stated that its clinical medication and prescribing guidelines serve as its practice guidelines and that it would provide additional documentation post review. Post review, the MHP provided examples

of education and resource materials; however, it is not evident that the MHP has established practice guidelines which meet the requirements of the MHP Contract.

DHCS deems the MHP out of 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.

Corrective Action Description

MHP will update our existing practice guidelines to ensure contract requirements are met including valid and reliable clinical evidence or a consensus of health care professionals in the applicable field. Practice guidelines will consider the needs of the beneficiaries and incorporate feedback from network providers.

The guidelines will also encompass the structure of the therapeutic approaches for services provided to children, youth, and adults which is broken down according to assessments, psychoeducation, and evidence-based interventions.

Proposed Evidence/Documentation of Correction

Updated practice guidelines that meet the requirements in the MHP contract.

Ongoing Monitoring (if included)

Once the practice guidelines document is completed, ongoing monitoring will occur to ensure the practice guidelines are current and continue to meet the requirements in the MHP contract.

Person Responsible (job title)

Dr. Ana Gonzalez, DO, Co-Chief Medical Officer, Deputy Director of Adult and Older Adult Outpatient Services

Dr. Lisa Inman, MD, Co-Chief Medical Officer, Deputy Medical Director of CYF Outpatient Services and Comprehensive Clinics

Maximilian Rocha, LCSW, Director of Systems of Care

Implementation Timeline:

November 2023 – March 2024: Establish work group to update practice guidelines to meet contract requirements.

April 30, 2024: BHS Leadership review practice guidelines.

May 31, 2024: Finalize and approve practice guidelines.

Requirement

The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. *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

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it posts its guidelines on its website, meets regularly with providers, and follows up on individual beneficiary health concerns. Post review, the MHP submitted medication and prescribing guidelines as well as patient education material; however, it is not evident practice guidelines were developed or disseminated during the review period.

DHCS deems the MHP out of 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.

Corrective Action Description

Upon completion of the updated practice guidelines MHP will disseminate the guidelines through existing mechanisms to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

Guidelines will be disseminated to an All Providers email listserv, posted on the public website, and promoted in technical assistance.

Proposed Evidence/Documentation of Correction

- Sample email of updated practice guidelines to all providers.
- Weblink to public website with updated practice guidelines.
- Technical assistance schedule.

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Dr. Ana Gonzalez, DO, Co-Chief Medical Officer, Deputy Director of Adult and Older Adult Outpatient Services

Dr. Lisa Inman, MD, Co-Chief Medical Officer, Deputy Medical Director of CYF Outpatient Services and Comprehensive Clinics

Maximilian Rocha, LCSW, Director of Systems of Care

Implementation Timeline:

Disseminate updated practice guidelines by June 7, 2024.

Requirement

The MHP must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. *MHP contract, exhibit A, attachment 5, section 6(D); Code of Federal Regulations, title 42, section 438, subdivision 236(d); and California Code of Regulations, title 9, section 1810, subdivision 326*

DHCS Finding 3.5.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP takes steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP explained its utilization review process and its use of the Tools to Improve Practice (TIPs) website as a resource for patient and provider education. Post review, the MHP submitted its peer review audit tool; however, this evidence was insufficient in demonstrating compliance with the regulations as it is not evident that the MHP has established practice guidelines.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, section 6(D); Code of Federal Regulations, title 42, section 438, subdivision 236(d); and California Code of Regulations, title 9, section 1810, subdivision 326.

Corrective Action Description

MHP has chart audit procedures in place and have been conducting peer review chart audits annually. Upon completion of the practice guidelines, MHP will update the audit tool to reflect the new practice guidelines.

The QA training officer is designing and developing learning programs, facilitating and disseminating materials and the QA clinical lead will support with providing clinical consultation to providers in need of additional support. These roles were created to ensure that providers and staff are adhering to practice guidelines.

Proposed Evidence/Documentation of Correction

Updated chart audit tool to reflect the new practice guidelines.

MHP will continue to conduct annual peer review chart audits. Co-Chief Medical Officers will review chart audit results.

Person Responsible (job title)

Dr. Ana Gonzalez, DO, Co-Chief Medical Officer, Deputy Director of Adult and Older Adult Outpatient Services

Dr. Lisa Inman, MD, Co-Chief Medical Officer, Deputy Medical Director of CYF Outpatient Services and Comprehensive Clinics

Maximilian Rocha, LCSW, Director of Systems of Care

Implementation Timeline:

July 24, 2023: Hired QA Clinical Lead

May 27, 2023: Hired QA Training officers

November 30, 2022: Established Office Hours in response to providers needing additional support with clinical documentation and procedures.

June 2024: Update chart audit tool

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 toll-free telephone number provides information to beneficiaries to the below listed requirements:

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

DHCS Finding 4.2.2

Test Call Findings								
Date/time of call	Th 3/9/23 at 7:50am	F 2/3/23 at 9:51am	Tu 1/31/23 at 8:48am	Th 2/2/23 at 7:41am	Tu 3/21/23 at 7:27am	M 3/13/23 at 11:42am	F 3/17/23 at 7:29am	
Required Elements	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**Compliance Percentage**
1	N/A	IN	IN	N/A	IN	N/A	N/A	100%
2	OOC	IN	IN	OOC	IN	N/A	N/A	60%
3	N/A	IN	IN	OOC	IN	N/A	N/A	75%
4	N/A	N/A	N/A	N/A	N/A	IN	IN	100%

Based on the test calls, DHCS deems the MHP *in partial compliance* with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

Repeat deficiency: Yes

Corrective Action Description

Findings from the report indicate that requirements 2 and 3 were out of compliance due to the operator stating to the caller that they had called the wrong number or asking the caller to call back during business hours. This resulted in the operator not providing information about access to specialty mental health services or services needed to treat a beneficiary's urgent condition. Both out of compliance calls were conducted during afterhours.

Test call #1 was out of compliance due to the operator stating to the caller that they had reached the afterhours service and could either call back during business hours or leave a message with identifiable information for a call back. This call was conducted at 7:50am, 10 minutes before the transition to business hours at 8:00am.

Test call #4 was conducted at 7:41am. The operator who answered the call identified the line as the Suicide Prevention line and instructed the caller to hang up and dial a different number for further assistance.

Our analysis of the two calls indicated a lack of quality assurance regarding the adequacy and uniformity of call coverage and quality during afterhours coverage. We are working with senior management of the afterhours subcontractor to address these findings in the following ways:

1. Beginning November 2023, we are implementing a monthly operational meeting with the afterhours subcontractor where we will identify, review and track challenges and deficiencies, especially any re-occurring deficiencies, and additionally track interventions and those outcomes.
2. Beginning November 2023, Behavioral Health Access Line (BHAL) staff will provide quarterly trainings to the afterhours subcontractor call operators, including all full-time, part-time and volunteer staff who cover the 24/7 Access Line. The training will be a requirement prior to covering the Access Line to ensure operators are clear on their role when transitioning to the Access Line, the hours of coverage, how to navigate and effectively provide information and assistance, as well as staying up to date on referral program resources and workflows. The frequency of these trainings may be adjusted depending on subcontractor need.
3. Finally, BHAL will additionally provide technical assistance to the subcontractor as needed and continue to monitor the steps the subcontractor has taken for ongoing quality assurance.

Proposed Evidence/Documentation of Correction

1. Training materials and attendance logs of participating staff in the BHAL trainings provided to the subcontractor – June 2024.
2. Sample meeting minutes from monthly Operational meetings with the afterhours subcontractor including documentation of discussions on any challenges or deficiencies and actions taken to address them – June 2024.
3. Any tracking and performance outcomes if applicable.

Ongoing Monitoring (if included)

In addition to the monthly Operational meetings, a standing agenda item will be added to the existing monthly QA meetings between BHAL, BHS Quality Management and the afterhours subcontractor for the next 6 months. Status updates on actions implemented to improve call coverage, adequacy, accuracy, and quality, will be provided here. This will begin October 2023 until March 2024.

Person Responsible (job title)

Adela Morales, Program Coordinator, Behavioral Health Access Line

Implementation Timeline:

October 2023 – March 2024: Ongoing monitoring in Quality Assurance monthly meetings with BHAL, BHS-QM, Subcontractor

November 2023 – ongoing: Begin BHAL quarterly trainings for subcontractor operators on Access Line program and operator standards.

November 2023 – ongoing: Monthly operational meetings with subcontractor to identify, discuss and track challenges or deficiencies and countermeasures.

Requirement

The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request. *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.*

DHCS Finding 4.2.4

While the MHP submitted evidence to demonstrate compliance with this requirement, one (1) of the five (5) required DHCS test calls were not logged on the MHP's written log of initial request. The table below summarizes DHCS' findings pertaining to its test calls:

Log Results					
Test Call #	**Date of Call**	**Time of Call**	**Name of the Beneficiary**	**Date of the Request**	**Initial Disposition of the Request**
1	3/9/2023	7:50 a.m.	IN	IN	IN
2	2/3/2023	9:51 a.m.	IN	IN	IN
3	1/31/2023	8:48 a.m.	IN	IN	IN

4	2/2/2023	7:41 a.m.	OOC	OOC	OOC
5	3/21/2023	7:27 a.m.	OOC	IN	IN
	Compliant Percentage		**60%**	**80%**	**80%**

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).

Repeat deficiency: Yes

Corrective Action Description

Findings from the DHCS report indicate areas out of compliance in the written logs. Call #4 is out of compliance due to not having a written log. Call #5 is out of compliance due to the caller's name not being recorded in the written log. Both out of compliance calls were conducted during afterhours.

The importance of accurate and timely logging of incoming calls while providing after-hours coverage is an essential function of the MHP's afterhours subcontractor. We have identified that additional monitoring, training and technical assistance are necessary to ensure that the afterhours subcontractor adheres to this important and essential State requirement. We will address these areas in the following ways:

<u>Monitoring:</u>

1. SF BHS is updating our FY23-24 contract with the afterhours subcontractor to reinforce requirements including mandatory trainings for staff, accurate documentation, and timely submission of afterhours call logs.
2. Starting November 2023, we are implementing a monthly operational meeting with the afterhours subcontractor where we will identify, review and track challenges and deficiencies, especially any re-occurring deficiencies, and additionally track interventions and those outcomes.
3. Accurate and complete logging of calls and their timely submission will be a priority item to be monitored and discussed in the monthly operational meetings. We are currently reviewing for any deficiencies in logs submitted by the subcontractor starting from July 2023 onward. We will track for required fields and who completed the logs in order to identify areas and reasons for deficiencies. This data will be used to guide our trainings, technical assistance and improvement work.

<u>Training and technical assistance:</u>

1. Starting November 2023 we will begin providing trainings to the afterhours contractor on a quarterly basis to ensure operators are clear on their role when transitioning to the Access Line, the hours of coverage, step by step instruction where needed, such as in best practices for documenting and submitting call logs, how to navigate and effectively provide information and assistance, as well as staying up to date on referral program resources and workflows. The frequency of these trainings may be adjusted depending on subcontractor need.
2. We will consult with the Behavioral Health Services Training Unit to enhance the Access Line training to apply adult learning theories and promote quality customer service. The expectation will be that all subcontractor staff operators, including full-time, part-time and volunteer operators, will be required to complete the training prior to assuming any Access Line duties.
3. We will work with the subcontractor to solidify an updated script and workflow that line operators must adhere to that include required documentation and timely logging of information.

Proposed Evidence/Documentation of Correction

1. Training materials and attendance logs of participating staff in the BHAL trainings provided to the subcontractor – June 2024.
2. Sample meeting minutes from monthly Operational meetings with the afterhours subcontractor including documentation of discussions on any challenges or deficiencies and actions taken to address them – June 2024.
3. Updated script and workflow for afterhours subcontractor operators – January 2024.
4. Tracking and performance outcomes report for any log deficiencies – June 2024.

Ongoing Monitoring (if included)

In addition to the monthly Operational meetings, a standing agenda item will be added to the existing monthly QA meetings between BHAL, BHS Quality Management and the afterhours subcontractor for the next 6 months. Status updates on actions implemented to improve call coverage, adequacy, accuracy and quality, will be provided here. This will begin October 2023 until March 2024, or until performance is deemed sufficient.

Person Responsible (job title)

Adela Morales, Program Coordinator, Behavioral Health Access Line

Implementation Timeline:

October 2023 – March 2024: Ongoing monitoring in Quality Assurance monthly meetings with BHAL, BHS-QM, Subcontractor

November 2023 – ongoing: Begin BHAL quarterly trainings for subcontractor operators on Access Line program and operator standards.

November 2023 – ongoing: Monthly operational meetings with subcontractor to identify, discuss and track challenges or deficiencies and countermeasures.

January 2024: Final script and workflow for subcontractor operators completed.

June 2024: Complete tracking and performance outcomes report for log deficiencies.

Requirement

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. 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. *BHIN No 22-016; Welfare & Institution Code, section 14197.1; Health and Safety Code, section 1367.01(h)(4); Code of Federal Regulations, title 42, section 438, subdivision 210(c).*

DHCS Finding 5.1.5

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP includes the name and direct telephone number of the professional who made the authorization decision and offers the treating provider the opportunity to consult with the professional who made the authorization decision. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it has close relations with providers and hospitals and can communicate with them directly about authorization decisions. Post review, the MHP provided samples copies of authorization denials; however, these denials did not demonstrate compliance to the requirement.

DHCS deems the MHP out of compliance with BHIN No 22-016; Welfare & Institution Code, section 14197.1; Health and Safety Code, section 1367.01(h)(4); Code of Federal Regulations, title 42, section 438, subdivision 210(c).

Corrective Action Description

MHP has edited our electronic health records template to the provider notification to include the name and telephone number (or other effective means for contact) of the professional who made the authorization decision.

Proposed Evidence/Documentation of Correction

Please see highlighted areas for the name and telephone number (or other effective means for contact) of the professional who made the authorization decision in document: 5.1.5 Provider Contact Sample

Ongoing Monitoring (if included)

The change of the template to the provider notification is in effect since October 6, 2023. All future provider notifications will include the required information.

Person Responsible (job title)

Annie Shui, LMFT, Program Manager, Utilization Management

Implementation Timeline:

Effective October 6, 2023

Requirement

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. Peer Support Services
    vii. 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

DHCS Finding 5.2.13

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP established and implemented policies regarding prior authorization and/or MHP referral requirements for outpatient SMHS. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would review its policies and procedures. Post review, the MHP submitted an updated authorization policy that included the required contract language that it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-016.

Corrective Action Description

BHS updated the policy for prior authorization and/or MHP referral requirements for outpatient SMHS. The updated Authorization of Outpatient SMHS policy is in accordance with BHIN 22-016 and now states the following:

Prior Authorization or MHP Referral for Outpatient SMHS BHS civil service and contracted providers shall follow prior authorization and/or MHP referral requirements for outpatient SMHS as specified below: MHPs shall not require prior authorization for the following services/service activities:

- Crisis Intervention
- Crisis Stabilization
- Mental Health Services, including initial assessment;
- Targeted Case Management;
- Intensive Care Coordination;
- Peer Support Services; and,
- Medication Support Services.

Proposed Evidence/Documentation of Correction

See page 5 for highlighted text in **5.2.13 3.03-22 Authorization of Outpatient SMHS.docx**

5.2.13 PURQC AOA Memo

5.2.13 PURQC CYF Memo

Ongoing Monitoring (if included)

As stated in the Authorization of Outpatient SMHS policy, MHP does not require prior authorization to the listed outpatient services.

MHP conducts a clinical quality chart review to ensure appropriate level of care/intensity of services and monitor quality of care. See the two attached memo which describes the MHP's CYF and AOA systems of care quality monitoring process.

Person Responsible (job title)

Angelica M. Almeida, Ph.D., Director, Adult/Older Adult System of Care

Heather Clendenin LeMoine, MFT, Clinical Operations Manager, CYF System of Care

Implementation Timeline:

Effective April 26, 2023

Requirement

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.

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.
The MHP submitted the following documentation as evidence of compliance with this requirement:
• Copy of SAR WorkSheet Post tr
• SAR 2 B-A, S
• SAR A, R
• SAR B, A (1)
• SAR D, D
• SAR J, E (signed)
• SAR J, I
• SAR MP, A (signed)
• SAR S, K (updated)
• SAR S, P (updated)
• SAR W, S

- License verification Brad Harms
- Niki Smith License Sep 2021
- 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC
- 3.03-22 Authorization of Outpatient SMHS
- UM for IHBS and TFC Policy v2
- Continued Service Authorization Request (SAR) For Intensive Services cleaned (2)
- Expedited auth letter template

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

Authorization	# of Service Authorization In Compliance	# of Service Authorization Out of Compliance	Compliance Percentage
Regular Authorization: The MHP makes a decision regarding a provider's request for prior authorization, not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination.	7	3	70%

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, not to exceed five (5) business days from the MHP's receipt of the information. Per the discussion during the review, the MHP explained its service authorization request (SAR) process and stated it would submit samples of its SAR approval process post review. Post review, the MHP submitted a sample of ten (10) SARs; however, three (3) were not completed within the required five (5) day timeframe.

DHCS deems the MHP in partial compliance with BHIN 22-016.

Corrective Action Description:

BHS updated the policy for prior authorization and/or MHP referral requirements for outpatient SMHS. The updated Authorization of Outpatient SMHS policy is in accordance with BHIN 22-016 and states the following:

The CYF UM Committee shall notify the treating provider in writing within five (5) business days of a decision and provide the client written notice of any decision by CYF to deny a service authorization or request, or to authorize a service in an amount,

duration, or scope that is less than required. The notice to the client shall meet the requirements pertaining to the notices of adverse benefit determination.

Additionally, DHCS requested 10 SAR's demonstrating Out of County Requests for Presumptive Transfer (not under the purview of BHIN 22-016). Presumptive Transfer and Out of County Service Request Procedures Memo DRAFT has been drafted to include a five (5) day timeframe. This Memo will be signed and distributed by February 15, 2024.

Proposed Evidence/Documentation of Correction:

See page 3 of CYF Authorization of Outpatient SMHS Policy

See page 2 of Presumptive Transfer and Out of County Service Request Procedures

Ongoing Monitoring (if included):

MHP conducts a clinical quality chart review to ensure appropriate level of care/intensity of services and monitor quality of care.

Person Responsible (job title):

Heather Clendenin LeMoine, MFT, Clinical Operations Manager, CYF System of Care

Implementation Timeline:

CYF Authorization of Outpatient SMHS Policy is effective as of May 10, 2023. Quarterly Monitoring of SMHS for ICC and IHBS is ongoing.

Requirement

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

DHCS Finding 5.2.15

While the MHP submitted evidence to demonstrate compliance with this requirement, it is **not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.** This requirement

was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP explained that it did not receive any expedited requests during the review period but stated **it would use a 48-hour timeline if one should occur**; however, the MHP acknowledged that it does not identify this process in any policy. Post review, the MHP submitted a revised policy with the required language that it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-016 and Code of Federal Regulations, title 42, section 438, subdivision 210(d)(2)(i).

Corrective Action Description

BHS has updated **5.2.15 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC** and **5.2.15 3.03-22 Authorization of Outpatient SMHS** policies to establish a standard timeframe for an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires.

Proposed Evidence/Documentation of Correction

The updated **5.2.15 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC** (pg 3)

states the following:

> For cases in which the provider indicates, or the CYF UM Committee determines, that the standard timeframe could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, the CYF UM Committee shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, **but no later than 72 hours after the receipt of the request for service.**

Additionally, on the **5.2.15 3.03-22 Authorization of Outpatient SMHS** policy (pg 6), it states the following:

> 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. For cases in which a provider indicates, or the MHP determines, that the standard timeframe could seriously 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, but no later than 72 hours after receipt of the request for service.** 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.

Ongoing Monitoring (if included)

UM services are monitored quarterly. The CYF UM Committee reviews all requests for prior authorization for ICC and IHBS services and their timelines. CYF UM Committee notes the timeline between the Expedited Request for services and the authorization determination date, not to exceed 72 hours, which is aligned with the current policies outlined above.

Person Responsible (job title)

Heather Clendenin LeMoine, MFT, Clinical Operations Manager, CYF System of Care

Implementation Timeline:

Policies effective on April 26-27, 2023

Requirement

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

DHCS Finding 5.2.15

While the MHP submitted evidence to demonstrate compliance with this requirement, it is **not evident that the MHP makes an expedited authorization decision and provides notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.** This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP explained that it did not receive any expedited requests during the review period but stated **it would use a 48-hour timeline if one should occur**; however, the MHP acknowledged that it does not identify this process in any policy. Post review, the MHP submitted a revised policy with the required language that it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-016 and Code of Federal Regulations, title 42, section 438, subdivision 210(d)(2)(i).

Corrective Action Description

BHS has updated **5.2.15 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC** and **5.2.15 3.03-22 Authorization of Outpatient SMHS** policies to establish a standard timeframe for an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires.

Proposed Evidence/Documentation of Correction

The updated **5.2.15 3.03-18 Prior Authorization P&P for CYF ICC IHBS and TFC** (pg 3)

states the following:

> For cases in which the provider indicates, or the CYF UM Committee determines, that the standard timeframe could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function, the CYF UM Committee shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, **but no later than 72 hours after the receipt of the request for service.**

Additionally, on the **5.2.15 3.03-22 Authorization of Outpatient SMHS** policy (pg 6), it states the following

> 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. For cases in which a provider indicates, or the MHP determines, that the standard timeframe could seriously 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, but no later than 72 hours after receipt of the request for service.** 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.

Ongoing Monitoring (if included)

UM services are monitored quarterly. The CYF UM Committee reviews all requests for prior authorization for ICC and IHBS services and their timelines. CYF UM Committee notes the timeline between the Expedited Request for services and the authorization determination date, not to exceed 72 hours, which is aligned with the current policies outlined above.

Person Responsible (job title)

Heather Clendenin LeMoine, MFT, Clinical Operations Manager, CYF System of Care

Implementation Timeline:

Policies effective on April 26-27, 2023

Requirement

At the beneficiary's request, the MHP must identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing SMHS to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary. Assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. *MHP contract, exhibit A, attachment 12, section 1(B)(8) and California Code of Regulations, title 9, section 1850, subdivision 205(c)(4); and Code of Federal Regulations, title 42, section 438, subdivision 406(a).*

DHCS Finding 6.1.7

While the MHP submitted evidence to demonstrate compliance with this requirement, it is **not evident that the MHP identifies an alternative individual to assist the beneficiary if the individual initially identified by the MHP is the person providing SMHS to the beneficiary requesting assistance.** This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would review its policies. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(8); California Code of Regulations, title 9, section 1850, subdivision 205(c)(4); and Code of Federal Regulations, title 42, section 438, subdivision 406(a).

Corrective Action Description

BHS has updated the Grievance and Appeal policy which includes identifies an alternative individual to assist the beneficiary if the individual initially identified by the MHP is the person providing SMHS to the beneficiary requesting assistance. On page 3, the policy specifies:

A client may ask for assistance in resolving issues regarding the provision of behavioral health services. If the individual identified by BHS is the person providing behavioral health services to the client requesting assistance, BHS shall identify another individual to assist that client.

Proposed Evidence/Documentation of Correction

See page 3 of attached: **6.1.7 Grievance and Appeal System for Behavioral Health Services**

Ongoing Monitoring (if included)

The change in the policy has been in effect since April 2023. All future informing materials will include the required information.

Person Responsible (job title)

William Gramlich, CADC-II, Grievance & Appeal Officer, Quality Management

Melissa Bloom, PhD, Risk Manager, Quality Management

Implementation Timeline: Policy updated April 25, 2023

Requirement

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.

DHCS Finding 6.1.14

While the MHP submitted evidence to demonstrate compliance with this requirement, it is **not evident that the MHP provides information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance.** This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it would process Discrimination Grievances similar to standard grievances, noting additional reporting requirements. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of compliance with MHP contract, exhibit A, attachment 11, section 3(F)(3)(a-b) and Welfare and Institution Code, section 14727(a)(4) and (5).

Corrective Action Description

BHS has updated the Grievance and Appeal policy which describes how **all beneficiaries, prospective beneficiaries, and members of the public can file a Discrimination Grievance.** On page 2, the policy defines grievances and appeals including the definition of discrimination grievance as:

> **Discrimination Grievance** means a complaint by a beneficiary about their Specialty Mental Health or Drug Medi-Cal services concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including 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.

On page 5, the policy describes the process of filing any type of grievance as:

> **<u>Filing a Grievance</u>**
>
> Grievances may be filed at any time by the client, the minor client's parent/legal guardian, or an authorized representative. Individuals may present their grievances orally or in writing, and maybe submitted in person, by phone, or via US Mail using the Grievance and Appeal Form (BHS 316). Assistance may be obtained from the Behavioral Health Access Center (BHAC), San Francisco Mental Health Clients' Rights Advocates, or authorized representative. Orally filed grievances can be entered on the form (BHS 316) by the individual aiding. Individuals filing a grievance shall begiven a copy of their completed Grievance and Appeal Form upon request. Grievances may be submitted:
>
> In person or by phone- Officer of the Day
> Behavioral Health Access Center
> 1380 Howard Street, 1st floor
> San Francisco, CA 94103
> 1-415-255-3737 or 1-888-246-3333
> TDD: 1-888-484-7200

Via US Mail or by phone- Grievance/Appeal Office
Quality Management
1380 Howard Street, 2nd Floor
San Francisco, CA 94103
1-415-255-3632
-OR-
postage-paid, self-addressed envelope

Proposed Evidence/Documentation of Correction

See page 2 for the definition and page 5 for the process to file a grievance of attached,
6.1.14 Grievance and Appeal System for Behavioral Health Services

Ongoing Monitoring (if included)

The change in the policy has been in effect since April 2023. All future informing materials will include the required information.

Person Responsible (job title)

William Gramlich, CADC-II, Grievance & Appeal Officer, Quality Management

Melissa Bloom, PhD, Risk Manager, Quality Management

Implementation Timeline:

Policy effective April 25, 2023

Requirement

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.

DHCS Finding 6.1.15

While the MHP submitted evidence to demonstrate compliance with this requirement, it is **not evident that the MHP has designated 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.** This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated the Grievance and Appeal Officer would serve as the Discrimination Grievances

Coordinator. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of 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).

Corrective Action Description

BHS has updated the Grievance and Appeal policy to clearly designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, the updated policy states the following (see page 7) : Discrimination Grievances

The Grievance/Appeal Officer is designated by BHS as the Discrimination Grievance Coordinator who, in collaboration with the BHS ADA Coordinator as needed, 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.

Proposed Evidence/Documentation of Correction

See page 7 of attached; **6.1.15.Grievance and Appeal System for Behavioral Health Services**

Ongoing Monitoring (if included)

The change in the policy has been in effect since April 2023. All future informing materials will include the required information.

Person Responsible (job title)

William Gramlich, CADC-II, Grievance & Appeal Officer, Quality Management

Melissa Bloom, PhD, Risk Manager, Quality Management

Implementation Timeline: Policy updated April 25, 2023

Requirement

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.

DHCS Finding 6.1.16

While the MHP submitted evidence to demonstrate compliance with this requirement, it is **not evident that the MHP does 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.** This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it would follow the requirements in processing Discrimination Grievances. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of 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).

Corrective Action Description

BHS has updated the 6.1.16 Grievance and Appeal policy to clearly state that a beneficiary does not have 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.

Proposed Evidence/Documentation of Correction

See page 7 of attached: **6.1.16 Grievance and Appeal System for Behavioral Health Services**

Ongoing Monitoring (if included)

The change in the policy has been in effect since April 2023. All future informing materials will include the required information.

Person Responsible (job title)

William Gramlich, CADC-II, Grievance & Appeal Officer, Quality Management

Melissa Bloom, PhD, Risk Manager, Quality Management

Implementation Timeline: Policy updated April 25, 2023

Requirement

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.

DHCS Finding 6.1.17

While the MHP submitted evidence to demonstrate compliance with this requirement, **it is not evident that the MHP submits the required information regarding a complaint to the DHCS Office of Civil Rights within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary.** This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it had not received or identified any discrimination grievances**, but would submit the required information within ten days to the Office of Civil Rights when appropriate**. Post review, the MHP submitted a revised grievance and appeal policy that includes this requirement that it will implement moving forward.

DHCS deems the MHP out of 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.

Corrective Action Description

BHS has updated the 6.1.17 Grievance and Appeal policy. On page 12, it states that:

Within 10 calendar days of mailing a discrimination grievance resolution letter to the beneficiary, the following information will be submitted to the DHCS Office of Civil Rights' designated email at DHCS.DiscriminationGrievances@dhcs.ca.gov:

- the original complaint
- the provider's or other accused party's response to the grievance o contact information for the Grievance/Appeal Officer
- contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance
- all correspondence with the beneficiary regarding the grievance including, but not limited to, the acknowledgement and resolution letters
- the results of the investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination

Proposed Evidence/Documentation of Correction

See pages 7 and 12 of attached: **6.1.17 Grievance and Appeal System for Behavioral Health Services**

Ongoing Monitoring (if included)

The change in the policy has been in effect since April 2023. All future informing materials will include the required information.

Person Responsible (job title)

William Gramlich, CADC-II, Grievance & Appeal Officer, Quality Management

Melissa Bloom, PhD, Risk Manager, Quality Management

Implementation Timeline: Policy updated April 25, 2023

Requirement

The MHP promptly notifies DHCS if the MHP finds a party that is excluded.

DHCS Finding 7.5.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded. Per the discussion during the review, the MHP described its database check process and agreed to provide a sample of completed monthly reports as well as a policy and procedure demonstrating it reports excluded providers to DHCS; however,

the MHP stated it had not identified an excluded party during the review period. Post review, no additional evidence was provided.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 602(d).

Corrective Action Description

The BHS Compliance Officer developed a policy and procedures to promptly notify DHCS if the MHP finds a party that is excluded. The policy specifies:

a. If BHS Credentialing and Private Provider Network identify an individual provider who is no longer eligible to participate in the managed care program due to Disclosure and/or Exclusion Lists, the BHS Compliance Unit first communicates this information internally to SFDPH OCPA, BHS Billing/Fiscal, BHS CDTA/BOCC and subsequently, **refers the case, including the provider's name and NPI number to the DHCS Provider Enrollment Division at 1501 Capitol Ave, Sacramento, CA 95814, (916) 323-1945**. That communication from BHS to DHCS is stored in the provider's credentialing file.
b. In the course of implementing Individual Provider Screening and Enrollment processes (CFR42, Part 455, Subpart E) and Disclosures of Information by Individual Providers (CFR42, Part 455, Subpart B), in circumstances where BHS Credentialing observes an individual who is not eligible for participation in the federal insurance program, then the BHS Compliance Unit first communicates this information internally to SFDPH OCPA, BHS Billing/Fiscal, BHS CDTA/BOCC and subsequently, **refers the issue to the DHCS Provider Enrollment Division at 1501 Capitol Ave, Sacramento, CA 95814, (916) 323-1945**.

Proposed Evidence/Documentation of Correction

Please see p. 9, Section 5 of the attached: **7.5.3 Individual Provider Enrollment, Screening, and Credentialing Standards in Federal Insurance Programs**

Ongoing Monitoring (if included)

BHS Compliance will report to DHCS as needed.

Person Responsible (job title)

Office of Compliance and Privacy Affairs:
Joseph A. Turner, PhD, CHC, BHS Compliance Officer

Implementation Timeline: