San Benito County Behavioral Health

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

Corrective Action Plan

System Review

Requirement

The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet beneficiary access criteria for SMHS as medically necessary.

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0010 Medical Array of MH Services
• CLN 1640 Intensive Services for Youth
• 22-23 SENECA CHILDREN'S AGENCIES (1.2.3)
• SBCBH ICC-IHBS-TFC Referral

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. Per the discussion during the review, the MHP stated that it has a TFC contractor; however, it has not screened or referred children and youth for this service during the review period.

DHCS deems the MHP out of compliance with the BHIN No. 21-073 and Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic

Corrective Action Description

The MHP will continue to work with providers to identify a provider in the region that offers TFC and work with the provider to execute a contract for TFC. We will also add the topic to the regional network provider meeting agenda, to document efforts to find a provider that offers TFC services.

Proposed Evidence/Documentation of Correction

The MHP will explore two (2) providers it currently contracts with for outpatient services to see if either can be contracted to provide TFC services.

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Shannon Gomez, LCSW, Clinical Supervisor – Childrens System of Care

Implementation Timeline: February 1, 2024

Requirement

The MHP has an affirmative responsibility to determine if children and youth who meet beneficiary access criteria for SMHS need TFC.

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0010 Medical Array of MH Services
• CLN 1640 Intensive Services for Youth
• 22-23 SENECA CHILDREN'S AGENCIES (1.2.3)
• SBCBH ICC-IHBS-TFC Referral

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth to determine if they meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it has not assessed children and youth for the need TFC during the review period.

DHCS deems the MHP out of 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.

Corrective Action Description

The MHP will continue to work with providers to identify a provider in the region that offers TFC and work with the provider to execute a contract for TFC. We will also add the topic to the regional network provider meeting agenda, to document efforts to find a provider that offers TFC services.

Proposed Evidence/Documentation of Correction

The MHP will explore two (2) providers it currently contracts with for outpatient services to see if either can be contracted to provide TFC services.

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Shannon Gomez, LCSW, Clinical Supervisor – Childrens System of Care

Implementation Timeline: February 1, 2024

Requirement

The MHP shall 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 1810.435

DHCS Finding [1.4.4]

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 435 and MHP contract, exhibit A, attachment 8, section 8(D). 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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• ADM 3250 Medi-Cal Certification of Contract Providers, throughout the policy
• CLN 3210 County Site Self Certification, throughout the policy
• 2022.12.19 Fire Clearance
• DHCS 1735
• 3500 Recert Letter
• 2021.11.15 RCS Letter Final
• 2022.12.19 Fire Clearance_1131 Community Pkwy
• DHCS 1737 SELF-SURVEY
• Rebekahs Children's Certification
• SBCBH re-certification

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 to certify the organizational providers that the MHP subcontracts with to provide SMHS. Of the nine (9) MHP providers, six (6) providers had overdue certifications. Per the discussion during the review, the MHP does not currently track provider certifications. Post review, the certification 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).

Corrective Action Description

The MHP will update the policy on certifying providers, and/or utilizing another MHP's certification, to ensure timely Medi-Cal certification for each of the organizational providers that have a contract with SBCBH. The MHP will review each contract with each organizational provider to determine what is needed to complete the certification process for each organization.

Proposed Evidence/Documentation of Correction

Update PIMS to reflect current information and provide updated Medi-Cal certifications for each organizational provider.

Ongoing Monitoring (if included)

Updated Medi-Cal certifications will be discussed at the QI Meeting and monitored quarterly to update the certification in a timely manner.

Person Responsible (job title)

Maxe Cendana, MPA - QI supervisor

Implementation Timeline: November 2023

Requirement

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

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0970-Med Monitoring
• CLN 0975-Medication Chart Review
• ADM 2455-Practice Guidelines for SMHS_FINAL 03-12-20
• Standard Contract
• SBCBH Provider Handbook

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. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not have evidence of how it disseminates practice guidelines to providers.

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

The MHP will document dissemination activities when materials, including practice guidelines, are routinely distributed to organizational providers.

Proposed Evidence/Documentation of Correction

MHP log of dissemination activities, which materials were distributed, the number of brochures, the date, and the name of each organization.

Ongoing Monitoring (if included)

Review contracts yearly and send out proper guidelines and notices with executed contracts.

Person Responsible (job title)

Molly Ramer, Administrative Services Manager

Implementation Timeline: November 2023

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:

1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days a 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 SMHS, including SMHS required to assess whether criteria for beneficiary access to SMHS are met.
3) The toll-free telephone number provides information to beneficiaries about services needed to treat 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]

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

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

The seven (7) test calls are summarized below.

Test Call #1
Test call was placed on Monday, January 9, 2023, at 11:21 p.m. The call was answered after five (5) rings via a live operator. The caller requested information about accessing mental health services in the county concerning his/her child's mental health and his disruptive behavior in school. The operator asked for the child's personal identifying information, which the caller provided. The operator explained the assessment and screening process for receiving services and provided the caller with the location and hours for the walk-in clinic.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

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

Test Call #2
Test call was placed on Tuesday, January 17, 2023, at 8:44 a.m. The call was answered after one (1) ring via a live operator. The caller asked for assistance with what he/she described as feeling down the past couple of weeks, with bouts of crying, the inability to sleep, and loss of appetite. The operator assessed the caller's need for urgent care services, which the caller responded in the negative. The operator explained the screening and assessment process. The operator explained that walk-ins are available and provided the hours of operation and address to the MHP office. The operator explained that someone is available 24 hours a day via the after-hours line if the caller experiences a need for urgent assistance.

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

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

Test Call #3
Test call was placed on Friday, January 27th at 10:35 a.m. The call was answered after three (3) rings via a live operator. The operator greeted the caller and said something unintelligible. The caller asked for clarification; the call was then disconnected.

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

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

Test Call #4
Test call was placed on Thursday, March 2, 2023, at 5:12 p.m. The call was answered after four (4) rings via a live operator. The caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator stated that the office was closed and to call back during business hours to make an appointment to be assessed for services. The operator

stated that the caller could walk into the clinic and stated the hours of operation, address, and phone number.

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

FINDING
The call is deemed *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 Call #5
Test call was placed on Tuesday, March 7, 2023, at 10:37 a.m. The call was answered after two (2) rings via a live operator. The caller asked the operator for information about mental health services in the county and explained he/she had been providing care for an elderly parent and had been feeling isolated, sad, and unable to sleep. The operator provided information about how to access SMHS including hours of operation, options for walk-in services, and the assessment process. The operator stated the caller could call back anytime as he/she had reached the 24/7 access line.

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

FINDING
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 Call #6
Test call was placed on Wednesday, March 1, 2023, at 7:29 a.m. The call was answered via a live operator. The caller requested information for how to file a complaint about a therapist he/she was seeing through the county. The operator offered the caller a different number to call or to take the callers information for a return phone call. The caller declined and ended the call.

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

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

Test Call #7
Test call was placed on Thursday, March 2, at 4:00 p.m. The call was answered after one (1) ring via a live operator. The caller asked how to file a complaint in the county. The operator stated that grievance forms can be found on the county's website, are

located in the clinic lobby, or the caller could speak in person or over the phone with a supervisor. The operator provided the clinic hours and location.
The caller was provided information about how to use the beneficiary problem resolution and fair hearing process.

FINDING
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).

SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	IN	OOC	IN	IN	N/A	N/A	80%
3	N/A	IN	OOC	OOC	OOC	N/A	N/A	25%
4	N/A	N/A	N/A	N/A	N/A	OOC	IN	50%

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

Share findings with Clerical Team and after-hours contractor. The Clerical Team is made up of several new employees and as such a retraining will be scheduled during a future clerical team meeting. Training materials will be shared with after-hours contractor to use for their staff training.

Proposed Evidence/Documentation of Correction

Training agenda, pertinent materials, and sign in sheet will be submitted once training has occurred.

Ongoing Monitoring (if included)

MHP will continue to monitor access call reports as they are received and review as necessary with clerical team as well as after-hours team.

Person Responsible (job title)

Rumi Saikia, LMFT – QI Supervisor, Molly Ramer, Administrative Services Manager

Implementation Timeline: November 2023

Requirement

The written log(s) contain the following required elements:

a) Name of the beneficiary
b) Date of the request
c) Initial disposition of the request

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1715-Access Line and Log_ 24-7 Services
• FY 21-22 Access Log
• Agenda 4.7.23

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged on the MHP's written log of initial request. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	1/9/2023	11:21 p.m.	IN	IN	IN
2	1/17/2023	8:44 a.m.	OOC	OOC	OOC
3	1/27/2023	10:35 a.m.	OOC	OOC	OOC
4	3/2/2023	5:12 p.m.	IN	IN	IN
5	3/7/2023	10:37 a.m.	OOC	OOC	OOC
Compliance Percentage			**40%**	**40%**	**40%**

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

Share findings with Clerical Team. The Clerical Team is made up of several new employees and as such a retraining will be scheduled during a future clerical team meeting.

The clerical team will be trained on how to use the client inquiry screen in SmartCare so that all calls are logged properly.

Proposed Evidence/Documentation of Correction

Training agenda, pertinent materials, and sign in sheet will be submitted once training has occurred.

Ongoing Monitoring (if included)

Log will be reviewed monthly to verify required calls are logged accordingly.

Person Responsible (job title)

Rumi Saikia, LMFT – QI Supervisor, Molly Ramer – Administrative Services Manager

Implementation Timeline: November 2023

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.

DHCS Finding [5.1.5]

The MHP did not furnish evidence to demonstrate 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). 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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• CLN 1600 Inpatient Treatment Authorization Requests
• CLN 1701 Authorization Process for Outpatient MH Services
• Service Authorization Request with MHP modification
• DENIAL NOTICE 4010777_06272022 SP
• DELIVERY SYSTEM 4010806_06292022 SP
• FY 2122 Inpatient Census Log - SBCMH Sample
• March 2022 Approved Invoice for AS 4008843_5062022
• CL 1630 Notices of Adverse Benefit determination

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides notification to the provider for a modification of an authorization request. Of the Service Authorization Requests (SAR) reviewed by DHCS, one (1) was modified but did not included evidence of notification to the beneficiary's treating provider. Per the discussion during the review, the MHP stated it provides notification to the provider when it makes a modification to an authorization request. The MHP was provided the opportunity to submit evidence of this process post review; however, no additional evidence was provided.

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

Proper notification will be sent to the provider for modification of an authorization request. An NOABD will be sent to client and provider when service modifications occur.

Proposed Evidence/Documentation of Correction

After review and approval, any modified SARs will be handed off to the QI Supervisor fulfilling the task of sending out NOABDs where the decision will be logged into the NOABD log and letter written and sent to client and provider.

Ongoing Monitoring (if included)

Updates will be given at Quality Improvement Committee Meetings and documented into the minutes.

Person Responsible (job title)

Rumi Saikia, LMFT – QI Supervisor, Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: November 2023

Requirement

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.

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• CLN 1600 Inpatient Treatment Authorization Requests
• CLN 1701 Authorization Process for Outpatient MH Services
• March 2022 Approved Invoice for AS 4008843_5062022
• QIC Minutes - 3.9.22
• QIC Minutes - 9.14.22
• Approved SAR for JH 4001875_05112022
• TAR BM 4010411_12222021
• San Benito FY 2021 - 2022 Implementation Plan Update
• TARs (Beneficiary initials: CW, DD, EC, EKL, ES, FL-Y, MH, MTG, RS, RS, SR, TS, VM, VM)
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR for JH 4008175_05112022
• TAR BM 4010411_12222021
• Inpt dc planning PN EC 4000788_07222021
• Inpt dc planning PN FL-Y 4010221_09232021
• Inpt dc planning PN FL-Y 4010221_09242021(c).
• Inpt dc planning PN FL-Y 4010221_09242021. (a)
• Inpt dc planning PN FL-Y 4010221_09242021. (b)
• Inpt dc planning PN MTG 4001282_10182021
• Inpt dc planning PN MTG 4001282_10192021

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a UM program that evaluates medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries

prospectively, such as through prior or concurrent authorization review procedures. Per the discussion during the review, the MHP stated its case managers currently perform concurrent authorization review; however, it is working to implement a process for the clinical team to perform this review and it would submit evidence of this process post review. Post review, the MHP submitted a draft concurrent review form and policy it will implement moving forward; however, it is not evident the concurrent review was occurring during the review period.

DHCS deems the MHP out of 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).

Corrective Action Description

Implement the new concurrent review process currently being developed and train staff involved in the concurrent review to the new process.

Proposed Evidence/Documentation of Correction

Final Approved Concurrent Review Policy CLN 1590, Concurrent Review process review with clinicians (minutes and training materials)

Concurrent Review and Authorization form
Care Plan form

Ongoing Monitoring (if included)

Concurrent Review will be added to the weekly clinical team meeting agenda and discussed to determine how the new process is progressing. These discussions will be documented via meeting minutes.

Person Responsible (job title)

Rumi Saikia, LMFT - QI Supervisor

Implementation Timeline: November 2023

Requirement

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.

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• FY2221 Inpatient Census Log - SBCMH samples
• 5.1. - 5.2 TARs
• 5.1. - 5.2 LPHA License
• Service Authorization Request with MHP modification
• Approved SAR for JH 4008175_05112022
• TAR BM 4010411_12222021
• San Benito Medi-Cal Beneficiary Handbook English

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP complies with all communication requirements outlined in the contract. Per the discussion during the review, the MHP stated it communicates with DHCS and contracting providers about prior authorization and concurrent review but does not disseminate this information to beneficiaries. The MHP was provided the opportunity to submit evidence of the communication to contract providers and DHCS post review; however, no additional evidence was provided.

DHCS deems the MHP out of compliance with BHIN 22-017 and Code of Federal Regulations, title 42, section 438, subdivision 10(g)(2)(iv).

Corrective Action Description

Proper notification will be sent to DHCS and contracting providers in writing of all the services that require prior or concurrent authorization and the procedures and timeframes necessary to obtain authorization for these services.

Proposed Evidence/Documentation of Correction

MHP will make the criteria or guidelines available through written and or electronic communication to contract providers.

Final Concurrent Review Policy CLN 1590
Updated Beneficiary Handbook

Ongoing Monitoring (if included)

Updates will be given at Quality Improvement Committee Meetings and documented into the minutes.

Person Responsible (job title)

Rumi Saikia, LMFT QI Supervisor

Implementation Timeline: December 2023

Requirement

The MHP shall 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.*

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.*

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• CLN 1000 - Crisis Response and Intervention Services
• CLN 1000 - Crisis Response and Involuntary Holds (5150s)
• CLN 1005 - Involuntary Holds (5150s)
• Sample Concurrent Review 1
• Sample Concurrent Review 2
• FY2122 Inpatient Census Log - SBCBH sample
• SARs and TARs
• TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR
• CLN 1590-Authorization and Concurrent Review-Inpatient and Residential Services FINAL 03-13-20
• CLN 1590-Concurrent Review policy DRAFT UPDATES 04-11-23

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes expedited authorization decisions and provides notice as expeditiously as the member's health condition requires, and not later than 72 hours after receipt of the request for services. Per the discussion during the review, the MHP stated that it would update its policy to include this requirement. Post review, the MHP submitted a draft concurrent review policy it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-017.

Corrective Action Description

MHP will make every effort to expedite authorization decisions and provide notice as expeditiously as possible as the member's health conditions require, and not later than 72 hours after the receipt of the request.

Proposed Evidence/Documentation of Correction

Final Concurrent Review Policy CLN 1590
Concurrent Review and Authorization form
Care Plan form

Ongoing Monitoring (if included)

Updates will be given at Quality Improvement Committee Meetings and documented into the minutes.

Person Responsible (job title)

Rumi Saikia, LMFT QI Supervisor

Implementation Timeline: November 2023

Requirement

Continued Stay Authorization Request

- 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.*

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.*

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• CLN 1000 - Crisis Response and Intervention Services
• Sample Concurrent Review 1
• Sample Concurrent Review 2
• Sample Pre-TAR
• FY2122 Inpatient Census Log - SBCBH sample
• SARs and TARs
• TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR
• CLN 1590-Authorization and Concurrent Review-Inpatient and Residential Services FINAL 03-13-20
• CLN 1590-Concurrent Review policy DRAFT UPDATES 04-11-23_see highlighted

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP issues 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. Per the discussion during the review, the MHP stated that it will update its policy to include this requirement. Post review, the MHP submitted a draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-017; Welfare and Institution Code, section 14197.1; and Health and Safety Code, section 1367.01(h)(2).

Corrective Action Description

Case Managers will document discharge planning efforts. On-call clinician will be required to fill out paperwork that will authorize the stay as soon as a hospital is found.

The MHP has developed a template that on-call clinicians can use for authorization of the first 24 hours. Before the end of the initial authorization period, the Concurrent review team will assess and determine medical necessity of the inpatient stay and will check with hospital daily for authorization review for additional days. MHP will 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 of medical necessity.

Any and all authorizations of initial stay and continued stay will be documented by authorizing LPHA in the client chart.

Proposed Evidence/Documentation of Correction

Final Concurrent Review Policy 1590, template used for the authorization of the first 24 hours.
Concurrent Review and Authorization form
Care Plan form

Ongoing Monitoring (if included)

Concurrent Review will be added to the weekly clinical team meeting agenda and discussed to determine how the new process is progressing. These discussions will be documented via meeting minutes.

Person Responsible (job title)

Rumi Saikia, LMFT – QI Supervisor

Implementation Timeline: November 2023

Requirement

Adverse Decision, Clinical Consultation, Plan of Care and Appeal

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.

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
4. The opportunity to consult with the professional who made the authorization decision.
5. 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.
6. 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.
7. 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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• FY2122 Inpatient Census Log - SBCBH sample
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• CLN 1630 Notices of Adverse Benefit Determination
• Care Plan 3.6.23 draft (form)
• CONCURRENT REVIEW 3.6.23 draft (form)
• SARs and TARs
• TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR
• CLN 1590-Concurrent Review policy DRAFT UPDATES 04-11-23_see highlighted
• Sample TAR denial and modification

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP will work with a hospital treating provider to develop a treatment plan for a beneficiary if there is a disagreement with a modification or denial of an authorization as required per the regulation. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP

stated that it will update its policy to meet this requirement. Post review, the MHP submitted a draft concurrent review policy that it will implement moving forward.

DHCS deems the MHP out of 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.

Corrective Action Description

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.

The MHP will make every effort to work with a hospital treating provider to develop a treatment plan for a beneficiary if there is a disagreement with a modification or a denial of authorization as required by regulation.

Any and all discussions with a hospital treating provider regarding treatment planning for a beneficiary if there is a disagreement with a modification or a denial of authorization will be documented within the client file.

Proposed Evidence/Documentation of Correction

Final Concurrent Review Policy CLN 1590
NOABD to Hospital and beneficiary for any denials
Concurrent Review and Authorization form
Care Plan form

Ongoing Monitoring (if included)

Concurrent Review will be added to the weekly clinical team meeting agenda and discussed to determine how the new process is progressing. These discussions will be documented via meeting minutes.

Person Responsible (job title)

Rumi Saikia, LMFT – QI Supervisor

Implementation Timeline: November 8, 2023

Requirement

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 seven-day 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.)

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 seven-day 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.)

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• Care Plan 3.6.23 draft (form)
• CONCURRENT REVIEW 3.6.23 draft (form)
• Sample Concurrent Review 1
• Sample Concurrent Review 2
• Sample Pre-TAR
• TAR
• FY2122 Inpatient Census Log - SBCBH sample
• SARs and TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR
• CONCURRENT REVIEW4.11.23 draft

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP conducts concurrent review and authorizes administrative days. Per the discussion during the review, the MHP stated it has not authorized administrative days and would review its process to determine how it can ensure this is tracked as required in the contract. Post review the MHP submitted an updated concurrent review authorization form that includes the administrative day claiming information that it will implement moving forward.

DHCS deems the MHP out of 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.

Corrective Action Description

The MHP will review its current process and determine how it will conduct and track concurrent review and authorize administrative stay day/s.

Proposed Evidence/Documentation of Correction

Final Concurrent Review policy CLN 1590
NOABD to Hospital and beneficiary for any denials
Concurrent Review and Authorization form
Care Plan form

Ongoing Monitoring (if included)

Concurrent Review will be added to a Quality Improvement Team meeting agenda and discussed to determine how the new process is progressing. These discussions will be documented via meeting minutes.

Person Responsible (job title)

Rumi Saikia, LMFT – QI Supervisor

Implementation Timeline: November 2023

Requirement

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.

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1590 Authorization Concurrent Review - Inpatient and Residential Svcs
• TAR
• FY2122 Inpatient Census Log - SBCBH sample
• SARs and TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR
• CONCURRENT REVIEW 3.6.23 draft (form)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP utilizes a referral and/or concurrent review and authorization for all CRTS and ARTS. Per the discussion during the review, the MHP stated it received one (1) CRTS authorization request during the review period and it would provide evidence of this process post review. Post review, no additional evidence was provided.

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

Corrective Action Description

MHP will train staff in the difference between an inpatient unit vs. residential treatment. MHP will also train staff on new concurrent review process and required documents.

Proposed Evidence/Documentation of Correction

Contract for emergency Single Case Agreement with Discovery Center

Concurrent review form

Ongoing Monitoring (if included)

Monthly at QIC meeting

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor I

Lindsay Garfield, CPHQ – QI Supervisor I

Regina Kendall, LCSW – QI Supervisor II

Rumi Saikia, LMFT – QI Supervisor II

Implementation Timeline: November 2023

Requirement

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

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:
- 4010634 CPS HOT PINK REFERRAL PACKET
- CLN 1701-Authorization policy DRAFT UPDATE 04-11-23
- CLN 1701-Authorization Process for Outpatient Mental Health Services FINAL 5.10.21

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. Of the four (4) Service Authorization Requests (SAR) reviewed by DHCS, three (3) exceeded the required timeframe. Per the discussion during the review, the MHP stated it would review its process to ensure this requirement is met moving forward. Post review, the MHP submitted a draft policy with the required language that it will implement moving forward.

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

Corrective Action Description

The MHP will endeavor to review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires and ensure it does not exceed 5 business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make a determination.

All SARs coming in with all the required completed documents will be tracked on an excel spreadsheet.

Proposed Evidence/Documentation of Correction

Updated policy CLN 1701 and excel spreadsheet.

Ongoing Monitoring (if included)

All SARS tracking logged will be reviewed quarterly at a QI Committee meeting to ensure compliance with timelines.

Person Responsible (job title)

Shannon Gomez, LCSW – Clinical Supervisor, Childrens Systems of Care

Implementation Timeline: Now

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]

FINDING
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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• 4010634 CPS HOT PINK REFERRAL PACKET
• Sample of Expedited Authorizations v2
• SARs and TARs
• TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR
• CLN 1701-Authorization policy DRAFT UPDATE 04-11-23
• CLN 1701-Authorization Process for Outpatient Mental Health Services FINAL 5.10.21

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 stated that it did not have any expedited authorization requests during the review period and it would update its policy to reflect this requirement. Post review, the MHP submitted a draft policy 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

MHP will make every effort to expedite authorization decisions and provide notice as expeditiously as possible as the member's health conditions require, and not later than 72 hours after the receipt of the request.

Proposed Evidence/Documentation of Correction

Intake Process for Outpatient Mental Health Services CLN 1700

Final Authorization Process for Outpatient Mental Health Services policy CLN 1701

Ongoing Monitoring (if included)

Monthly at QIC meeting

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor I

Lindsay Garfield, CPHQ – QI Supervisor I

Regina Kendall, LCSW – QI Supervisor II

Rumi Saikia, LMFT – QI Supervisor II

Implementation Timeline: January 2024

Requirement

The MHP must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:
• Retroactive Medi-Cal eligibility determinations.
• Inaccuracies in the Medi-Cal Eligibility Data System.
• Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually eligible beneficiaries; and/or,
• Beneficiary's failure to identify payer.

DHCS Finding [5.2.17]

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016 and BHIN 22-017. The MHP must establish written policies and procedures regarding retrospective authorization of SMHS (inpatient and outpatient). MHPs may conduct retrospective authorization of SMHS under the following limited circumstances:
• Retroactive Medi-Cal eligibility determinations.
• Inaccuracies in the Medi-Cal Eligibility Data System.
• Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dually eligible beneficiaries; and/or,
• Beneficiary's failure to identify payer.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1701 Authorization Process for Outpatient MH Services
• LPHA License
• CLN 1590-Concurrent Review policy DRAFT UPDATES 04-11-23
• CLN 1701-Authorization Process for Outpatient Mental Health Services FINAL 5.10.21

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established written policies and procedures regarding retrospective authorization of SMHS for outpatient services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it would update its policy to reflect the requirement. Post review, the MHP submitted a draft policy it will implement moving forward.

DHCS deems the MHP out of compliance with BHIN 22-016 and BHIN 22-017.

Corrective Action Description

MHP updated its Concurrent Review policy CLN 1590 and Authorization Process for Outpatient Mental Health Services policy CLN 1701 to reflect procedures regarding retrospective authorization of SMHS Outpatient Services.

Proposed Evidence/Documentation of Correction

Final Concurrent Review policy CLN 1590 and final Authorization Process for Outpatient Mental Health Services policy CLN 1701.

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: July 2023

Requirement

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

DHCS Finding [5.2.18]

The MHP did not furnish evidence to demonstrate compliance with BHIN 22-016. In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and shall be communicated to the provider in a manner that is consistent with state requirements.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1701 Authorization Process for Outpatient MH Services
• SARs and TARs
• TARs
• LPHA License
• Service Authorization Request with MHP modification
• Approved SAR

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that where the MHP's review is retrospective, the MHP's authorization decision is communicated to the individual who received services within 30 days of the receipt of information that is reasonably necessary to make this determination and is communicated to the provider in a manner that is consistent with state requirements. Per the discussion during the review, the MHP stated it had a retrospective authorized SAR during the review period and would provide evidence of this authorization post review. Post review, no additional evidence was provided.

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

Corrective Action Description

The MHP will make every effort to ensure that its authorization decision is communicated to the individual who received services within 30 days of the receipt of information that is reasonably necessary to make the determination and is communicated to the provider in a manner that is consistent with state requirements.

Proposed Evidence/Documentation of Correction

NOABD – Payment Denial Notice template in English and Spanish

Ongoing Monitoring (if included)

Monthly at QIC Meeting

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor I

Lindsay Garfield, CPHQ – QI Supervisor I

Regina Kendall, LCSW – QI Supervisor II

Rumi Saikia, LMFT – QI Supervisor II

Implementation Timeline: January 2024

Requirement

The MHP must provide beneficiaries with a NOABD under the following circumstances:
1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. (42 C.F.R. § 438.400(b)(1))
2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2))
3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))
4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4))
5) The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5)).
6) The denial of a beneficiary's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, co-insurance, and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7))

DHCS Finding [5.4.1

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 404(a); MHSUDS IN No. 18-010E; and MHP Contract, exhibit A, Attachment 12, section 10(A)(1)-(6). The MHP must provide beneficiaries with a NOABD under the following circumstances:
1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit. (42 C.F.R. § 438.400(b)(1))
2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2))
3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))
4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4))
5) The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5)).
6) The denial of a beneficiary's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, co-insurance, and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7))

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 1630 - Notices of Adverse Benefit Determination
• NOABD FY21-22
• NOABD to send
• NOABD-1 Denial Notice English FINAL 06-07-18 v3
• NOABD-3 Medical Necessity Denial Notice English FINAL 06-07-18

• RE_ NOABD to send

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides beneficiaries with a NOABD when it denies or limits authorization of requested services; or when it fails to act within the timeframes regarding standard resolution of an appeal. Of the SARs reviewed by DHCS, one was modified with no evidence of a NOABD being provided to the beneficiary. The one (1) appeal reviewed by DHCS failed to be resolved within the required timeframe and no evidence of NOABD being provided to the beneficiary was present. Per the discussion during the review, the MHP stated its office assistants send out all NOABDs and track this process via spreadsheet to ensure timeliness. The MHP was provided the opportunity to submit the missing NOABDs post review; however, no additional evidence was provided.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 404(a); MHSUDS IN No. 18-010E; and MHP Contract, exhibit A, Attachment 12, section 10(A)(1)-(6).

Repeat deficiency Yes

Corrective Action Description

The MHP will make every effort to provide beneficiaries with an NOABD when it denies or limits authorization of requested services or when it fails to act within the timelines regarding standard resolution of an appeal.

Proposed Evidence/Documentation of Correction

The MHP is aware of the required timelines and will ensure that a proper back up is assigned to address NOABD requirements to beneficiaries should the primary person tasked with the duty be absent.

Ongoing Monitoring (if included)

Discussions regarding any denials or limitations to requested services will be reviewed at weekly QI meetings and will be reflected in meeting minutes.

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: November 2023

Requirement

1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.
2. The acknowledgment letter shall include the following: 24 | Page
   a. Date of receipt
   b. Name of representative to contact
   c. Telephone number of contact representative
   d. Address of Contractor
3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

DHCS Finding [6.1.5]

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(5); Code of Federal Regulations, title 42, section 438, subdivision 406(b)(1) and 228(a), California Code of Regulation, title 9, section 1850, subdivision 205(d)(4); and MHSUDS IN 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements:
1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.
2. The acknowledgment letter shall include the following:
   a. Date of receipt
   b. Name of representative to contact
   c. Telephone number of contact representative
   d. Address of Contractor
3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• APPEAL Acknowledgment Letter
• Acknowledgement Letter Template - NOABD Appeal
• Grievance
• GRIEVANCE TRACKING LIST FY 21-22
• GRIEVANCE TRACKING LIST FY 20-21

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides a written acknowledgement letter to the beneficiary within five (5) calendar days of receipt of the grievance. Of the nine (9) grievances review by DHCS, one (1) grievance did not have evidence of an acknowledgement letter sent within the timeframe. Per the discussion during the review, the MHP acknowledged this deficiency.

In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below.

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	9	8	1	89%
APPEALS	1	1	0	100%

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 12, section 1(B)(5); Code of Federal Regulations, title 42, section 438, subdivision 406(b)(1), 228(a); California Code of Regulation, title 9, section 1850, subdivision 205(d)(4); and MHSUDS IN 18-010E

Repeat deficiency Yes

Corrective Action Description

The MHP is aware of the required timelines and will ensure that a proper back up is assigned to address NOABD requirements to beneficiaries should the primary person tasked with the duty be absent.

Proposed Evidence/Documentation of Correction

N/A

Ongoing Monitoring (if included)

Reports regarding NOABDs will be given during QI meetings and will be reflected in meeting minutes.

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: November 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]

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• Appeal Sample 21-022
• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22
• CLN-0310 Client Problem Resolution policy DRAFT UPDATE 04-12-23

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 Grievances. Per the discussion during the review, the MHP stated that it has not had a discrimination grievance request and it will update its existing grievance and appeal policy to meet the

contract requirement. Post review, the MHP submitted a draft policy with the required language that it will implement moving forward.

Post review, the MHP submitted a draft client problem resolution policy with 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

The MHP will submit the updated Client Problem Resolution policy CLN 0310 that includes the requirement of how to file a Discrimination Grievance.

Proposed Evidence/Documentation of Correction

Final Client Problem Resolution policy CLN 0310

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: July 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]

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• Appeal Sample 21-022
• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22
• CLN-0310 Client Problem Resolution policy DRAFT UPDATE 04-12-23

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP designates 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. Per the discussion during the review, the MHP stated that its standard grievances coordinator serves as its Discrimination Grievance Coordinator and it would update its existing policy to include this requirement. Post review, the MHP submitted a draft policy with the required language 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

The MHP will submit the updated Client Problem Resolution policy CLN 0310 that includes the requirement of designating a Discrimination Grievance Coordinator.

Proposed Evidence/Documentation of Correction

Final Client Problem Resolution policy CLN 0310

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: July 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]

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• Appeal Sample 21-022
• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22
• CLN-0310 Client Problem Resolution policy DRAFT UPDATE 04-12-23

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP adopted procedures to ensure the prompt and equitable resolution of discrimination-related complaints. Per the discussion during the review, the MHP stated that it has not had a discrimination grievance request and it will update its existing policy to meet this contract requirement. Post review, the MHP submitted a draft policy with the required language 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

The MHP will submit the updated Client Problem Resolution policy CLN 0310 that includes procedures to ensure the prompt and equitable resolution of discrimination-related complaints.

Proposed Evidence/Documentation of Correction

Final Client Problem Resolution policy CLN 0310

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: July 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]

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• Appeal Sample 21-022

• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22
• CLN-0310 Client Problem Resolution policy DRAFT UPDATE 04-12-23

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits 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. Per the discussion during the review, the MHP stated that it will update its existing policy to meet the contract requirement. Post review, the MHP submitted a draft policy with the required language 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

The MHP will submit the updated Client Problem Resolution policy CLN 0310 that includes the requirement to submit 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.

Proposed Evidence/Documentation of Correction

Final Client Problem Resolution policy CLN 0310

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: July 2023

Requirement

Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one business day of the date of receipt of the grievance, appeal or expedited appeal.

DHCS Finding [6.2.1]

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 416(a); California Code of Regulations, title 9, section 1850, subdivision 205(d)(1); and MHP Contract, exhibit A, attachment 12, section 2(A). The MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP maintains a grievance and appeal log and records grievances in the log within one working day of the date of receipt of the grievance. Of the nine (9) grievances, one (1) was not logged within one working day of the date of the receipt of the grievance. Per the discussion during the review, the MHP acknowledged this deficiency.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 416(a), California Code of Regulations, title 9, section 1850, subdivision 205(d)(1), and MHP Contract, exhibit A, attachment 12, section 2(A).

Repeat deficiency Yes

Corrective Action Description

The MHP is aware of the required timelines and will ensure that a proper back up is assigned to address NOABD requirements to beneficiaries should the primary person tasked with the duty be absent. The MHP will update the grievance and appeal log and policies and procedures to ensure that every grievance will be recorded in the log within one working day of the date of receipt of the grievance, and all other timeliness components will be recorded in compliance with the standard.

Proposed Evidence/Documentation of Correction

Grievance and appeal log

Ongoing Monitoring (if included)

Staff will review the grievance and appeal log at least quarterly, present the findings at the QI meeting and will be reflected in meeting minutes.

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: November 2023

Requirement

Resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.

DHCS Finding [6.4.3]

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 408(a) and 408(b)(2); and MHP Contract, exhibit A, attachment 12, section 5(A)(3). The MHP must resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22
• NGR Notice of Grievance Resolution English

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal. The one (1) appeal reviewed by DHCS, was not resolved within the 30-calendar day timeframe. Per the discussion during the review, the MHP acknowledged this deficiency.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 408(a); 408(b)(2); and MHP Contract, exhibit A, attachment 12, section 5(A)(3).

Corrective Action Description

The MHP is aware of the required timelines and will ensure that a proper back up is assigned to address NOABD/Appeal requirements to beneficiaries should the primary person tasked with the duty be absent.

Proposed Evidence/Documentation of Correction

N/A

Ongoing Monitoring (if included)

Reports regarding NOABDs and appeals will be given during QI meetings and will be reflected in meeting minutes.

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: November 2023

Requirement

Allow the beneficiary, their representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.

DHCS Finding [6.4.7]

The MHP did not furnish evidence to demonstrate compliance with Code of Federal Regulations, title 42, section 438, subdivision 406(b)(6) and MHP Contract Exhibit A, Attachment 12, section 5(A)(7). The MHP must allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• CLN 0310-Client Problem Resolution Process FINAL 4.10.20
• Grievance Form English
• Grievance Form Spanish
• Link to website for Problem Resolution
• SBCBH Client Problem Resolution Guide-English LARGE Print
• SBCBH Medi-Cal MH BENEFICIARY HANDBOOK-English
• Grievance Samples 21-22
• GRIEVANCE TRACKING LIST FY 20-21
• GRIEVANCE TRACKING LIST FY 21-22
• CLN-0310 Client Problem Resolution policy DRAFT UPDATE 04-12-23
• CLN-0310 Client Problem Resolution Process DRAFT UPDATE

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP allows the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal. Per the discussion during the review, the MHP stated that it has not experienced scenario and it would update its policy to reflect this requirement. Post review, the MHP submitted a draft policy that it will implement moving forward.

DHCS deems the MHP out of compliance with Code of Federal Regulations, title 42, section 438, subdivision 406(b)(6) and MHP Contract Exhibit A, Attachment 12, section 5(A)(7).

Corrective Action Description

The MHP will submit the updated Client Problem Resolution policy CLN 0310 to include the requirement of allowing the beneficiary, his or her representative or the legal representative of a deceased beneficiary's estate to be include as parties to the appeal.

Proposed Evidence/Documentation of Correction

Final Client Problem Resolution policy CLN 0310

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Maxe Cendana, MPA – QI Supervisor

Implementation Timeline: July 2023