DEPARTMENT OF HEALTH CARE SERVICES

TRIENNIAL REVIEW OF THE Placer/Sierra County MENTAL HEALTH PLAN

FINDINGS REPORT

Review Dates: December 3, 2018 – December 4, 2018

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EXECUTIVE SUMMARY

The purpose of this review was to determine the MHP's compliance with State and Federal laws and regulations and the terms of contracts between DHCS and the MHP. The review consisted of an examination of the documents relating to the MHP's program and system operations, to verify the medically necessary services are provided to Medi-Cal beneficiaries who meet medical necessity criteria within compliance with State and Federal laws and regulations and the terms of contracts between DHCS and the MHP. DHCS utilized its Fiscal Year 2018/2019 Annual Review Protocol for SMHS and Other Funded Programs (Protocol) to conduct the review.

The system review evaluated the MHP's performance in the following categories:

- Section A: Network Adequacy and Availability of Services
- Section B: Care Coordination and Continuity of Care
- Section C: Quality Assurance and Performance Improvement
- Section D: Access and Information Requirements
- Section E: Coverage and Authorization of Services
- Section F: Beneficiary Rights and Protections
- Section G: Program Integrity
- Section H: Other Regulatory and Contractual Requirements

Below is an overview of DHCS' findings.

DHCS identified several strengths after touring the Federally Qualified Health Center (Roseville) which provides a Crisis Stabilization Area with 16 beds, an on campus Psychiatric Health Facility, Substance Use Disorder Area, Medication Services, Conservator Services, Crisis Team, In-Home-Based Services, a Community Garden, a Gym with a bicycle and treadmill and the availability of a hearing judge for on-sight hearings. In addition, which was observed was the High commitment to integrated behavioral health services and the collaboration with Adult Protective Services, In-Home Services, Public Employers, Public Administrator and Guardian Services and the County Welfare Services. One of the highlights mentioned was how to tackle the homelessness population, which is across all reporting structures under the Health and Human Services Agency. Also addressed, was the walk-in model and the three (3) days-of-the-week were screening for (mild, moderate, sever) conditions where clients get a full assessment, and same day services for psychiatric services if urgent. Furthermore, Sierra County, which is a small rural area with a population of about three-thousand, has the ability of integration and familiarity within the community they serve; Sierra County is one of the only counties left that does not bill Medi-Cal and recently opened a facility in Downieville.

During the review period, the DHCS reviewed Section D, Access and Information Requirements and determined that the areas reflecting DHCS's test calls and County's written logs were out of compliance regarding CCR, title 9, chapter 11, sections 1810.410(e)(1) and 1810.405(f). In addition, Section E, Coverage and Authorization of Services was also out of compliance regarding of 42 C.F.R. § 438.210(d)(1).

This report details the findings from the triennial system review of the **Placer/Sierra County** Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY 2018/2019 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services, specifically Sections A-H and the Attestation. This report details the requirements deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS. The corresponding regulatory and/or contractual authority will be followed by the specific findings and required Plan of Correction (POC). For informational purposes, this findings report also includes additional information that may be useful for the MHP, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone access line and a section detailing information gathered for the "SURVEY ONLY" questions in the protocol.

The MHP will have an opportunity to review the report for accuracy and appeal any of the findings of non-compliance (for both System Review and Chart Review). The appeal must be submitted to DHCS in writing within 15 business days of receipt of the findings report. DHCS will adjudicate any appeals and/or technical corrections (e.g., calculation errors, etc.) submitted by the MHP and, if appropriate, send an amended report.

A Plan of Correction (POC) is required for all items determined to be out of compliance. The MHP is required to submit a POC to DHCS within 60 days of receipt of the findings report for all system and chart review items deemed out of compliance. The POC should include the following information:

(1) Description of corrective actions, including milestones
(2) Timeline for implementation and/or completion of corrective actions
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should purpose an alternative corrective action plan to DHCS
(5) Description of corrective actions required of the MHP's contracted providers to address findings

RESULTS SUMMARY: SYSTEM REVIEW

SYSTEM REVIEW SECTION	TOTAL ITEMS REVIEWED	SURVEY ONLY ITEMS	TOTAL FINDINGS PARTIAL or OOC	PROTOCOL QUESTIONS OUT-OF-COMPLIANCE (OOC) OR PARTIAL COMPLIANCE	IN COMPLIANCE PERCENTAGE FOR SECTION
SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES	63	2	0		100%
SECTION B: CARE COORDINATION AND CONTINUITY OF CARE	17	1	0		100%
SECTION C: QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT	42	0	0		100%
SECTION D: ACCESS AND INFORMATION REQUIREMENTS	67	0	6	D.VI.B2, D.VI.B3, D.VI.B4, D.VI.C1 & D.VI.C2	91%
SECTION E: COVERAGE AND AUTHORIZATION OF SERVICES	42	1	4	E.I.H1	90%
SECTION F: BENEFICIARY RIGHTS AND PROTECTIONS	67	0	0		100%
SECTION G: PROGRAM INTEGRITY	43	0	0		100%
SECTION H: OTHER REGULATORY AND	3	0	0		100%

CONTRACTUAL REQUIREMENTS					
TOTAL ITEMS REVIEWED	344	4	10		

Overall System Review Compliance

Total Number of Requirements Reviewed		344		
Total Number of SURVEY ONLY Requirements		4 (NOT INCLUDED IN CALCULATIONS)		
Total Number of Requirements Partial or OOC		11		OUT OF 344
OVERALL PERCENTAGE OF COMPLIANCE	IN (#333/344)	97%	OOC/PARTIAL (#OOC/344)	3%

FINDINGS

SECTION D: ACCESS AND INFORMATION REQUIREMENTS

	REQUIREMENT
B.	Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).) 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 DHCS review team made seven (7) calls to test the MHP's 24/7 toll-free line. The seven (7) test calls are summarized below:

Test Call #1 was placed on Thursday, October 4, 2018, at 7:46 a.m. The call was initially answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to spell their full name and county of residence. The caller provided the name Jean Williams and provided a Forest Hill residence. The operator provided two (2) methods to receive services. 1) Receive a referral, or 2) use the walk-in services located in Roseville from 9:00 a.m. to 10:00 a.m. The operator also informed the caller that the wait may be long and it is the first step in receiving mental health services in the county, but they would be seen the same day. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.2 and D.VI.B.3.

Test Call #2 was placed on Monday, September 24, 2018, at 9:54 a.m. The call was initially answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller about residency, insurance i.e., Medi-Cal or Anthem. The caller implied, I don't know. The operator informed the caller that they could call for a referral to be seen and that Placer does not have walk-in services. The caller informed operator that they have Medi-Cal. The operator informed caller they could collect their information and set up an appointment if they would like. The caller asked if that was the only way. The operator stated, "No," that Roseville offers a walk-in clinic on Tuesday's 1:00 p.m. - 2:00 p.m. and Thursday's 9:00 a.m. - 10:00 a.m. The caller informed the operator they live in Auburn. The operator informed the caller that Auburn has a walk-in clinic on Wednesday's 9:00 a.m. - 10:00 a.m. and they are located at 11512 B Avenue. 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.

The caller is deemed in compliance with regulatory requirements for protocol D.VI.B.2 and out of compliance with D.VI.B.3

Test Call #3 was placed on Monday, October 1, 2018, at 12:20 p.m. The call was initially answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator provided several options to the caller with two (2) locations and times for walk-in services. The caller was provide 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 need to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.2 and out of compliance with D.VI.B.3.

Test Call #4 was placed on Thursday, September 27, 2018, at 7:26 a.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about filing a grievance in the county. The operator stated they did not understand the question; therefore, the caller repeated the scenario for filing a grievance. The operator informed the caller they would give them the Patient Rights Advocate phone number (916) 787-8979. The operator asked the caller for their name and the caller provided May Lee. The operator stated they would document the call and confirmed that she gave the patient advocate phone number to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition, or the problem resolution and fair hearing processes.

The call is deemed out of compliance with the regulatory requirements for protocol questions D.VI.B.4.

Test Call #5 was placed on Tuesday, October 16, 2018, at 11:53 a.m. The call was initially answered after two (2) rings via a live operator. The caller requested information about filing a grievance in the county. The operator gave the name Lisa Long for the Patient Rights Advocate with the following two (2) numbers (530) 886-5419 and (916) 787-8979. The caller asked if there were any other way to file a complaint. The operator then asked for the caller's name. The caller stated they did not want to give their name. The operator stated they would document the call and that the caller should call Lisa for help. The caller thanked the operator and ended the call. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition, or the problem resolution and fair hearing process.

The call is deemed out in compliance with the regulatory requirements for protocol question D.VI.B.4.

Test Call #6 was placed on Tuesday, October 16, 2018, at 12:31 p.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator informed the caller about counseling, therapy services and county-paid services would depend on insurance, and then asked the caller for the type of insurance. The caller stated Medi-Cal. The operator provided instruction to the caller and the telephone number (916) 872-6549; and, to choose option 3 for Children's System of Care. The phone tree answered after one (1) ring. The caller heard instructions for 911, CPS, and Mental Health Services in Spanish, and then a live operator greeted the caller. The caller requested information about accessing mental health services in the county and would be using Medi-Cal. The operator informed the caller the county provided all-inclusive team of services, which included a case manager, facilitator, specialist, a parent-focused partner and a Fast-Track family service program offered through the county contractor. The operator then asked the caller if they would like to be transferred to another person who could immediately conduct an assessment and provide a referral over the phone this would take 5-10 minutes. The caller declined and stated they would call back. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.2 and D.VI.B.3.

Test call #7 was placed on Wednesday, November 7, 2018, at 1:28 p.m. The call was initially answered after two (2) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller if they knew who their insurance provider was and listed several. The caller informed the operator that they knew they had Medi-Cal but was not sure about a specific type. The operator instructed the caller to retrieve their insurance information and call back for assistance. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed out in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

FINDINGS

Test Call Results Summary

Test Call Findings								
Protocol Question	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**Compliance Percentage**
D.VI.B.1	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**0%**
D.VI.B.2	**IN**	**IN**	**IN**			**IN**	**OUT**	**80%**
D.VI.B.3	**IN**	**OUT**	**OUT**			**IN**	**OUT**	**40%**
D.VI.B.4				**OUT**	**OUT**	**IN**	**OUT**	**0%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Advance Health Care Directive, Revised Date 01/29/18, Advanced Health Care Directive pamphlet and the call log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, both the DHCS and MHP test calls indicated inconsistency in the 24/7 toll free telephone number for compliance. The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(d) and 1810.410(e)(1). Protocol requirement D.VI.B.2, D.VI.B.3 and D.VI.B4 are deemed OOC.

PLAN OF CORRECTION

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with protocol requirements D.VI.B.2, D.VI.B.3 and D.VI.B4

REQUIREMENT	
C.	1) The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, title 9, chapter 11, section 1810.405(f)).
	2) The written log(s) contain the following required elements: CCR, title 9, chapter 11, section 1810.405(f) a) Name of the beneficiary.
	b) Date of the request.
	c) Initial disposition of the request.

In addition, the logs made available by the MHP did not include all required elements for calls. The table below details the findings:

Log Results				
Date of Call	Time of Call	Name of the Beneficiary	Date of the Request	Initial Disposition of the Request

10/4/2018	7:46 a.m.	IN	IN	IN
9/24/2018	9:54 a.m.	OUT	OUT	OUT
10/1/2018	12:20 p.m.	IN	IN	IN
10/16/2018	12:31 p.m.	OUT	OUT	OUT
11/7/2018	1:28 p.m.	OUT	OUT	OUT
Compliance Percentage		40%	40%	40%

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

Protocol question(s) D.VI.C2a, D.VI.C2b and D.VIC3c are deemed in Partial Compliance. These requirements were OOC in the previous Triennial Review Cycle and are repeat deficiencies.

FINDINGS

The MHP did not furnish evidence its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Placer County Call Log and Sierra County call log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the access log did not contain three (3) of the five (5) DHCS test calls. The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(f).

PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with all regulatory requirements.

SECTION E: COVERAGE AND AUTHORIZATION OF SERVICES

I. Service Authorization Requirements

In addition, DHCS inspected a sample of 100-treatment authorization request to verify compliance with regulatory requirements. The treatment authorization request sample review findings are detailed below:

	PROTOCOL REQUIREMENT	# SERVICE AUTHORIZATIONS IN COMPLIANCE	# SERVICE AUTHORIZATIONS OOC	COMPLIANCE PERCENTAGE
E.I.C	Service authorization approved or denied by licensed mental health or waivered/registered professionals	100	0	100%

Protocol question(s) E.I.C is deemed in partial compliance.

REQUIREMENT	
H.	1) For standard authorization decisions, the MHP shall provide notice as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when: a) The beneficiary, or the provider, requests extension; or,
	b) The MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the beneficiary's interest. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(d)(1).)
	2) SURVEY ONLY. PLEASE SEE SURVEY ONLY FINDINGS
	3) 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. (42 C.F.R. § 438.210(d)(2)).
	4) The MHP may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary. (42 C.F.R. § 438.210(d)(2))

FINDINGS

DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Request for Authorization/Treatment Plan Report Draft, and Service Authorization for System of Care Network and Organizational Providers, Dated 10/1/18. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, DHCS reviewed 37 standard authorization request four (4) of the standard authorizations were deemed out-of-compliance for the following reasons: one (1) did not have a signature for approval; two (2) were outside of the 14 calendar days, and one (1) had no date-of-receipt for validation. This requirement is deemed OOC. The MHP must come into compliance with the provisions of 42 C.F.R. § 438.210(d)(1).

PROTOCOL REQUIREMENT		# SERVICE AUTHORIZATION DECISIONS IN COMPILANCE	# SERVICE AUTHORIZATION DECISIONS OOC	COMPLIANCE PERCENTAGE
E.I.H.1	MHP makes authorization decisions and provides notice within 14 calendar days	37	4	89%

E.I.H.3	MHP makes expedited authorization decisions and provide notice within 72 hours following receipt of the request for service or, when applicable within 14 calendar days of an extension.	37	4	89%

Protocol question E.I.H.1 is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with 42 C.F.R. § 438.210(d)(1).

SECTION F: BENEFICIARY RIGHTS AND PROTECTIONS

I. Grievance and Appeal System Requirements

DHCS inspected 29 grievances to verify compliance with regulatory requirement F.II.A1 thru A6. The grievances resolved within the timeframe review findings are detailed below:

RESOLVED WITHIN TIMEFRAMES					
	# REVIEWED	# IN COMPLIANCE	# OOC	REQUIRED NOTICE OF EXTENSION EVIDENT	COMPLIANCE PERCENTAGE
GRIEVANCES	29	29			100%
APPEALS	N/A	N/A	N/A		N/A
EXPEDITED APPEALS	N/A	N/A	N/A		N/A

DHCS inspected 29 grievances to verify compliance with regulatory requirements F.II.A1 thru A6 and Section F.III.E. The acknowledgement and disposition review findings are detailed below:

ACKNOWLEDGEMENT				
	# OF SAMPLE REVIEWED	# IN	#OOC	COMPLIANCE PERCENTAGE
GRIEVANCES	29	29		100%
APPEALS	N/A			N/A
EXPEDITED APPEALS	N/A			N/A
DISPOSITION				

	# OF SAMPLE REVIEWED	# IN	#OOC	COMPLIANCE PERCENTAGE
GRIEVANCES	29			100%
APPEALS	N/A			N/A
EXPEDITED APPEALS	N/A			N/A

Protocol question(s) F.II.A1 thru A6 are deemed in partial compliance.

SURVEY ONLY FINDINGS

SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES
III. Children's Services

	REQUIREMENT
F.	**SURVEY ONLY** The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

SURVEY FINDING
DHCS reviewed the following documentation provided by the MHP for this survey item: Koinonia Foster Homes, Inc. Treatment Foster Care (TFC): Services provided by foster parents with specialized training to children and adolescents, with significant emotional, behavior, or social issues or medical needs. These services shall be coordinated by the Contractor on an as needed basis.

SUGGESTED ACTION
DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements or to strengthen current processes in this area to ensure compliance in future reviews: Establish Policy and Procedures including TFC services criteria and monitoring mechanisms to ensure the implementation of this requirement with an ongoing monitoring mechanism and update contracts to reflect this requirement for future compliance.

	REQUIREMENT
G.	**SURVEY ONLY** The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

SURVEY FINDING
DHCS reviewed the following documentation provided by the MHP for this survey item: Koinonia Family Services and Uplift Family Services.
SUGGESTED ACTION

DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements or to strengthen current processes in this area to ensure compliance in future reviews: Establish Policy and Procedures including TFC services criteria and monitoring mechanisms to ensure the implementation of this requirement with an ongoing monitoring mechanism and update contracts to reflect this requirement for future compliance.

SECTION B: CARE COORDINATION AND CONTINUITY OF CARE
III. Coordination of Physical and Mental Health Care

	REQUIREMENT
C.	**SURVEY ONLY** The MHP shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.62(b)(1)-(2).)

SURVEY FINDING
DHCS reviewed the following documentation provided by the MHP for this survey item: MOU between Placer County and KP Cal, LLC (Kaiser). However, DHCS did not receive any evidence of Policy and Procedure for survey protocol B.III.C.

SUGGESTED ACTION
DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements or to strengthen current processes in this area to ensure compliance in future reviews: Developing a Policy and Procedures outlining the requirements stated in Information Notice 18-051, Dated, October 25, 2018, which outlines CFR 438.62(b)(1)-(2).

Section E: COVERAGE AND AUTHORIZATION OF SERVICES
I. Service Authorization Requirements

	REQUIREMENT
H.	**Survey Only:** 5) MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

SURVEY FINDING
DHCS reviewed the following documentation provided by the MHP for this survey item: Service Authorization for System of Care Network and Organizational Providers, EA 530, Revision Date, 10/1/18.

No further action required at this time.

	PROTOCOL REQUIREMENT	# PRIOR AUTHORIZATIONS IN COMPLIANCE	# PRIOR AUTHORIZATIONS OOC	COMPLIANCE PERCENTAGE

E.I.H.5	Prior authorization approved or denied within five (5) business days after receiving the request.	N/A	N/A	N/A

SUGGESTED ACTION

No further action required at this time.