SAN BERNARDINO COUNTY

Behavioral Health

Fiscal Year 2018/2019
Medi-Cal Specialty Mental Health Services
Triennial Review

Corrective Action Plan

June 30, 2020

Contents

Section A: Network Adequacy and Availability of Services
I. Availability of Specialty Mental Health Services

REQUIREMENT: D. The MHP shall implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type and geographic distribution of mental health services within the MHP's delivery system.

FINDING: The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A. Att. 8; 42 C.F.R. § 438.207(b)(2). The MHP must implement mechanisms to assess the capacity of service delivery for its beneficiaries...While the MHP strives to comply with timely access standards and mapping of services areas to show geographical coverage and concentration of MHP services, the MHP has been unsuccessful regarding implementation of mechanisms to assess the capacity of service delivery for its beneficiaries…

1) **Description of corrective actions, including milestones:** To ensure network adequacy, DBH developed and implemented the Network Adequacy Monitoring Procedure that has proven to work. To ensure DBH has an appropriate number of providers throughout its County, DBH is completing the following actions on a quarterly basis (January, April, July and October):
    - Pulling and reviewing the current and anticipated Medi-Cal enrollment and utilization rates;
    - Pulling and reviewing the population, Medi-Cal population and prevalence rates;
    - Mapping the geographic locations of DBH and its contract providers to clients' homes to determine if time and distance standards are being met;
    - Confirming the number of mental health providers, including their full-time equivalency and work site(s), by requesting updated information from DBH staff, contract agencies and Fee-For-Service (FFS) providers;
    - Utilizing the most recent Department of Health Care Services' NACT information such as the Behavioral Health Information Notice No: 20-012 regarding 2020 Federal Network Certification Requirements for County Mental Health Plans (MHPs), Medi-Cal data for San Bernardino County and MHP provider information to calculate the provider-to-beneficiary ratios; and
    - Notifying the DBH Executive Team and Senior Management regarding the outcomes for provider-to-beneficiary ratios and time and distance requirements so necessary action can be taken, if needed.
        - In May/June 2019, using the aforementioned steps DBH Program Support Services (PSS) was able to advise its Executive Team that it would be short the required number of adult outpatient providers for the NACT. As such, DBH began strategizing on what it could do to become compliant. Therefore, when DBH received the NACT non-compliance letter from DHCS, it was not surprised by the findings and adjusted its strategies to correctly obtain the required number of providers [517.15 FTE] before the January 2020 deadline.
        - The strategy proved to work as DBH was able to clearly indicate what corrective actions it was taking to come into compliance on its CAP, which was approved by DHCS November 2019.
        - DBH submitted its corrected NACT and CAP response December 2019, showing it was in compliance with a total of 551.7 FTE.
        - DBH closed out its CAP when it submitted a total of 545.2 FTE, which was in excess of the DHCS minimum requirement.

- Additionally, DBH has identified its applicable zip codes that will require Alternative Access, which are Trona, Big River, Baker/Earp, and has identified/confirmed how services are rendered for those areas that exceed time and distance standards.

2) **Timelines for implementation and/or completion of corrective actions:** To implement the aforementioned steps, DBH Program Support Services (PSS) has completed or will complete the following with the associated timeframes:
   - PSS shall send the NACT Survey Tool quarterly to the contract agencies, FFS providers and DBH clinics requesting update (this is a change as it was previously required monthly):
     - Issue no later than Dec 1 and require return by Dec 31
     - Issue no later than March 1 and require return by March 31
     - Issue no later than June 1 and require return by June 30 *
     - Issue no later than September 1 and require return by September 30
   - Research and Evaluation (R&E) shall follow existing DBH procedure, *Network Adequacy Monitoring Procedure*, regarding the pulling of data by no later than 30 days after contract agencies, FFS providers and DBH clinics are issued the NACT Survey Tool.
   - PSS shall review the rendering provider and clinic information provided by contract agencies, FFS providers and DBH clinics to determine if updates are necessary and if so, make the changes within 20-25 days following submission.
     - Also review clinic changes that may affect time and distance standards such as additional sites, clinic closure, additional modalities of services offered, loss of service type, loss of providers, implementation of satellite site, etc.
   - PSS shall analyze and determine the Provider Counts within 1-2 days from the date all updates are made.
   - R&E shall complete analysis regarding provider ratios and work with PSS to confirm numbers before final determination made no later than one month following submission from the contract agencies, FFS providers and DBH clinics.
   - PSS Deputy Director (DD) shall notify DBH Leadership at the Operations Meeting within one to two weeks of the analysis regarding DBH's provider ratios so action can be taken, if needed. Also, included will be any new zip codes not covered by the time and distance standards. Lastly, the PSS DD will apprise DBH leadership of its appointment wait times and include any updates the Quality Management Action Committee may be making to address wait times.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
   - Actual evidence is DBH procedure QM6043-1, *Network Adequacy Monitoring Procedure*
   - Proposed evidence is formalized documentation of the quarterly reviewed data, number of rendering providers, provider ratios, time and distance standards, and final outcomes/determination, which is beneficial for San Bernardino for audit purposes.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

To assess the effectiveness of the corrective actions over time, as previously stated DBH will review its provider ratios on a quarterly basis so it can address any shortages in advance and possibly before the annual NACT is due. Additionally, DBH will be reviewing its maps on a quarterly basis to determine if time and distance standards continue to be met and/or if there continue to be areas within the county that do not meet time and distance standards so we can continue current practices to meet alternative access

or develop strategies to address. Currently, the only measure DBH has to determine effectiveness is the annual NACT findings from DHCS, which is typically five (5) months after the April submission. Therefore, DBH will ask its assigned liaison for assistance with other possible measures.

5) **Description of corrective actions required of the MHP's contracted providers to address findings:** DBH are currently notified of the NACT reporting requirements and have been submitting information monthly. With the change of the mental health NACT now only being submitted on an annual basis, DBH recently notified its contract agencies via its monthly meeting of the change in frequency and the reason why. Therefore, since this is not a new requirement for DBH contract agencies, training is not required but rather verbal notification followed by written instruction, which are both attached:
    - Association of Community Based Providers meeting minutes 05/18/20
    - Draft Interim Instruction Notice regarding NACT Updates that will be posted no later than 07/31/20

**Note:* With the COVID-19 pandemic, DBH will not be completing the aforementioned steps for July 2020 to ease the burden for its clinics and providers as the paramount focus is the provision of services to clients.

Section A: Network Adequacy and Availability of Services
I. Availability of Specialty Mental Health Services

REQUIREMENT: H. The MHP shall establish mechanism to ensure that network providers comply with the timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).)

1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).)
2. The MHP shall take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).)

FINDING: The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.206(c)(1)(iv), (v) & (vi). The MHP must establish mechanisms to ensure that network providers comply with the timely access requirements as well as monitor network providers regularly to determine compliance with timely access requirements, and take corrective action if there is a failure to comply with timely access requirements…While the MHP has mechanisms to monitor network providers timely access requirements DHCS determined that timeliness was not met with respect to response following initial contact. Additionally, evidence was not provided that corrective action was taken when timeliness standards were not met…

1) **Description of corrective actions, including milestones:** To ensure compliance with network providers meeting timely access requirements, DBH is completing the following steps as corrective action:
   - Updated the DBH Timely Access Policy.
   - Updated the DBH Timely Access Procedure addressed to its staff, contract agencies and individual Fee for Service (FFS) providers regarding the following:
     - Reminder regarding timely access standards;
     - Advisement of actions providers must make if they determine timely access standards cannot be met; and
     - Advisement of corrective actions DBH will take if standards cannot be achieved.
   - Will conduct training with DBH staff and its contract agencies at the upcoming QM Quarterly Forums and FFS Provider Training regarding DBH Information Notice regarding timely access.
   - Will conduct online training with DBH staff, contract agency staff and FFS providers regarding requirements for the Initial Contact Log (ICL).

2) **Timelines for implementation and/or completion of corrective actions:** Timelines for the aforementioned corrective actions are as follows:
   - Post revision of the DBH Timely Access Policy and Procedure no later than July 3, 2020.
   - Conduct QM Quarterly Forum training with DBH staff and its contract agency staff regarding timely access on the following dates and times:
     - June 25, 2020 1pm – 4pm via WebEx
     - June 30, 2020 9am – 12pm via WebEx
   - Conduct training with DBH FFS providers regarding timely access on June 18, 2020 from 1pm – 4pm via WebEx.
   - Conduct online training via DBH's learning management system regarding ICL requirements approximately October- December 2020.
   - Timely access will be monitored on a quarterly basis [on the same timeframes as assessing its capacity of service delivery for the NACT].

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
Proposed evidence of correction includes the following:
- Completed and posted DBH Timely Access Policy and Procedure
- Attendance records, training flyers and training materials from the QM Quarterly Forum
- Attendance records, training flyers and training materials from the QM FFS Provider training
- Attendance records, training flyers and training materials from the online ICL training

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
To ensure compliance with the plan of correction, DBH will maintain documentation and records of programs and providers that are determined not to meeting timely access standards. DBH will implement and document the following actions to monitor effectiveness:
- When providing technical assistance to programs when not meeting timely access, DBH will consider the following:
  - Redirect clients to nearby clinics/programs (DBH or its contract providers) where timely access can be met
  - Exam workflow to identify efficiencies and redundancies, if any
  - Other actions deemed necessary
- Should a program need to be placed on probation, DBH will review and take into consideration the following:
  - Efforts and strides the program has taken towards complying with timely access
  - Accomplishments achieved to meet timely access and inabilities to achieve timely access, if any and reason
  - Areas of strengths and improvements for the program
  - Compliance with DBH contract regarding target population served, services rendered, staffing levels, and performance outcomes
- If the agency cannot meet timely access despite technical assistance and probationary status, DBH Executive Team will discuss next steps that may include continued probation and/or contract termination. Discussion will include the following topics:
  - If they are located in a rural or frontier area of the county
  - Other available nearby DBH programs and providers
  - Reduction of contract that may include funding, targeted number of clients served, etc.

5) **Description of corrective actions required of the MHP's contracted providers to address findings:**
DBH's contracted providers are involved in this corrective action as they must do the following:
- Meet/adhere to timely access standards
- Complete and submit ICLs as instructed and required by DBH
- Document extensions to timely access standards, for mental health services, in the client's medical record if it is determined the client can wait a longer time to obtain service
- Provide notification to DBH if it is not meeting timely access standards
- Take immediate action to meet timely access standards, if applicable
- Issue the applicable Notice of Adverse Benefit Determination to applicable clients
- Obtain training regarding Timely Access Information Notice, specifically the corrective actions DBH will take if standards cannot be met – probation and/or contract termination
- Obtain training regarding ICL requirements

Note: With the COVID-19 pandemic, DBH will not be assessing NACT service capacity therefore, timely access is included in the NACT service capacity and will not be completed for the quarter of July 2020 to ease the burden for its clinics and providers as the paramount focus is the provision of services to clients.

Section A: Network Adequacy and Availability of Services
III. Children's Services

REQUIREMENT:

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

3D2. The MHP convenes a CFT for children and youth who are receiving ICC, IHBS, or TFC, but who are not involved in the child welfare or juvenile probation systems. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018) (42 C.F.R 438.206(b)(1).)

FINDING:

The MHP must provide ICC and IHBS to all youth who meet medical necessity.
The MHP must convene a Child Family Team (CFT) for youth receiving ICC, IHBS, TFC but not involved in child welfare/probation.

1) Description of corrective actions, including milestones:

Department of Behavioral Health (DBH) Children and Youth Collaborative Services (CYCS) has developed several reports to assist with monitoring the provision of ICC, IHBS, and TFC to youth in the MHP. The Monthly Caseload (MCL) report provides point in time data about subclass membership, Child and Family Services (CFS) status, and ICC provision for CYCS and the MHP Contract Providers. The Special Programs Report for Outcome, Utilization, and Treatment (SPROUT) Addendum provides data on the frequency of ICC and IHBS provided to subclass and non-subclass members in the MHP over a period of time.

ICC Provision

Data from May 20, 2020 MCL report indicates the provision of these services at a point in time:

- 9152 unduplicated youth open in SB MHP
- 1144 subclass members identified
- -1119 subclass members open longer than 30 days, ICC provided
- =25 subclass members open longer than 30 days, No ICC

The 25 subclass members who did not received ICC should be receiving ICC services. Their programs and clinicians will be prompted to provide these services.

- 8008 non-class members
- 1525 non-class members provided ICC services (19% non-class received ICC)
- 503 non-class members open longer than 30 days, Child and Adolescent Needs and Strengths (CANS) CAIR scores over 15

A CAIR (Core Actionable Items Report) score of 15 counts scores of 2 or 3 on CANS items that possibly indicate medical necessity for mental health services. The 503 non-class members, with a high level of need as measured on the CANS, should be evaluated for ICC services.

IHBS Provision

As documented in the SPROUT Addendum for the period of 07-01-19 to 03-31-20, the following unduplicated youth received IHBS Services in CYCS and the DBH Contracted Programs:

13,979 Unduplicated Count of Youth Receiving EPSDT Service
1082 Count of Youth Receiving IHBS (7.7%)
740 Count of Subclass Youth Receiving IHBS (68%)
495 Count of Non-Subclass Youth Receiving IHBS (46%)

*153 youth were subclass and then non-subclass, or vice versa, so these groups are not exclusive

CFT Convening for Youth receiving ICC, IHBS, and TFC not involved in Child Welfare or Probation

The Katie A. Settlement of 2011 determined that the responsibility for the provision of ICC, IHBS, and TFC would lie with the MHP of each county and the monitoring of Child and Family Team Meetings would lie with the Child Welfare Services of each county. These provisions work well when data can be reliably shared between departments and the youth are dependents or wards. These provisions are problematic when the youth are not dependents or wards.

DBH does not currently have an Electronic Health Record which further complicates the data collection process. However, DBH is currently implementing its EHR with a timeline of November 2020. DBH intends to add Evidence-Based Practice Special Service codes that will indicate that Child and Family Team meetings occurred during that service. Having these dedicated codes will enable DBH to quantify the delivery of CFT meetings. Furthermore, DBH will be able provide data regarding frequency, duration, and related outcomes.

TFC Service Provision

San Bernardino County MHP began providing TFC services in February 2020. Since that time the following youth have received services:

- Female opened on 2/3/2020 at Greater Hope FFA-MHS program for TFC for 90 days; continuing services for another 90 days
- Male opened on 2/24/2020 at ChildNet FFA-MHS program for TFC for 90 days; continuing services for another 90 days
- Male opened on 4/30/2020 at ChildNet FFA-MHS for TFC for 90 days

Each of these youth have Child and Family Team Meetings documented in the clinical record of the youth.

2) Timelines for implementation and/or completion of corrective actions:

- 2019 - The MCL and SPROUT reports were developed and implemented.
- February 2020 - TFC services began to be conducted in February 2020.
- June 30, 2020 – CYCS will prompt clinicians of youth requiring ICC services and/or IHBS

evaluations to conduct an evaluation for ICC and document the evaluation in the clinical record.

- July 31, 2020 – Program clinicians due date for dispositions regarding the ICC services and IHBS evaluations for services.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

The following actual evidence will be submitted:

- MCL Report Cheat Sheet (Provided)
- MCL Report 5-20-20 (Provided)
- QIPP-QMAC Report 2018-2019 (Provided)
- SPROUT Addendum Cheat Sheet (Provided)
- MHP SPROUT Addendum (Provided)
- CCN numbers of youth receiving TFC

4) Mechanisms for monitoring the effectiveness of corrective actions over time. *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

CYCS will continue to monitor and analyze ICC, IHBS and TFC via the Monthly Caseload Report and the Quarterly SPROUT Addendum. The data that is obtained from these analyses will be provided to clinical supervisors and program administrators during regularly scheduled meetings that CYCS holds with providers.

- Two times per year CYCS meets with program agencies to review their individual agency services and outcomes in Agency Meetings.

- Two times per year CYCS meets with program agency staff in Program Meetings.

- Two times per year CYCS meets with all agency staff in an All Providers' Meeting to review issues impacting contract providers and the entire Children's System of Care.

- One time per year CYCS conducts an Annual Program Review to review service outcomes, chart documentation, and Policy and Procedure Updates.

5) Description of corrective actions required of the MHP's contracted providers to address findings

San Bernardino contracted providers will evaluate and respond to the prompts for ICC services and IHBS evaluations provided by CYCS. Providers will document evaluations in the clinical records of the youth. Contract providers will attend the meetings noted above and research and analyze the data reports provided by CYCS.

Section C: Quality Assurance and Performance Improvement

I. **Quality Assessment and Performance Improvement Program**

REQUIREMENT: IB. The MHP evaluates the impact and effectiveness of the QAPI Program annually and updates the Program as necessary.

FINDING: The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, 42 C.F.R. § 438.330(a)(e)(2) and Att. 5; CCR, title 9, section 1810.440(a)(6)…The MHP did not submit evidence of annual QAPI program evaluations. The evaluation would include goals met, continued or modified and the rationale for selecting new goals…

1) **Description of corrective actions, including milestones:** DBH is committed to continued quality improvement, which is documented in its Quality Assessment and Performance Improvement (QAPI), also known by DBH as the Quality Improvement Performance Plan (QIPP). Additionally, each year DBH completes an evaluation of the prior year's QIPP, but acknowledges an opportunity to improve its evaluation of the QIPP, specifically it shall implement the following actions:
   - Documenting what goals were met including the effectiveness of the goal;
   - Articulating what goals will continue and explain why;
   - Describing what goals need to be modified and explain why; and
   - Explaining the rationale for pursuing new goals, including any relevant data.

   DBH will implement the aforementioned actions this coming fiscal year [20/21] when evaluating the FY 19/20 QIPP.

2) **Timelines for implementation and/or completion of corrective actions:** To ensure compliance with the DHCS requirement to complete an evaluation annually, DBH shall complete the following actions:
   - DBH will begin obtaining written status reports bi-monthly from its QIPP Sub-Committee Chairs so it can incorporate progress as well as challenges faced with quality improvement goals in the annual evaluation beginning July 6, 2020.
   - DBH will continue to include the Quality Management Action Committee (QMAC) members' involvement in the completion of the FY 19/20 QIPP Evaluation.
   - DBH will also consult with Behavioral Health Concepts, Inc., in Sept/Oct 2020 regarding recommendations for a successfully written QIPP and QIPP Evaluation.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:** Attached are the former and most recent QIPP Performance Evaluation for Fiscal Year 2018/2019, which demonstrate improvement strides in the evaluation of the QIPP:
   Actual Evidence:
   - Annual QIPP Evaluation FY 17/18
   - Annual QIPP Evaluation FY 18/19

   Proposed Evidence:
   - Annual QIPP Evaluation FY 19/20

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
   DBH will do the following actions to monitor the effectiveness of corrective actions over time:

- Utilize the feedback from its External Quality Review Organization (EQRO) review to monitor the effectiveness of its corrective actions;
- Utilize the feedback from its QMAC to monitor effectiveness; and
- Request feedback from seasoned Quality Improvement Coordinators (QIC) of other CA counties.

5) **Description of corrective actions required of the MHP's contracted providers to address findings:** As many DBH contract providers are members of QMAC, they will be contributing to the QIPP Evaluations; however, there are not any corrective actions for the contracted providers to complete.

Section C: Quality Assurance and Performance Improvement
II. QAPI Work Plan

REQUIREMENT: F The QAPI work plan includes evidence of compliance with the requirements for cultural competence and linguistic competence.

FINDING: "The MHP did not furnish evidence of compliance with MHP Contract, Ex. A, Att.5. The MHP must ensure the QAPI work plan includes evidence of compliance with the requirements for cultural competence and linguistic competence...while the…QI work plan includes goals related to increasing penetration rates…it does not address linguistic competence."

1) **Description of corrective actions, including milestones:** The Department of Behavioral Health (DBH) Quality Management Division (QMD) will work closely with the Office of Cultural Competence and Ethnic Services (OCCES) to incorporate elements of linguistic competence into the QAPI. The following linguistic elements will be added to the QAPI:

   - Effective June 1, 2020, OCCES will manage the entire mystery shopper program for both Substance Use Disorder and Recovery Services (SUDRS) and the Mental Health Plan (MHP). OCCES will utilize the reports on calls made in threshold and other prevalent non-English languages spoken by clients to tailor and inform future language services trainings for staff and focus on areas for improvement in language services delivery. OCCES will take over this program starting June 1, 2020 for the MHP. Currently OCCES is conducting Mystery Shopper calls for SUDRS as of November 2019. Additionally, OCCES will reach out to the Cultural Competency Advisory Committee (CCAC) and its subcommittees to offer opportunities for community stakeholders to participate in the program and conduct mystery shopper calls in non-English languages.
   - A new goal will be added to the QIPP for fiscal year 20/21: To review and update language services training staff to ensure clients receive services in their preferred language.
   - The following elements will also be implemented and added to the QIPP for fiscal year 20/21 for workgroup review and monitoring:
     i. OCCES will continue to facilitate Un Momento Por Favor/One Moment Please, a live training provided to staff on how to connect and interact with non-English speaking clients, with the addition of other prevalent non-English languages to expand staff's ability to provide linguistically appropriate responses to a larger percentage of the population. Ensuring that staff have all the resources and information to connect clients to certified bilingual staff or to a language services vendor. The training curriculum will also cover communicating with individuals who are deaf and hard of hearing by incorporating how to use the California Relay Service: 7-1-1. The Un Momento Por Favor/One Moment Please training will take on a different name in order to align the training with the objective of communicating in all threshold and prevalent languages.
     ii. OCCES will continue to monitor the department's ability to provide services in clients preferred language (language capacity) by reviewing bilingual staff list and levels, language related grievances, language training evaluations, and data on the preferred language of San Bernardino County Medi-Cal beneficiaries and individuals accessing services. OCCES will also review 2020 census data taking into consideration the evolving

characteristics of our county's population that would offer opportunities for us to modify our linguistic support and provide additional training to internal and external customers.

iii. OCCES will increase the number of incoming call phrases to include a greater variety of languages. This should be determined based on linguistic demand and the increased benefit to clients, stakeholders and county employees. To achieve this, OCCES is currently analyzing which languages to add. This action should be completed during the summer of 2020.

Call Phrase Example:

Incoming Calls: If someone calls the clinic speaking Spanish or any other language **DO NOT** hang up.
These are two sentences you can use with Spanish speaking clients.

1. **Un momento por favor, voy a conectar su llamada.** *Translation: One moment please, I will be connecting your call.*	Oon- moh mint oh-por fa vor,- voy- ah- cone ekctar- sue- ya mah dah.
2. **Su llamada es importante, por favor no cuelgue.** *Translation: Your call is important please do not hang up.*	Sue- yah mah dah- es-eem por tahn tay,- Por fah vor- no- quel geh.

iv. The Video Interpretation Project (VIP) is a result of the department's increased demand for linguistic services throughout the county utilizing video conferencing. The project will allow an increase in linguistic capacity to not only clients, but it will allow DBH clinicians to communicate from a remote location if necessary. The VIP has expanded the language options the DBH client has for interpretation services without compromising the quality of service. The VIP has increased in importance because of the social distancing requirements currently in place due to the COVID-19 emergency; therefore placing a premium on quality and reliable face-to-face communication. This project is at 30% completion and at the current rate would be finalized next winter with appropriate funding (December-March 2021).

2) Timelines for implementation and/or completion of corrective actions:

`All of the proposed corrective actions will be ongoing. The implementation timeline for each is listed below:

- Conduct Un Momento Por Favor/One Moment Please training with updated subject matter effective fall 2020.
- Monitor the department's linguistic capacity and appropriate program responsiveness to the linguistic needs of clients.
- Update call phrases based on the ongoing linguistic needs of the population DBH serves, expected completion summer 2020.
- Expand interpretation services provided through the Video Interpretation Project. Full expansion of services for this project are expected to be completed between December 2020 thru March 2021.
- Conduct Mystery Shopper calls for the MHP and SUDRS effective June 1, 2020.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

The following will be submitted as proposed evidence of correction:

- Updated Un Momento Por Favor/One Moment Please curriculum and training evaluation analysis/summary completed by staff.
- Documented trends and analysis of linguistic needs and utilization of language services.

- Documentation of updated call answering phrases in most utilized prevalent non-English languages.
- Documentation and analysis of the Video Interpretation Program language utilization.
- Mystery Shopper call documentation and analysis of call outcomes.

4) Mechanisms for monitoring the effectiveness of corrective actions over time. *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

The department will regularly assess and review the effectiveness of the corrective actions internally and with stakeholders in the following intervals:

- Un Momento Por Favor/One Moment Please training outcomes, mystery shopper calls, Video Interpretation Project progress and utilization, and any newly identified linguistic needs or trends will be shared with the QAPI Cultural Competence workgroup on a quarterly basis and with the CCAC on an annual basis.

The department will also incorporate workgroup and stakeholder feedback on the outcomes of the corrective actions and actively incorporate the feedback into the corrective actions to ensure the proposed actions support sustainable improvement of linguistic capacity.

5) Description of corrective actions required of the MHP's contracted providers to address findings
Corrective actions needed are the responsibility of the MHP, however, DBH will continue to ensure contract providers are aware of linguistic service requirements and ensure providers meeting the linguistic needs of clients.

Section C – Quality Assurance and Performance Improvement
III. Quality Improvement Committee (QIC)

REQUIREMENT: III.A2 - The QIC shall:
Recommend policy decisions, review and evaluate the results of QI activities, including performance improvement projects (PIP), institute needed QI actions, ensure follow-up of QI processes, document QI committee meeting minutes regarding decisions and actions taken. (MHP Contract, Ex. A, Att. 5)

FINDING: The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 5. The QIC must review and evaluate the results of QI activities, institute needed QI actions and ensure follow up of QI processes…DHCS deems the MHP out of compliance with (MHP Contract, Ex. A, Att.5).

1) **Description of corrective actions, including milestones:** The Department of Behavioral Health (DBH) Quality Management (QM) Division acknowledges all evidence may not have been provided or received regarding this requirement as DBH completes the requirements of the MHP Contract, specifically Exhibit A, Attachment 5. However, to ensure it addresses the finding regarding the requirement for DBH QMAC to review and evaluate the results of QI activities, institute needed QI actions and ensure follow-up of QI processes, DBH implemented the following corrective actions:

- Developed QMAC subcommittees for every quality improvement goal/objective listed on the Quality Improvement Performance Plan (QIPP) to ensure all required review and evaluation are completed as it is difficult to review various aspects of data and quality improvement during the QMAC meetings since it is combined for both mental health (MH) and substance use disorder (SUD) services.
    - Every subcommittee is chaired by a subject matter expert for the QI project who meet to discuss the progress, data, problems and results of their respective QI project.
    - The subcommittees include the following:
        - Timeliness, which includes routine appointments and urgent conditions and chaired by QM Program Manager or designee;
        - MHP Service Delivery System for the Safety & Effectiveness of Medication Practices, chaired by the DBH Medical Director or designee;
        - Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), chaired by the DBH Deputy Director of Children Services or designee;
        - Mental Health needs in Specific Cultural and Ethnic Groups, chaired by the DBH Cultural Competence Officer or designee;
        - Responsiveness of the 24/7 Toll Free Access Line and Access to Services, chaired by the Program Manager I over the 24/7 Access Unit; and
        - Performance Improvement Plans (PIPs), chaired by the DBH Research and Planning Supervisor.
    - The subcommittees meet and provide a report out at QMAC.
- Finalized and posted the updated Quality Management Action Committee Policy, QM6009, that includes required QMAC activities, including, but not limited to, the following:
    - Recommend policy development and changes;
    - Review and evaluate the results of quality improvement (QI) activities, including performance improvement projects (PIPs);
    - Institute necessary QI actions;
    - Ensure follow-up of QI processes;

- Document QMAC minutes regarding decisions and actions taken; and
- Review data pertaining to the following:
  - Existence and responsiveness of a 24/7 telephone access line with prevalent non-English languages;
  - Timeliness for scheduling routine appointments and urgent conditions;
  - Access to after-hours care; and
  - Other applicable data related to quality improvement.

2) **Timelines for implementation and/or completion of corrective actions:** Timelines for the aforementioned corrective actions are as follows:

- Discussed the specific role of the QMAC subcommittees with committee members, along with expected subcommittee activities, and DBH staff responsible for leading each subcommittee in May 2019.
- Implemented the QMAC subcommittees effective September 2019; and
- Finalized and posted the updated QMAC Policy effective August 28, 2019.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:** Actual evidence of corrective actions includes the following:

- QMAC meeting minutes including discussion of subcommittees:
  - May 6, 2019
  - September 3, 2019
  - November 4, 2019
  - March 2, 2020
  - May 4, 2020
- QMAC Subcommittee documentation regarding Timeliness:
  - August 20, 2019 notes;
  - September 23, 2019 notes;
  - February 24, 2020 notes;
  - April 30, 2020 agenda, minutes, attendance sheet and data metrics; and
  - May 26, 2020 agenda, minutes and attendance sheet.
- QMAC Subcommittee documentation regarding Safety & Effectiveness of Medication Practices:
  - Peer Review Report October 2019
- QMAC Subcommittee documentation regarding Specific Cultural and Ethnic Groups:
- QMAC Subcommittee documentation regarding PIPs:
  - September 19, 2019
    - Sign in sheet
  - September 26, 2019
    - Sign in sheet
  - November 21, 2019
    - Sign in sheet
  - January 9, 2020
    - Agenda
    - Sign in sheet
  - March 12, 2020
    - PIP Subcommittee minutes

        - PIP Process Flow
        - Sign in sheet
        - Agenda
    - May 14, 2020
        - PIP Subcommittee minutes
        - PIP Process Flow
        - Agenda
        - CalEQRO Thinking through a PIP
    - July 9, 2020
        - PIP Subcommittee minutes
- DBH Policy, QM6009 Quality Management Action Committee Policy

4) Mechanisms for monitoring the effectiveness of corrective actions over time. *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

To ensure compliance with the plan of correction, DBH will implement and document the following actions to monitor effectiveness:

- Develop a schedule of QI topics to discuss at the QMAC meetings, based on the goals and objectives of the QIPP, to ensure the committee has ample time to conduct a deeper level review and evaluation of the QI activity, identify any needed actions or changes, and address any needed follow-up including timeframes. Since the QIPP is combined for MH and SUD, the schedule will address one topic for MH and one for SUD. If the goal and objective is applicable to both, then only one topic will be discussed but both services will be addressed. The schedule will be developed by September 2020, once the QIPP is formally combined with SUD.
- Monitor the progress of the subcommittees by requiring written reports or evaluation reports for each QMAC meeting beginning September 2020, that can be shared with the committee but can also be utilized by QM when writing the annual QIPP evaluation.
- Compare the 2020-2021 EQRO QIPP results to past years to measure improvement.

5) Description of corrective actions required of the MHP's contracted providers to address findings

No corrective actions are required from contractor providers for this finding.

Section C – Quality Assurance and Performance Improvement
III. Quality Improvement Committee (QIC)

REQUIREMENT: III.B - The MHP QAPI program includes active participation by the MHP's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI program. (MHP Contract, Ex. A, Att. 5)

FINDING: …[T]he MHP QAPI program must include active participation by the MHP's practitioners and providers, as well as beneficiaries and family members; in the planning, design and execution of the QI program…
While the MHP has a Quality Management Action Committee (QMAC) and documented meeting minutes, [t]he MHP did not identify sufficient evidence of the mechanism for the recruitment and selection of QMAC members which should include beneficiaries and their family members. Additionally, the MHP did not provide evidence that beneficiaries and their families participate in the planning, design, and the execution of the QI plan. The QIC minutes sign in sheets from 2018/19 indicated that there was one person who could be identified as a beneficiary in only one of the meetings…DHCS deems the MHP out of compliance with (MHP Contract, Ex. A, Att.5).

1) **Description of corrective actions, including milestones:**
The Department of Behavioral Health (DBH) Quality Management (QM) Division has taken the following actions to increase involvement of client and their family members in the QMAC, in addition to increased involvement in the planning, design and execution of the QI plan:

- QM, specifically DBH Research and Evaluation (R&E) developed and implemented a committee called the Consumer Evaluation Council (CEC), chaired by a R&E Business Systems Analyst (BSA)III. The council is composed of vested clients and family members who want to contribute their views, concerns, questions, etc., to DBH.
- The R&E BSA III provides the following information to the CEC:
    - Advisement of the purposes of the various meetings, committees and projects that request their input, feedback and view;
    - Encouragement to participate in the QMAC [and/or other applicable DBH meetings, committees or projects to which the council members are interested] and advised that QM will actively seek their input and feedback on elements of the QI Plan and implementation as well as other QMAC activities and subcommittees; and
    - Description of the QMAC resulted in three (3) clients or family members volunteering to participate and who will provide verbal reports to CEC.
- QM updated its QMAC sign in sheets for meeting attendance by adding a column to allow participants to identify stakeholders, including clients and/or family members.

Additionally, QM determined to fulfill the requirements of the MHP Contract, specifically Exhibit A, Attachment 5, it shall take the following actions to increase involvement of clients and their family members in the QMAC, in addition to increased involvement in the planning, design and execution of the QI plan:

- Establish a separate QMAC subcommittee or meeting (name undetermined until the committee establishes collaboratively) for clients and family members that participate in QMAC in order to have a concentrated, dedicated discussion of what the request is of them, e.g., feedback/input

regarding Quality Improvement Performance Plan (QIPP), areas/topics of interest of the clients and family members that need improvement to be considered for PIP or QIPP, suggested changes to QM or DBH processes etc.
    - The separate subcommittee/meeting will be chaired by the QM quality improvement coordinator or designee and in addition to the council members who volunteer to participate will be attended by a few applicable QM staff, the R&E BSAIII or designee and Clubhouse Program Manager.
    - The participating council members of this new subcommittee will establish a designated person to serve as the spokesperson who will provide a report out at each QMAC.
- Continue to request clients and family member participation in the QMAC through the CEC;
- Work closely with the Office of Cultural Competence and Ethnic Services (OCCES), specifically its Cultural Competence Advisory Committee (CCAC), to increase participation of clients and family members in the QMAC meetings, QI plan design and implementation.
- Continue ongoing recruitment efforts of Clubhouse members (who are current or former MHP clients and family members) to participate in QMAC and QI plan design and implementation.

2) **Timelines for implementation and/or completion of corrective actions:** Timelines for the aforementioned corrective action are as follows:

- The CEC began meeting September 2019, and meets at least once a month and when able, twice a month;
- The QMAC sign in sheet was updated March 2020 to allow participants to self-identify as clients or family members of the MHP.
- DBH QM will establish the QMAC subcommittee or meeting, including the name of the subcommittee or meeting as well as an identified spokesperson no later than September 30, 2020.
- The recruitment and outreach to clients and family members to increase participation in QMAC and in QI planning will occur on an ongoing basis via CEC and CCAC.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**

Evidence of correction includes the following:

Actual evidence:

- CEC meeting minutes demonstrating recruitment of client and family member participation in QMAC
    - September 5, 2019 minutes
    - September 19, 2019 minutes
    - October 3, 2019 minutes
    - October 17, 2019 minutes
    - November 21, 2019 minutes
    - January 16, 2020 minutes
    - February 20, 2020 minutes
    - March 5, 2020 minutes
    - May 7, 2020 minutes
    - May 21, 2020 minutes
    - June 18, 2020 minutes
- Updated QMAC sign in sheet

Proposed evidence:

- QMAC subcommittee charter and/or meeting minutes, including the name of the subcommittee designated spokesperson
- Applicable meeting minutes or documentation demonstrating recruitment and/or selection efforts of clients and family members via the CEC, CCAC and Clubhouses.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

QM will actively monitor and track the participation of beneficiaries and family members via the updated sign in sheet. QM staff will also attend CCAC and CEC meetings to increase program visibility and increase beneficiary awareness of the QM program, the Quality Improvement Plan and planning.

5) **Description of corrective actions required of the MHP's contracted providers to address findings**

No corrective actions are required from contractor providers for this finding.

Section D – Access and Information Requirements
VI. 24/7 Access Line and Written Log of Requests for SMHS

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

VI. B.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.

4)The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.
(CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

FINDING: Test call #4 was placed on Monday, February 25, 2019 at 4:27 p.m. The call was answered by an automated message. Once the caller selected the appropriate option to request for information, the call was looped between the welcome automated message and a ringing sequence for over three (3) minutes. Once a live operator was reached, the caller attempted to request how to file a complaint three (3) times. Each time, the operator refused to give this information until the caller provided personal information (name and phone number) about themselves. No information, including about how to file a complaint or grievance, was provided to the caller before the call ended. It took over 3 minutes to gain hold of a live operator. Once an operator was on the line, the operator refused to provide the caller with any information.

The call is deemed out of compliance with the regulatory requirements for protocol question D-VI-B4.

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP's toll free telephone number did not provide all required information to beneficiaries. DHCS deems the MHP in partial compliance with CA Code of Regulations, title 9 , section 1810.405 (d) and 1810.405 (e)(1). The MHP must complete a POC for this finding of non-compliance.

1) Description of corrective actions, including milestones:

- In January 2020 all staff (including After Hours Access Unit (AHAU)) were provided with and trained to use an updated call script in which the staff provides available information on how to access specialty mental health services including services needed to treat a beneficiary's urgent condition/crisis situation as well as information on how to use the beneficiary problem resolution and fair hearing processes. At this training staff were also advised that although it would be beneficial to get the callers' name and phone number, it is not required to provide information on how to access SMHS. (See attached documentation from this training including staff sign in sheets and employee expectations regarding test calls).

    - The 24-7 Access Line Policy and Procedures have been updated and awaiting final approval from DBH Compliance to be formally issued. The revised policy and procedures provide additional direction to staff on how to assist callers in accessing specialty mental health services, including services needed to treat an urgent condition/crisis situation. This includes clarification on obtaining callers names and contact information during the call. Although it would be beneficial to get the callers' name and phone number, it is not required to obtain this information before providing information on how to obtain specialty mental health services..
    - As of January 2020, Quality Management (QM) staff has increased the number test calls per month as well the specific type of calls made each month as indicated below.
- Conduct at least 15 test calls per month as specifically indicated below:
    - 8 resource/referral test calls per month
    - 2 Spanish test calls during business hours
    - 2 English test calls during business hours
    - 1 Vietnamese test calls afterhours
    - 1 Spanish test calls after hours
    - 2 English test calls after hours
- 3 customer service test calls in Spanish/Vietnamese per month
    - 2 Spanish test calls during business hours
    - 1 Vietnamese test calls afterhours
    - 1 Spanish test calls after hours
- 4 Grievance test calls per month
    - 2 English test calls during business hours
    - 1 Spanish test calls during business hours (bi monthly)
    - 2 English test calls after hours
    - 1 Spanish test calls after hours (bi monthly)
- 2 voicemail verification test calls per month
- 5 test calls per month of an urgent condition (included in the calls as listed above)
- This plan above reflects the data required for the 24/7 Test Call Quarterly Reports required by DHCS.

- 4. In January 2020 Quality Management created, implemented, and trained test call staff on the new urgent test calls script (script attached). A minimum of 5 test calls per month will be completed regarding urgent conditions. 3 will be completed during business hours and 2 after hours. Test call completion will be monitored at the end of each month by the supervisor to ensure that calls have been made and documented. Each test call is documented on the Test Call Form (see attached) and placed in the shared drive before the end of the month for supervisor review. Additional staff training will be provided should any issues arise.

- 5. Quarterly 24-7 Access Line Test Call reports will be submitted to DHCS to provide evidence of correction. DBH now handles all after hours calls and no longer contracts out the afterhours calls.

2) Timelines for implementation and/or completion of corrective actions:
These issues were corrected in November 2019 and through the current period have been successful.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
Quarterly 24-7 Access Line Test Call reports will be submitted to DHCS to provide evidence of correction. DBH now handles all after hours calls and no longer contracts out the afterhours calls.

4) Mechanisms for monitoring the effectiveness of corrective actions over time. If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.

Quarterly 24-7 Access Line Test Call reports will be submitted to DHCS to provide evidence of correction. DBH now handles all after hours calls and no longer contracts out the afterhours calls and will continue monitoring for effectiveness through the test calls.

5) Description of corrective actions required of the MHP's contracted providers to address findings
The MHP no longer contracts with 211, there are no other actions required from other contract providers.

SECTION D-ACCESS AND INFORMATION REQUIREMENTS
VI. 24/7 Access Line and Written Log of Requests for SMHS

Requirement- VI. C.2: 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. CCR, title 9, chapter 11, section 1810.405(f)

Finding: The MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, chapter 11, § 1810.405(f). The MHP must maintain a written log of the initial requests for SMHS from beneficiaries of the MHP. The requests must be recorded whether they are made via telephone, in writing, or in person. The log must contain the name of the beneficiary, the date of the request, and the initial disposition of the request..The MHP submitted their 24/7 Access Call log as evidence of compliance with this requirement. While, the MHP submitted evidence to demonstrate compliance with this requirement, one of the five calls was not logged on the MHP's access log...DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, § 1810.405(f). The MHP must complete a POC addressing this finding of non-compliance.

1) **Description of corrective actions, including milestones:**
   - The service protocol for maintenance of the written log will be reviewed by the Quality Management Division (QMD) QMD will facilitate annual trainings and conduct monthly call log reviews with staff to ensure that all calls are logged. The initial contact log used by DBH clinics is an online system that allows us to record the date of initial contact, the reason for the call, the disposition of the call, the first offered appointment, and the accepted date for an appointment. It was developed in response to the preliminary requirements of the Final Rule. We have an Avatar request to expand that to include an identifier for whether the call is for psychiatric services as well, and to include the ability to record up to three offered appointments. Our intent is to design a spreadsheet for contractors to use that will allow this same data to be collected or reported on from their EHRs.

2) **Timelines for implementation and/or completion of corrective actions:**
   - Updated technology will be available at the new call center (August 2020) which will increase the effectiveness in which calls are able to be logged.
   - The new electronic health record (EHR) (August 2020) will allow for more effective logging of initial requests for SMHS from beneficiaries.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
   The MHP will submit the following proposed evidence:
   - Contact logs generated using updated technology from the call center and EHR.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
   - The MHP will closely monitor logs generated by the EHR and call center to measure effectiveness and ensure all calls are logged as required.
   - Quality Management (QM) staff will cross check test calls with the written log at the time of the 24-7 Quarterly Report to ensure adherence to the service protocol for compliance in filling out the call log.

- Additional training shall be conducted to maintain compliance with regulatory guidelines and corrective feedback and training will be provided as needed.

5) Description of corrective actions required of the MHP's contracted providers to address findings

This finding does not require any action from the MHP's contracted providers.

Section D-Access and Information Requirements
VII-Cultural Competence Requirements

REQUIREMENT:

Section D-VIIA: The MHP has updated its Cultural Competence Plan annually in accordance with regulations. (CCR title 9, Section 1810.410)

Section D-VIIB: Regarding the MHP's Cultural Competence Committee (CCC):

2.) The MHP has evidence of policies, procedures and practices that demonstrate the CCC activities include the following:

a.) Participates in overall planning and implementation of services at the county,

b.) Provides reports to the Quality Assurance and/or the Quality Improvement Program. (CCR title 9, section 1810.410)

Section D-VIIC: The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410)

FINDING: The MHP did not furnish evidence to demonstrate it complies with CCR title 9, section 1810.410. The MHP must ensure it completes its Annual Report of CCC activities as required in CCPR.
The MHP submitted the following documentation as evidence of compliance with this requirement:

- Cultural Competence Advisory Committee meeting minutes,
- CCAC Work Plan 2017-19,
- Cultural Competency Plan 2017,
- Cul 1004 Satisfying Beneficiary Language Policy

The MHP submitted a Cultural Competency Plan for2017. In that plan, cultural competency plans and objectives were outlined and specifically described, with timelines in the cultural competency work plan for 2017-2019, however evidence was not provided regarding the required annual updates.
DHCS deems the MHP out of compliance with CCR title 9, section 1810.410.

1) **Description of corrective actions, including milestones:** The Cultural Competency Officer (CCO) meets with the Cultural Competency Advisory Committee (CCAC) leadership on an annual basis to remind them of CCR title nine requirements per CCAC by laws and annual requirements. The new CCO has met with CCAC leadership monthly since the beginning of her tenure as CCO in July of 2019. The new CCAC leadership for calendar year 2020 started in January 2020. As part of their orientation to their roles, CCAC leadership was provided with the requirement to complete an Annual Report. Additionally, they have been informed of this finding.

   CCAC participates in the overall planning and implementation of county services by participating in the department's various stakeholder community planning process meetings and events. CCAC with the support of the Office of Cultural Competence and Ethnic Services (OCCES) takes an active role in creating opportunities for stakeholders to provide input and feedback on the DBH system of care. They do this by utilizing CCAC and Subcommittee meetings as venues where community and CCAC members can provide feedback, recommendations and support for the programs and services the department is planning and implementing. On an annual basis the departments Mental Health Services Act (MHSA) Administration Unit presents to CCAC and its 13 subcommittees on annual accomplishments and future programs and services in development. CCAC members during these meetings have an opportunity to provide feedback, recommendations and ensure cultural and linguistic competency is embedded in the

overall planning and implementation of services. These efforts are documented in the most recent Cultural Competency Plan (CCP) for Fiscal Year 18/19 on page 61 and there are many examples of regular meetings and special forums designed to inform stakeholders, committee members and the general public in the attachment section of the CCP.

2) **Timelines for implementation and/or completion of corrective actions:** The new CCO was hired in July of 2019 and completed an updated version of the Cultural Competency Plan (CCP), which was submitted to the state in December 2019, and included an Annual Report of CCAC activates for the reporting period and CCP goals. The CCAC Annual Report for FY 2018-19 was submitted to the CCO in November of 2019 and it outlined the progressive actions of the CCAC's subcommittees. Objectives and plan outlines for the CCAC and the subcommittees are updated as needed on the evolving CCAC work plan. Subcommittees also complete monthly updates that are submitted to the Office of Cultural Competence and Ethnic Services (OCCES) for CCO review and approval. Cultural Competency goals and objectives for the CCP are regularly monitored by OCCES and will be updated in the next CCP update. OCCES has also developed tools to monitor the current CCP goals and objectives, which we will begin reporting on in June of 2020 to the department's quality improvement program.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
The following items will be submitted as actual evidence:
   - CCAC Annual Report Year 2018-2019
   - CCAC Leadership minutes and agendas FY2019-2020
   - CCAC Subcommittee Updates Report FY2019-2020

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
To ensure the effectiveness of the proposed corrective actions, the Quality Management Division though the Quality Improvement Committee will conduct an annual review of the Cultural Competency Plan, CCAC Annual Report and Subcommittees Update Report.

5) **Description of corrective actions required of the MHP's contracted providers to address findings.**

There are no actions required at this time from DBH's contract providers.

Section D-Access and Information Requirements
VII. Cultural Competence Requirements

REQUIREMENT:

Section D-VIID: Regarding the MHP's plan for annual cultural competency training necessary to ensure the provision of culturally competent services:
1) There is a plan for cultural competency training for the administrative and management staff of the MHP.

FINDINGS: The MHP did not furnish evidence to demonstrate it complies with CCR title 9, section 1810.410 (c) (4). The MHP must provide an annual cultural competence-training plan necessary to ensure the provision of culturally competent services to beneficiaries. In addition, the MHP must provide a plan for cultural competency training for the administrative and management staff, on the one hand and for persons providing SMHS, employed by or contracting with the MHP on the other.
The MHP provided numerous examples of cultural competency training topics, a schedule for training and sign in sheets showing attendance of service providers (DBH staff and contracted providers alike); there was no clear evidence to support training provided to administrative and management staff.

1) **Description of corrective actions, including milestones:** The Office of Cultural Competence and Ethnic Services (OCCES) will work closely with the departments Workforce Education Training (WET) unit to create and pull clear reports of Cultural Competency training completed by administrative and management staff. The departments policy requires that Administrative staff (includes management staff) attend a minimum of two hours of cultural competency training each calendar year. Monitoring of Cultural Competency training completion is an activity of the department's Quality Management Action Committee and OCCES, and is included in the Quality Improvement Performance Plan (QIPP) for calendar year 2020. OCCES will present this finding at the next QIPP Cultural Competency Quality Improvement Workgroup Committee for further monitoring of training completed by administrative and management staff.

2) **Timelines for implementation and/or completion of corrective actions:** OCCES will present this finding at the July 2020 QIPP Cultural Competency Quality Improvement Workgroup Committee. Reports providing evidence that administrative and management staff have completed Cultural Competency training have already been provided by WET for FY 16/17, 17/18 and FY 18/19. Reports will be reviewed to ensure that they capture all administrative and management job titles for the department and contracted providers. Reports for FY 19/20 will be pulled after the July QIPP Cultural Competency Quality Improvement Workgroup Committee to ensure it captures all administrative and management job tiles.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
The following actual evidence will be submitted:
   - Reports detailing cultural competency training completed by administrative and management staff for fiscal years 16/17, 17/18 and 18/19.

   The following proposed evidence will be submitted:
   - List of cultural competency training provided to administrative and management staff for fiscal year 19/20.

- QIPP Cultural Competency Quality Improvement Workgroup Committee minutes for fiscal year 20/21.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

Alternative actions will be presented to the Quality Improvement Program for review.

5) **Description of corrective actions required of the MHP's contracted providers to address findings.**

There are no actions required at this time for contract providers.

Section E: Coverage and Authorization of Services
I. Service Authorization Requirements

REQUIREMENT: C. The MHP shall have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the beneficiary's behavioral health needs. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.2109b)(3).)

AND

Service authorization approved or denied by licensed mental health or waivered/registered professionals.

FINDING: The MHP did not furnish evidence it complies with regulatory requirements regarding the service authorizations. DHCS reviewed the MHP's service authorization policy and procedure. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements…In addition, DHCS inspected a sample of one hundred fifty (150) Service Authorization Requests. One (1) of the Service Authorization Requests related to Day Rehabilitation did not verify what services were authorized nor did it include the required signature by a licensed mental health or waivered/registered professional…DHCS deems the MHP out of compliance with (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(b)(3).)…

1) **Description of corrective actions, including milestones:** In accordance with DHCS MHSUDS Information Notice No. 19-026, DBH developed written policies and procedures regarding Service Authorization. As required by DHCS IN 19-026, the updated DBH service authorization policies and procedures require all decisions to deny or authorize a service be made by a licensed mental health professional. Although the Protocol stated a waivered/registered professional may deny or authorize a service, DBH only employs licensed staff to review authorizations as this is in accordance with the DHCS IN and Health & Safety Code § 1367.01(e), while still satisfying the MHP Contract and 42 CFR 438.210(b)(3) requirements.

   At the time of the Triennial review, DBH had a non-clinical Administrative Supervisor working in the DBH Access Unit, that includes the staff who authorize the services reviewed by DHCS. While it is clear that non-clinical positions including the Deputy Director overseeing DBH QM cannot review, deny, authorize or provide clinical direction to licensed mental health professionals, it was evident to DBH when reviewing all the authorizations that the Administrative Supervisor provided guidance for one authorization to a licensed mental health professional who did not sign the authorization but rather wrote what transpired, which was that the Administrative Supervisor authorized the service. DBH acknowledges the latter action was completely out of scope for a non-clinical unlicensed supervisor. To rectify this, effective September 14, 2019, DBH transferred a clinical Mental Health Program Manager I, Dr. Nashira Funn, Licensed Clinical Social Worker 28168, to the QM Access Unit to oversee and provide clinical guidance for authorizations. The former Administrative Supervisor position was vacated as the employee terminated employment with DBH, therefore, DBH requested the position be reclassified as a Licensed Mental Health Clinic Supervisor to prevent any further occurrences of non-clinical unlicensed supervisors working out of scope.

Therefore, the corrective action to address the deficiency is as follows:

- Changing the reporting structure within the DBH QM Access Unit to clinical supervision/management;
- Enforcing DBH policy QM6049, Authorization of Specialty Mental Health Services regarding the level of staffing who can approve or deny service authorization requests; and
- Monitoring the authorizations to ensure signature is captured on each authorization on a semiannual basis.

2) **Timelines for implementation and/or completion of corrective actions:** The policies remain in draft form until DBH receives feedback from DHCS as previously advised that it would be providing feedback on said policies and procedures. However, the draft policies have been slightly revised, posted to DBH's website and utilized by DBH QM staff. DBH will finalize the policies upon feedback from DHCS and once direction/guidance is provided for inpatient psychiatric hospitalizations.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
Actual evidence:

- Draft authorization policy and procedures that require appropriate clinical expertise by a licensed mental health professional:
  - Authorization of Adult Residential Treatment Services (ARTS) and Crisis Residential Treatment Services (CRTS) Procedure CLP0839
  - Authorization of Day Rehabilitation and Day Treatment Intensive Procedure CLP0840
  - Authorization of Psychiatric Inpatient Hospitalization Procedure QM6051
  - Authorization of Specialty Mental Health Services Policy QM6049
  - Prior Authorization for Intensive Home Based Services Procedure CHD0321
  - Prior Authorization for Therapeutic Behavioral Services Procedure CHD0319
  - Prior Authorization for Therapeutic Foster Care Procedure CHD0320
- Transfer documentation of Dr. Nashira Funn
- Licensure information for Dr. Nashira Funn
- Reclassification paperwork of DBH Access Unit Administrative Supervisor to Mental Health Clinic Supervisor
- Updated DBH QM organizational chart

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
To monitor the effectiveness of the corrective action, DBH will complete the following actions:

- Continuing to limit the approval and denial of authorization requests to only licensed health care professionals;
- Ensuring non-clinical unlicensed employees and/or supervisors are not reviewing, authorizing or documenting service authorization requests; and
- Reviewing and monitoring the authorizations to ensure signature is captured on each authorization.

5) **Description of corrective actions required of the MHP's contracted providers to address findings:**
This corrective action is not applicable to DBH contracted providers.

Section E: Coverage and Authorization of Services
I. Service Authorization Requirements

REQUIREMENT: D. The MHP shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c).)

FINDING: The MHP did not furnish evidence it complies with MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c). DHCS reviewed one hundred and fifty (150) Service Requests and corresponding NOABDs. Sixteen (16) of the requests did not provide evidence that the requesting provider was given written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

DHCS deems the MHP out of compliance with (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(c).)…

1) **Description of corrective actions, including milestones:** DBH corrected this finding by completing the following actions:

- DBH developed a written procedure in accordance with DHCS MHSUDS Information Notice (IN) No. 18-010E, regarding Notices of Adverse Benefit Determination (NOABD). The procedure adheres to the requirements of the DHCS IN, including, but not limited to, the following:
  - Uniform templates for DBH, contract agencies and FFS providers to issue when appropriate;
  - Timeframes for sending the NOABD to clients and requesting providers; and
  - A grid listing the appropriate NOABD to issue for what situation, denial or authorization of a services in an amount, duration or scope that is less than requested.
- DBH Quality Management (QM) in collaboration with Substance Use Disorder and Recovery Services (SUDRS) conducted several Train the Trainer sessions with DBH staff and contract agencies called the QM Quarterly Forum. The training topics included an explanation of the NOABDs as well as who and when to issue. Due to the number of providers needing to be trained, DBH determined it was best to train supervisors, managers or the clinic/program designee so they can train their respective staff.
- DBH Inpatient Authorization Nurse Supervisor conducted a training on the issuance of NOABDs by the reviewers if services are denied.
- DBH created a mailbox for DBH clinics, contract agencies and FFS providers to send a copy of all issued NOABDs.
  - This process centralizes all the NOABDs to DBH QM so it has for the following reasons:
    - Record of all NOABDs for State audit and review purposes;
    - Ability to review whether a NOABD was issued to determine if the client exhausted the appeals process; and
    - Opportunity for DBH QM to review all the NOABDs, to ensure the following:
      - Whether all the explanatory areas are completed,
      - Whether the NOABD issued was appropriate for the situation; and
      - Whether there are training needs identified.

2) Timelines for implementation and/or completion of corrective actions:

DBH developed the NOABD procedure May 3, 2019, and conducted the QM Quarterly Forum Training on the following dates:

- July 25, 2019
- July 29, 2019
- July 31, 2019
- August 1, 2019

The training topics included the following:

- Notice of Adverse Benefit Determination
- Utilizing NOABD letters to clients

DBH Inpatient Authorization Nurse Supervisor conducted training May 30, 2019, regarding the usage of the NOABDs and the responsibility to send to treatment providers and clients.

Therefore, DBH has completed the corrective action but will continue to monitor the effectiveness.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

DBH has the following evidence to demonstrate its completion of the corrective action:

- DBH policy: Notice of Adverse Benefit Determination (NOABD) Procedure QM6029-4
- QM Quarterly Forum Training Flyer
- QM Quarterly Forum Training power point
- QM Quarterly Forum sign in sheets
  - Dated July 25, 2019
  - Dated July 29, 2019
  - Dated July 31, 2019
  - Dated August 1, 2019
- 2019 Summer QM Quarterly Forum FAQs
- Inpatient Team Meeting Notes dated May 30, 2019
  - NOABD Payment Denial example utilized in the aforementioned meeting

4) Mechanisms for monitoring the effectiveness of corrective actions over time. *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

To monitor the effectiveness of the corrective action, DBH QM is completing the following actions:

- Reviewing all the NOABDs issued by DBH clinics, contract agencies and FFS providers;
- Reviewing to see if any program rendering services has not issued any NOABDs as this may be a training issue;
- Reviewing to see if the NOABD issued is correct for the situation, as early on QM identified this as an issue and directly trained those programs or providers;
- Reviewing to confirm that all explanatory areas of the NOABD are completed, as early on QM identified this as an issue and worked directly with the provider and immediate supervisor to correct; and

- Identifying any continued training issues that shall be addressed in a method that is conducive to providing documented evidence for audit purposes, such as web blasts, formal training, technical assistance via email, etc.

5) Description of corrective actions required of the MHP's contracted providers to address findings: DBH contracted providers were required to attend the QM Quarterly Forums to obtain up-to-date information. They are included in the sign-in sheets and have access to the DBH website where the procedure is posted as well as the FAQs. Should any of the agencies request further assistance, DBH can provide technical assistance regarding NOABDs which may be a training exclusively for the one agency, a question and answer session, or guidance on when a NOABD is needed, how to adequately document the reasoning behind the issuance of a NOABD and how to issue a NOABD to a client. Contracted providers' NOABDs are also reviewed by DBH QM as indicated in the prior section.

Section E-Coverage and Authorization of Services
I. Service Authorization Requirements

Requirement IH: 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).)

Finding: I.H- 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
b) The MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the beneficiary's interest.

Response:
Per MHSUDS IN No. 19-026 dated May 31, 2019, the MHP no longer requires authorizations for services to be provided to a beneficiary. Therefore, there is no need for extension based on a) the beneficiary or providers request or b) the need for additional information. These points are no longer applicable. Please see the attached IN#19-026.

Section E-Coverage and Authorization of Services
II. Day Program Authorizations

Requirement A1: The MHP requires providers to request payment authorization for day treatment intensive and day rehabilitation services: In advance of service delivery when day treatment intensive or day rehabilitation will be provided more than 5 days per week.

A2: The MHP requires providers to request payment authorization for day treatment intensive services at least every 3 months for continuation of Day Treatment.
A3: The MHP requires providers to request payment authorization for day rehabilitation services at least every 6 months for continuation of Day Rehabilitation.
A4: The MHP also requires providers to request authorization for additional SMHS provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions. These services are provided with the same frequency as he concurrent day treatment intensive or day rehabilitation services. (CCR, title 9, § 1810.227; CCR, title 9, § 1810.216 and 1810.253)

Finding: The MHP did not furnish evidence it requires providers to request authorization for additional SMHS provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions. These services are provided with the same frequency as the concurrent day treatment intensive or day rehabilitation services. DHCS reviewed the MHP's authorization policy and procedure…DHCS deems the MHP Out of-compliance with CCR, title 9, § 1810.227; CCR, title 9, § 1810.216 and 1810.253…

2) **Description of corrective actions, including milestones:** In accordance with DHCS MHSUDS Information Notice (IN) No. 19-026, DBH developed a written procedure regarding prior authorization for Day Rehabilitation and Day Treatment Intensive services; however, as indicated by DHCS, DBH has not received feedback regarding the procedure. In the reading of the aforementioned requirements and finding, DBH is cognizant that it may have misunderstood the requirement for additional Specialty Mental Health Services (SMHS) since the requirement is not indicated in MHSUDS IN 19-026, or needs clarification since the issuance of the IN is dated after its Triennial Review. Additionally, DBH determined the requirement was no longer existent since MHSUDS IN 19-026 clearly states the following services may not require prior authorization:
   - Crisis intervention;
   - Crisis Stabilization;
   - Mental Health Services;
   - Targeted Case Management;
   - Intensive Care Coordination; and
   - Medication Support Services.

Furthermore, since the recently issued MHSUDS INs indicate pursuant to WIC section 14197.1(b), DHCS has the authority to implement requirements via issuance of an IN in lieu of adopting regulations. Lastly, if the requirements of the IN conflict with CA Code of Regulations, Title 9, Chapter 11, federal regulations and state law reflected in the IN supersede those state regulations.

Therefore, DBH is respectfully requesting clarification if this finding is still applicable and if so, then it shall update its current procedure to clearly indicate that additional SMHS provided concurrently with day treatment intensive or day rehabilitation are needed for authorization.

3) **Timelines for implementation and/or completion of corrective actions:** DBH will update its current procedure within 30 days of a response from DHCS, clarifying if additional SMHS provided concurrently with day treatment intensive or day rehabilitation are needed.

4) **Proposed (or actual) evidence of correction that will be submitted to DHCS:** DBH is providing actual evidence of the current procedure, Authorization of Day Rehabilitation and Day Treatment Intensive Procedure, CLP0840, which remains in draft form until DHCS reviews its authorization policies.

5) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

DBH will monitor the effectiveness of this plan of correction (POC) as the only provider of Day Treatment Intensive and Day Rehabilitation is DBH and designated licensed staff from DBH QM division review and approve/deny the authorizations. Therefore, DBH can compare the billings of these services against the authorizations received to ensure all services were authorized, including any additional SMHS, if this is still required.

6) **Description of corrective actions required of the MHP's contracted providers to address findings**

This POC is not applicable to contracted providers as only DBH provides the services.

Section E: Coverage and Authorization of Services
III. Presumptive Transfer

REQUIREMENT III.A: The MHP shall have a comprehensive policy and procedure describing its process for timely provision of services to children and youth subject to Presumptive Transfer. (MHSUDS IN No., 17-032 **and 18-027)**

FINDING: The MHP must have a comprehensive policy and procedure describing its process for timely provision of services to youth subject to Presumptive Transfer

1) **Description of corrective actions, including milestones:**

   SB DBH has a comprehensive practice for timely provision of services to youth subject to Presumptive Transfer. The policy and procedures for this practice have been incorporated into the following policy and procedure documents: Providing Services to Foster Care, Adoption Assistance (AAP), and Kinship Guardianship Assistance Payment (KinGAP) Children Placed Out-of-County Policy and Providing Services to Out of County Foster Care Children Procedure. These documents were submitted for publication to the Office of Compliance in June 2020.

2) **Timelines for implementation and/or completion of corrective actions:**

June 2020 - Final drafts submitted to Quality Management

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**

Published versions of the Providing Services to Foster Care, Adoption Assistance (AAP), and Kinship Guardianship Assistance Payment (KinGAP) Children Placed Out-of-County Policy and Providing Services to Out of County Foster Care Children Procedure Policy which include the procedures for the provision of AB 1299 services will be submitted to DHCS for review

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

   Children and Youth Collaborative Services (CYCS) will monitor the accuracy of the policy and procedures for timely provision of services to children and youth subject to Presumptive Transfer. If the policy and/or procedure become out of date, CYCS will revise the policy and/or procedure as needed and re-submit to the Office of Compliance for review.

5) **Description of corrective actions required of the MHP's contracted providers to address findings**
   No corrective actions are required from the MHP contract providers at this time.

Section E: Coverage and Authorization of Services
III. Presumptive Transfer

REQUIREMENT:

IIID. 1) The MHP shall provide evidence of a single point of contact or a unit with a dedicated phone number and/ or email address for the purpose of Presumptive Transfer.
2) The MHP shall provide evidence the contact information is posted to its public website.

FINDING: The MHP must provide evidence of a single point of contact or unit with a dedicated phone number/email address for the purpose of Presumptive Transfer.

1) **Description of corrective actions, including milestones:**

In January 2020, Children and Youth Collaborative Services (CYCS) became the DBH unit responsible for managing the AB 1299 process for the MHP. In this role, the dedicated phone number and address for the purpose of Presumptive was re-established on the DBH public and the DHCS Websites.

2) **Timelines for implementation and/or completion of corrective actions:**

- January 2020 – CYCS assumed sole responsibility for AB 1299 Presumptive Transfer and Waiver Process for the San Bernardino County MHP
- May 2020 – CYCS obtained the dedicated phone number from Information Technology
- May 2020 - The DBH Website update was completed
- May 14, 2020 - DBH requested that the CDSS update the AB 1299 Website
- June 15, 2020 - CYCS will follow to check the status of the updated contact information

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**

SB DBH Website Link -- http://wp.sbcounty.gov/dbh/mental-health-services/children-youth/cycs/ooc/

Screenshot documentation is also provided.

CDSS Website:

https://www.cdss.ca.gov/inforesources/foster-care/presumptive-transfer/county-points-of-contact

AB1299PresumptiveTransfer@prob.sbcounty.gov

Copy of email sent by Marina Espinosa, Deputy Director DBH, sent on May 14, 2020. (Provided)

The CDSS Website currently continues to show the ACCESS contact which continues to an active working contact. Marina Espinosa, Deputy Director of Program Support Services, sent an email on May 14, 2020 and June 4, 2020 to update the site. CYCS will monitor the site for the update. A CDSS representative responded on June 4, 2020 advising the update will be made as soon as possible but as of June 26, 2020, the site was still not updated.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

The contact information will be maintained as long as the AB 1299 Legislation is in effect.

5) **Description of corrective actions required of the MHP's contracted providers to address findings**

There are no actions required of DBH's contract providers at this time.

Section E – Coverage and Authorization of Services
V. – Second Opinions

REQUIREMENT: A - The MHP provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

AND

B - At the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, §.1810.405(e)).

FINDING: A - The MHP did not furnish evidence it complies with (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b))…While the MHP provided evidence to meet this requirement. The evidence does not address the beneficiaries' option to obtain a second opinion outside of the network at no cost to the beneficiary… DHCS deems the MHP Out of-Compliance with (MHP Contract, Ex. A, Att. 2, 42 C.F.R. § 438.206(b))…

AND

B - The MHP did not furnish evidence it complies with MHP Contract, Ex. A, Att.2; CCR, title 9,§.1810.405(e)…While the MHP submitted evidence for this requirement. The MHP's Service Availability Policy identifies only that the MHP will provide a second opinion if requested. The Second Opinion Internal Policy outlines the counties process related to 2nd opinions requested or ordered from a judge but does not explain that it can be requested by a beneficiary or network provided or who can provide the second opinion or under what circumstances. The evidence provided did not meet the requirements… DHCS deems the MHP Out of-Compliance with ((MHP Contract, Ex. A, Att.2; CCR, title 9, §.1810.405(e))…

1) **Description of corrective actions, including milestones:** The Department of Behavioral Health (DBH) Quality Management (QM) Division acknowledges all evidence may not have been provided or received regarding the finding for B, regarding second opinion if a client does not meet medical necessity. However, to ensure it addresses both findings, DBH has developed several strategies to address Second Opinions, which include the following:

   - Revise its Request for Second Opinion form, QM048 to include the following updates:
     - Ability for clients to obtain a second opinion outside of the network at no cost;
     - Ability for clients to request a second opinion if they do not meet the medical necessity criteria and are not entitled to Specialty Mental Health Services (SMHS); and
     - Ability to have designated licensed mental health professional provide a second opinion.
   - Develop a Request for Second Opinion Procedure that will address requirements as indicated in the MHP Contract, Exhibit A, Attachment 2; 42 C.F.R. § 438.206(b); and 9 CCR §.1810.405(e).
   - Post the new Second Opinion procedure via the Announcements section of the DBH website for use by DBH staff, contract agencies and Fee For Service (FFS) providers. Additionally, the procedure will be published to DBH's Standard Practice Manual (SPM), which is accessible to all DBH staff, contract providers, FFS providers and the public.
   - Send an email to all contracted agencies and another targeted email to FFS providers advising of the new form and procedure.

2) Timelines for implementation and/or completion of corrective actions:

To implement the aforementioned steps, DBH Program Support Services (PSS) will complete the following items within the associated timeframes:

- Complete updates to the Request for Second Opinion on or before July 31, 2020;
- Draft the Request for Second Opinion Procedure no later than August 31, 2020;
- Forward the draft procedure to the DBH Office of Compliance who are responsible for finalizing policies and procedures and posting said policies and procedures by September 4, 2020;
- Post the procedure on the SPM no later than October 31, 2020;
- Publish the Announcements section of the DBH website no later than November 30, 2020. The DBH Announcements section is updated weekly (usually at the beginning of the week). The Announcements section reports Department announcements including policy, procedure and form revisions and is accessible to all staff, contract agencies, FFS providers and the public; and
- Send notices issued to DBH clinics, contract agencies and FFS providers requiring removal of the old Request for Second Opinion form from clinic lobbies and replace it with the newly revised form immediately following publishing of the form no later than November 30, 2020.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

DBH shall submit the following proposed evidence:

- Updated Request for Second Opinion form;
- Newly created Request for Second Opinion Procedure;
- Screenshot of the posted Request for Second Opinion Procedure on the SPM;
- Screenshot of the Announcements section of the DBH webpage; and
- Copy of the notice sent to DBH clinics, contract agencies and FFS providers advising to replace the form from the lobbies of their respective clinics/programs/practices.

4) Mechanisms for monitoring the effectiveness of corrective actions over time. *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

DBH QM is responsible for monitoring the effectiveness of the corrective actions for this POC, and will take the following actions:

- Review the incoming second opinion request forms to ensure the correct form is being utilized;
- Review the number of second opinion forms to determine if the number of requests have increased or decreased and possibly to create a baseline;
- Evaluate need for online training to explain the purpose of the Request for Second Opinions forms and procedure.

5) Description of corrective actions required of the MHP's contracted providers to address findings:

DBH contracted agencies and FFS providers will be required to utilize the updated forms and adhere to the procedure, once developed. The following outline their responsibility:

- Read and adhere to the email that will be issued no later than November 30, 2020, regarding the updated form and new procedure;
    - Adherence with the requirements includes the following:
        - Use of the updated Request for Second Opinion form with changes to the name of their agency or private practice;
        - Follow the procedure; and

- Failure to adhere to use of the new form and new procedure may result in technical assistance or a corrective action plan.

Section E-Coverage and Authorization of Services
VI. – Judicial Council Forms

REQUIREMENT A: The MHP maintains policies and procedures ensuring an appropriate process for the management of Forms JV 220, JV 220(A), JV 221, JV 222, and JV 223 and that related requirements are met. (Judicial Council Forms, 219)

FINDING: The MHP did not furnish evidence it complies with this requirement. DHCS reviewed the documentation presented by the MHP as evidence of compliance:

- Sample of completed forms

The requirements specifically identities the MHP must have policies and procedures for this requirement. MHP plan did not provide evidence of compliance.

1) Description of corrective actions, including milestones:

The Department of Behavioral Health (DBH) has implemented a policy that addresses DHCS's requirement for the management of JV 220 forms, *Medication Authorization for Dependent Children and Youth Policy.* It is the department's policy that all DBH staff or contractor psychotropic medication prescribers, must obtain approval by the Commissioner of the Juvenile Court prior to prescribing or renewing psychotropic medications for a child or youth who is a ward or dependent of the Juvenile Court and living in an out of home placement or foster care, as defined in Welfare and Institutions Code § 724.4.
Staff responsible for prescribing psychotropic medications must complete the following actions when prescribing or renewing a prescription for dependent children and youth:

- Examine the child/youth face to face, review all medical records, and complete the appropriate JV 220 form.
- Follow the process for submitting the completed form(s) to the Juvenile Court for filing in coordination with CFS staff.
- Place a copy of the completed form(s) in the child/youth's medical record once it is filed with the court.
    - The following filed forms are saved in the child/youth's medical record upon receipt from the Juvenile Court: JV 220A, JV 220B, JV 221, JV-222 (if applicable) and the JV 223.
- When psychotropic medications are administered in an emergency, the appropriate JV 220 forms will be completed and filed with the Juvenile Court no more than two court days after the administration of emergency medication.

2) Timelines for implementation and/or completion of corrective actions:

The department implemented the *Medication Authorization for Dependent Children and Youth Policy* in March 2018. All psychotropic medications for dependent children/youth have been prescribed following this policy starting from the implementation date.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

DBH is submitting **MDS2029**: *Medication Authorization for Dependent Children and Youth Policy.*

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

DBH will take the following actions to monitor the effectiveness of its JV 220 policy:

- Continue to monitor DHCS policy on the administration of psychotropic medication for dependent children and youth and update the DBH policy accordingly.
- Continue to monitor Superior Court forms to ensure the most current JV 220 forms are used.
- Continue participating in CBHDA and its respective workgroups/subcommittees that focus on behavioral health treatment for dependent children/youth.

5) **Description of corrective actions required of the MHP's contracted providers to address findings.**

There are no corrective actions required from DBH's contract or fee-for-service providers at this time, however the department will continue to advise of the current policy and proper forms to use in adherence.

Section F-Beneficiary Rights and Protections
II. Handling Grievances and Appeals

Requirement –II.A.1-The MHP shall adhere to the following record keeping, monitoring, and review requirements: 1) 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. (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).)

Finding: The MHP did not furnish evidence it complies with (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).) The MHP must ensure that all grievances, appeals, and expedited appeals are logged within one working day of receipt of the grievance, appeal or expedited appeal.

While the MHP submitted evidence to demonstrate compliance with this requirement, the evidence did not validate that all grievances, were logged within one working day of the date of receipt of the grievance. A sample of 52 grievances were reviewed for FY 16/17 and 17/18. Five (5) out of the fifty two (52) grievances were not logged within one working day of receipt.

1) **Description of corrective actions, including milestones:**
Quality Management Utilization supervisors and staff will monitor at least weekly to ensure adherence to the service protocol for compliance in logging grievances and appeals within one working day of receipt.

2) **Timelines for implementation and/or completion of corrective actions:**
Since September 2019, Quality Management staff have conducted weekly meetings with supervisory staff to review the Grievances and Appeals to ensure that they are logged within one working day and resolved within the required timeframe. Additional training is also provided as needed during this weekly meeting in order to maintain compliance with regulatory guidelines. Corrective feedback and training will continue be provided to staff on an individual basis as needed.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
The Grievance and Appeals Database is currently being created in collaboration with IT. Updated technology will be available (August 2020) which will increase the effectiveness in which grievances and appeals are able to be logged. This database will also provide electronic documentation as to when grievances and appeals were entered in, better allowing supervisors to ensure staff are inputting within one working day. (Grievance and Appeals Database Project Plan is attached)

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

The new Grievance and Appeal Database (August 2020) will also allow for more effective logging of grievances and appeals as well as improve the ability for supervisors to monitor the appeals and grievances to ensure compliance with required time frames. This database will be able to alert supervisors and staff when the time frames such as the initial log of the grievance or appeal are not in compliance. Monthly reports will be generated to include this data. Supervisors will issue reports to staff when non-compliance is observed and provide additional training and observation. Ensuring that appeals and grievances are logged within one working day of receipt will continue to be monitored on a weekly

basis during grievance and appeals meetings between supervisors and staff.

5) Description of corrective actions required of the MHP's contracted providers to address findings

DBH maintains the grievance and appeal log and expedited appeals; therefore, no action by the contractors is required. However, during QM Quarterly Forums, programs are provided an update on grievances and appeals for the previous quarters. Trends are identified and discussed. Additionally, programs are advised that they need to submit grievances timely.

Section F Beneficiary Rights and Protections
III. Grievance Process

Requirement: F. III. B-Resolve each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (42 C.F.R. § 438.408(a)-(b)(1).)

Finding: While the MHP submitted evidence to demonstrate compliance with this requirement, the evidence did not demonstrate that grievances were resolved expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the contractor receives the grievance.
A sample of fifty two (52) grievances were reviewed. Three (3) out of the (52) reviewed were resolved outside of the timeframe required. Review process included identifying and reviewing samples within timeframes before and after the issuance of MHSUDS Info Notice 18-010.

1) **Description of corrective actions, including milestones:**

   On a weekly basis, Quality Management supervisor/manager will monitor adherence to the service protocol for compliance in resolving each grievance expeditiously; not to exceed 90 days from the date of receipt. Additional training and corrective actions will continue to be provided by staff to increase efficiency in adhering to this service protocol.

2) **Timelines for implementation and/or completion of corrective actions:**
   Since September 2019, Quality Management staff have conducted weekly meetings with supervisory staff to review grievances and to ensure that they are resolved as soon as possible and do not extend past the required timeframe. Additional training is also provided as needed during this weekly meeting to maintain compliance with regulatory guidelines. Individual corrective feedback and training will continue to be provided as needed.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
   The Grievance and Appeals Database is currently being created in collaboration with IT and will replace the current Grievance Log as well as the Appeal Log. Updated technology will be available (August 2020) which will increase the timeliness in which grievances are able to be resolved. This database will also provide electronic documentation and track the date grievances and appeals were received, better allowing supervisors to monitor and ensure grievances are resolved expeditiously within 90 days.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
   The new Grievance and Appeal Database (August 2020) will allow for more effective logging and tracking of grievances which will provide supervisors with better monitoring methods to ensure compliance within required time frames (90 days). This database will be able to alert supervisors and staff at different intervals within the 90 days to remind when grievances are due, which will assist with meeting required timeless. Monthly reports will be generated to include this data. Supervisors will issue reports to staff when non-compliance is observed and provide additional training and observation. This will continue to be monitored on a weekly basis during Grievance and Appeals meetings between supervisors and staff.

5) Description of corrective actions required of the MHP's contracted providers to address findings

DBH maintains the grievance and appeal log and expedited appeals; therefore, no action by the contractors is required. However, during QM Quarterly Forums, programs and contract providers are provided an update on grievances and appeals for the previous quarters. Trends are identified and discussed. Additionally, programs are reminded to submit grievances in a timely manner.

Section F. Beneficiary Rights and Projections

IV. Appeals Process

Requirement IV.C- The MHP provides notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. (CCR, title 9, § 1850.205(d)(6)).

Finding- The MHP did not furnish evidence it complies with (Cal. Code Regs., tit. 9, § 1850.205(d)(6).) The MHP must provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.
While the MHP submitted evidence to demonstrate compliance with this requirement, the evidence did not identify that the provider received written notice of the final disposition of the beneficiary's grievance.
DHCS deems the MHP out-of-compliance with (Cal. Code Regs., tit. 9, § 1850.205(d)(6). The MHP should adopt the practice of sending disposition notices to beneficiaries that utilize the grievance and appeals systems.

The MHP must complete a POC addressing this finding of non-compliance.

1) **Description of corrective actions, including milestones:**

   The Quality Management supervisor/manager will conduct weekly meetings with staff to monitor adherence to the service protocol for compliance as required in the Appeals Process, including providing written notice to any providers identified in the appeal. During these meetings, additional training and corrective actions will also be implemented as required. In November 2019, staff were provided training and process flows regarding the Appeals Process in regards to required steps and timeframes.

2) **Timelines for implementation and/or completion of corrective actions:**

   When a grievance or appeal is received, the provider shall be contacted and notified in writing of the grievance or appeal within five working days. Providers will be notified in writing of expedited appeals within one business day. Providers will be notified of the final resolution in writing at the conclusion of the appeal.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**

   When a grievance or appeal is completed and resolved providers will be receive a resolution letter within the indicated time frames to maintain compliance and regulatory guidelines. The new Grievance and Appeal Database (August 2020) will allow for more effective logging and tracking of grievances which will provide supervisors with better monitoring methods to ensure compliance within required time frames for appeals and expedited appeals. This database will be able to alert supervisors and staff at different intervals as reminders of deadlines for different steps within the appeal process. This will assist with meeting required timeless. Monthly reports will be generated to include this data. Supervisors will issue reports to staff when non-compliance is observed and provide additional training and observation. This will continue to be monitored on a weekly basis during Grievance and Appeals meetings between supervisors and staff.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*

The Grievance and Appeals Database is currently being created in collaboration with IT. Updated technology will be available (August 2020) which will increase the effectiveness in which grievances and appeals are able to be processed. This database will also provide electronic documentation of the date that specific steps within the process were complete. Therefore, the database will track and therefore report the date providers were notified of the grievance and appeals. This will allow supervisors to more efficiently monitor notification to providers.

5) **Description of corrective actions required of the MHP's contracted providers to address findings**

DBH maintains the grievance and appeal log and expedited appeals; therefore, no action by the contractors is required. However, during QM Quarterly Forums, programs and contract providers are provided an update on grievances and appeals for the previous quarters. Trends are identified and discussed. Additionally, programs are reminded to submit grievances in a timely manner.

Section G: Program Integrity
I. Compliance Program

REQUIREMENT: I.B4. A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)

FINDING: The MHP did not furnish evidence it complies MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1). The MHP must provide a system for training and education for the Compliance Officer (CO)…the MHP has not identified sufficient evidence in support of training and education specific for the CO…[w]hile the MHP submitted evidence to demonstrate compliance with this requirement, the evidence did not substantiate that the current CO attended training or that there is a specific training plan for the current CO. DHCS deems the MHP out-of-compliance with MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).

1) **Description of corrective actions, including milestones:** DBH acknowledges the evidence provided by DBH Quality Management (QM) for the Triennial Review was only a partial submission of the trainings the Chief Compliance Officer attended for the three (3) year review period.

DBH prides itself in having Compliance Officers certified in healthcare compliance by the Health Care Compliance Association (HCCA) for the past 13 years (prior Chief Compliance Officers, CaSonya Thomas and Marina Espinosa). The most recent Chief Compliance Officer, Ms. Erica Porteous, became the compliance officer in November 2017 and became Certified in Healthcare Compliance (CHC) by the Compliance Certification Board(CCB) in association with HCCA in April 2018.

In order to be eligible to complete the CCB examination, a compliance professional must meet one of the following work experience criteria:

- At least one (1) year work experience in a full-time compliance position, or
- Have 1,500 hours of direct compliance job duties earned in the two (2) years preceding the application date, or
- Successfully completed a certificate program from a CCB-accredited university within the last two (2) years and within twelve (12) months of completing the university program.

Additionally, the compliance professional must attend and submit 20 CCB approved continuing education units (CEUs) to take the CCB examination. For the 20 CEUs, a minimum of 10 must be from attending a live training that is a face-to-face training or real-time web conferences, and be completed within the twelve (12) month period prior to the date of the exam.

Once certification is achieved, the compliance professional must maintain 40 CCB CEUs every two (2) years for certification renewal. Since Ms. Porteous has been certified since April 2018 and Ms. Espinosa has been CHC certified since May 2008, the DBH compliance officer training and education requirement has been met for 2017-2019 as required by the MHP Contract and 42 C.F.R. Section 438.608(a)(1). Please note, Ms. Marina Espinosa is currently the DBH Program Support Services (PSS) Deputy Director; and both Ms. Espinosa and Ms. Porteous are members of the MHP's Executive Management Team.

For the corrective action, the DBH Chief Compliance Officer, or designee, shall submit the completed training to DBH QM on an annual basis to ensure DBH maintains sufficient documentation and evidence

for future submission during Triennial Reviews.

2) **Timelines for implementation and/or completion of corrective actions:** DBH QM will begin requesting proof of completed Compliance Officer training(s) at the end of each fiscal year to ensure maintenance of sufficient evidence. The first request for documentation is scheduled for August 2020, and subsequent requests will occur the same month each year thereafter. The training and education evidence will be stored in the DBH QM Triennial folder in preparation, and available, for the following Triennial Review period. Additionally, QM and the Chief Compliance Officer will collaboratively review evidence submitted by DBH Compliance designees on a regular basis, to ensure all applicable evidence is actually submitted to DHCS to demonstrate compliance.

3) **Proposed (or actual) evidence of correction that will be submitted to DHCS:**
Actual evidence 07/2017 - 06/2019:
- CA Privacy, Security and Compliance Officials' CaPSCO Quarterly Roundtable, dated 11/16/17
- HCCA 22nd Annual Compliance Institute, dated 4/15-18,2018
- CIBHS 18th Annual Behavioral Health Informatics Conference and Exposition, dated 05/02-03, 2018
- CA Privacy, Security and Compliance Officials' CaPSCO Quarterly Roundtable, dated 8/16/2018
- CA Privacy, Security and Compliance Officials' CaPSCO Quarterly Roundtable, dated 02/21/2019
- CalQIC 2019, dated 03/13-15, 2019
- HCCA 23rd Annual Compliance Institute, dated 04/07-10, 2019
- HCCA CHC Certification for Erica Porteous

Actual evidence 07/2019 – 06/2022:
- AAPC Seattle Regional Conference, dated 10/14-16, 2019
- California Hospital Association (CHA): Behavioral Health Symposium, dated 12/9 – 10, 2019
- HIPAA Changes 2020 – What's New?, dated 11/26/2019
- OIG Work Plan & Other Federal Compliance Guidelines – 2019 Mid-Year Update, dated July 30, 2019
- Introduction to Confidentiality: 42 CFR Part 2 & HIPAA, dated 08/21/19

Lastly, DBH has a current policy, Compliance Plan Policy, COM0934, to which it abides where it states and requires training and education of the Chief Compliance Officer, specifically page 4.

4) **Mechanisms for monitoring the effectiveness of corrective actions over time.** *If at any time the POC is determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.*
To monitor the effectiveness of this corrective action, DBH QM will maintain a count of the number of CEUs received by Compliance as it should receive proof for 40 CEUs every two (2) years or an estimated 20 CEUs each fiscal year.

5) **Description of corrective actions required of the MHP's contracted providers to address findings:**
This corrective action is not applicable to DBH contracted providers.