Sonoma County Behavioral Health

Fiscal Year 19/20 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

This is the Corrective Action Plan (CAP) for the Department of Health Care Services' (DHCS) 2019-20 review of the Sonoma County Mental Health Plan.

Requirement: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

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

DHCS Finding Question A.III.F

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a current contract to provide TFC services, nor does it have evidence of an RFP to enlist eligible providers. During the facilitated discussion, the MHP indicated it would follow up with the DHCS County Liaison to inquire about local TFC contractors for single case agreements. The MHP also discussed its plans to release an RFP for TFC providers by the end of the 20/21 Fiscal Year. The MHP did not submit any further evidence of the RFP or its ability to provide single case agreements.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must complete a CAP addressing this finding of non-compliance.

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Corrective Action Description

Youth and Family Services (YFS) Section Manager met with Human Services Department (HSD) on July 22, 2021 to discuss a plan for securing TFC services. During this meeting, an agreement was made that HSD and DHS-BHD will engage in a joint Manager will develop a plan for collaborating to ensure that TFC services are available

and provided to eligible Sonoma County Medi-Cal beneficiaries. In the absence of a contracted TFC provider, DHS-BHD will utilize single-case agreements to ensure that necessary TFC services are provided to eligible beneficiaries. Once a Foster Family Agency (FFA) has been selected for TFC services, the YFS Section Manager will ensure that the scope of work for the contracted providers include all required elements for TFC service delivery. The YFS Section Manager is responsible for monitoring any/all contracts for TFC services.

In order to ensure proper screening for TFC services, the YFS Section Manager and QA Manager will revise the ICC/IHBS/TFC screening tool to reflect current eligibility criteria. The YFS Section Manager will ensure that all appropriate clinical staff are trained to use the revised ICC/IHBS/TFC screening tool, including when to administer the screening. To support proper administration of the screening tool, the YFS Section Manager will establish a workflow to ensure that the ICC/IHBS/TFC screening tool is being used at the time of assessment and reassessment for appropriate aged clients.

To ensure ongoing care coordination and that TFC referrals are made when indicated, the Foster Youth Team (FYT) Program Manager will attend weekly Placement Assessment Resource Committee (PARC) meetings. Additionally, the YFS Section Manager will conduct monthly spot checks of ICC/IHBS/TFC screenings to monitor appropriate usage. On a monthly basis the FYT Program Manager will run the TFC service report to ensure proper coordination of TFC services.

Proposed Evidence/Documentation of Correction

1. DHS-BHD meeting minutes with HSD to determine TFC service pathway
2. Contracts/agreements/RFP with TFC providers
3. Revised ICC/IHBS/TFC Screening tool
4. DHS-BHD Staff Training Documents – ICC/IHBS/TFC screening tool use and administration
5. Sample of monthly ICC/IHBS/TFC screening spot checks
6. Documentation of DHS-BHD monitoring of all TFC contracts
7. Documentation of DHS-BHD participation in PARC meeting

Ongoing Monitoring (if included)

1. Monthly spot checks to monitor appropriate use of ICC/IHBS/TFC screening tool
2. Monthly attendance of PARC meetings to ensure appropriate TFC service coordination.

Person Responsible (job title)

1. FYT Program Manager
2. FYT Program Manager

Implementation Timeline:

DHS-BHD and HSD will release a joint RFP by November 30th, 2021, in the interim effective immediately, single-case agreements will be used to obtain TFC services when necessary. TFC services will be available to eligible Sonoma County Medi-Cal clients by January 31st, 2022.

The YFS Section Manager and QA Manager will revise and issue the ICC/IHBS/TFC screening tool by August 31st, 2021. The YFS Section Manager will convene a Youth and Family section meeting by September 30th, 2021 to provide YFS and Transition Aged Youth (TAY) staff training covering the revised ICC/IHBS/TFC screening tool and screening tool administration requirements. The YFS Section Manager will provide the same training to all other necessary staff by September 30th, 2021.

By October 29th, 202, the FYT Program Manager will begin conducting monthly ICC/IHBS/TFC screening tool spot checks. The FYT Program Manager is regularly attending weekly PARC meetings and will do so ongoing to ensure proper care coordination and TFC referrals, as necessary.

Requirements: ACCESS AND INFORMATION REQUIREMENTS

The MHP must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: 1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county; 2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met; 3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition; and 4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

DHCS Finding D.VI.B

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The toll-free telephone number provides information to beneficiaries about 1) how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met; 2) services needed to treat a beneficiary's urgent condition; and 3) provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

TEST CALL #2

The test call was placed on Monday, October 21, 2019, at 7:29 a.m. The call was answered after one (1) ring via phone tree, which provided the caller with the option to dial 9-1-1 in an emergency. The recorded message informed the caller to stay on the line to speak to a counselor for non-emergency calls. The caller quickly reached a live operator who identified herself as Rebecca. The caller asked for assistance with what he/she described as overwhelming sadness and despair that was not going away on its own. The operator asked the caller questions including assessing the need for urgent and crisis care. The operator asked for personally identifying information. The operator offered to leave a message on behalf of the caller so that he/she would receive a return call for an assessment during regular business hours. The operator provided information on the 24/7 access line and reassured the caller that he/she could call and receive talk therapy and support at any time. The caller was not provided information about how to access Specialty Mental Health Services (SMHS), including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

Corrective Action Description

To ensure compliance with the requirement for phone operators to provide information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, the QI Manager will convene a meeting with Optum. During this meeting the QI Manager will review the current after-hours phone operator script, with an emphasis on the need to provide information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. Additionally, Optum will conduct a staff training to ensure that phone operators read the script in full every time.

Ongoing, the QI Manager will continue to conduct DHS-BHD test calls on a quarterly basis. Quarterly test call results will be reviewed and analyzed to determine training needs. As necessary, the QI Manager will coordinate with Optum to ensure trainings are provided based on test call results.

Proposed Evidence/Documentation of Correction

1. Current after-hours phone operator script sent to Optum (e-mail)
2. Meeting minutes with Optum reviewing the current after-hours phone operator script
3. Optum training documents

Ongoing Monitoring (if included)

1. Utilize existing quarterly test call monitoring (submitted to DHCS)

Person Responsible (job title)

1. QI Manager/Optum Staff

Implementation Timeline:

The QI Manager convened a meeting with Optum on 7/27/21 to review and provide the current after-hours phone operator script and associated requirements. Optum will conduct a staff training within 30 business days from the July meeting. The QI Manager will obtain evidence of Optum training within 10 business days of the Optum staff training. Additionally, the QI Manager will meet with Optum staff in October 2021 to review test call finding in order to monitor for any ongoing call deficiencies.

TEST CALL #4

The test call was placed on Friday, October 18, 2019, at 1:31 p.m. The call was answered via phone tree directing the caller to select a language option, which included the MHP's threshold languages. The caller then heard a recorded greeting, instructions to call 9-1-1 in an emergency. After reaching the operator, the caller requested information about obtaining a refill for anxiety medication although he/she had not yet established a care provider in the county. The operator asked the caller if he/she were in crisis or danger. The caller responded in the negative. The operator informed the caller that he/she could provide their name and telephone number and someone would call them back. No additional information about SMHS was provided to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

Corrective Action Description

To ensure compliance the requirement for phone operators to provide information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, the QI Manager will convene a meeting with Access Program Managers. During this meeting, the QI Manager will review the current Automatic Call Distributor (ACD) line operator script emphasizing the need to provide information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. Additionally, the Access Program Manager will conduct a DHS-BHD staff training to ensure that ACD line phone operators read the script in full every time.

Ongoing, the QI Manager will continue to conduct DHS-BHD test calls on a quarterly basis. Quarterly test call results will be reviewed and analyzed to determine training needs. As necessary, the QI Manager will coordinate with Access Program Manager to ensure trainings are provided based on test call results.

Proposed Evidence/Documentation of Correction

1. Current ACD line operator script to Access staff
2. Meeting minutes with Access staff reviewing the current ACD line operator script
3. ACD Line Operator training documents

Ongoing Monitoring (if included)

1. Utilize existing quarterly test call monitoring (submitted to DHCS)

Person Responsible (job title)

1. QI Manager/Access Program Managers

Implementation Timeline:

On 7/29/21, the QI Manager convened a meeting with Access Program Managers to review and provide current ACD line operator script and associated requirements. The Access Program Managers will conduct an ACD operator training with appropriate Access staff within 30 business days from the July 2021 meeting. QI Manager will obtain evidence of Access staff training within 10 business days of the Access staff training.

TEST CALL #5

The test call was placed on Wednesday, August 28, 2019, at 7:18 am. The call was answered immediately via phone tree, which instructed the caller to hang up and dial 9-1-1 in an emergency. The caller was given other options after selecting language preference and was transferred to speak to an operator. Upon transfer, the phone rang 16 times without an answer. After the sixteenth ring, the caller disconnected. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

Corrective Action Description

The QI Manager will review 3 months of Optum Summary reports to determine if there is a pattern to the identified issued (call dropped). The QI Manager will meet with Optum staff to review the call disconnection in order to research any technical issues specific to this call and determine if any further action is required. Ongoing, QI Manager will review the monthly Optum Summary report to monitor for recurring call disconnection issues and address issues with Optum if any arise.

Proposed Evidence/Documentation of Correction

1. Optum Meeting Minutes
2. Findings related to the specific call issues
3. Confirmation of no required process change, or evidence of implementation of process change
4. 3 months of Optum Summary reports

Ongoing Monitoring (if included)

1. Ongoing review of monthly Optum Summary report to monitoring issue

Person Responsible (job title)

1. QI Manager/Optum Staff

Implementation Timeline:

To determine the source of the technical issue, the QI Manager convened a meeting on 7/27/21 with Optum staff to review details about the call deficiency and identify next steps, including any necessary process changes. During this meeting, it was noted that power outages related to a natural disaster were a frequent occurrence during the time the test calls were made.

Optum will research the source of the problem and share the findings with the QI Manager. If required, implementation of any identified process changes will occur within 30 business days from the July 2021 Optum meeting. Additionally, the QI Manager will meet with Optum staff in October 2021 to review test call finding in order to monitor for any ongoing call deficiencies.

TEST CALL #6

The test call was placed on Tuesday, October 15, 2019, at 4:18 pm. The call was answered via phone tree that directed the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller heard a recorded greeting and instructions to call 9-1-1 in an emergency. The caller was placed on hold for a little over one minute while the call was transferred to a live operator. The caller requested information on how to file a complaint about a therapist he/she was seeing through the county. The operator instructed the caller to hang up, dial a different telephone number, and ask for the patient's right advocate. No additional information was provided. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

FINDING

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

Corrective Action Description

To ensure callers are properly informed of the DHS-BHD beneficiary problem resolution process, the QI Manager will convene a meeting with Access Program Managers. During this meeting, the QI Manager will review the beneficiary problem resolution

component of the script and the requirement to provide this information during every call. The Access Program Manager will conduct a training for DHS-BHD Access to ensure proper use of the beneficiary problem resolution section of the script.

Ongoing, the QI Manager will continue to conduct DHS-BHD test calls on a quarterly basis. Quarterly test call results will be reviewed and analyzed to determine training needs. As necessary, the QI Manager will coordinate with the Access Program Manager to ensure trainings are provided based on test call results.

Proposed Evidence/Documentation of Correction

1. Current ACD line operator script to Access staff
2. Meeting minutes with Access staff reviewing the current ACD line operator script
3. ACD Line Operator training documents

Ongoing Monitoring (if included)

1. Utilize existing quarterly test call monitoring (submitted to DHCS)

Person Responsible (job title)

1. QI Manager/Access Program Managers

Implementation Timeline:

On 7/29/21, QI Manager convened a meeting with Access Program Managers to review and provide the current ACD line operator script and associated requirements. The Access Program Managers will conduct an ACD operator training with appropriate Access staff within 30 business days from the July 2021 meeting. The QI Manager will obtain evidence of Access staff training within 10 business days of the Access staff training.

TEST CALL #7

The test call was placed on Thursday, October 17, 2019, at 7:22 a.m. The call was answered after one (1) ring via phone tree. The phone tree directed the caller to select a language option, which included the MHP's threshold languages. A recorded greeting provided instructions to call 9-1-1 in an emergency before the caller was placed on hold to wait for a live operator. The caller waited on hold for approximately one minute before reaching a live operator. The caller requested information on how to file a complaint about a county referred therapist. The operator asked the caller for his/her personally identifying information, including name and phone number. The caller declined to provide this information and again requested information on how to file a complaint. The operator asked for information about the provider, but the caller declined to provide the information over the phone. The operator then placed the caller on hold. The call was

disconnected approximately 30 seconds after being placed on hold. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

FINDING

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

Corrective Action Description

The QI Manager will meet with Optum staff to review call disconnection with Optum in order to research any technical issues specific to this call and determine if any further action is required. Ongoing, QI Manager will review the monthly Optum Summary report to monitor for recurring call disconnection issues and address issues with Optum if any arise.

Proposed Evidence/Documentation of Correction

1. Provide 3 months' worth of Optum summary reports
2. Any findings related to the specific call

Ongoing Monitoring (if included)

1. Ongoing review of monthly Optum Summary report to monitoring issue

Person Responsible (job title)

1. QI Manager/Optum Staff

Implementation Timeline:

To determine the source of the technical issue, the QI Manager convened a meeting on 7/27/21 with Optum staff to review details about the call deficiency and identify next steps, including any necessary process changes. During this meeting, it was noted that power outages related to a natural disaster were a frequent occurrence during the time the test calls were made.

Optum will research the source of the problem and share the findings with the QI Manager. If required, implementation of any identified process changes will occur within 30 business days from the July 2021 Optum meeting. Additionally, the QI Manager will meet with Optum staff in October 2021 to review test call finding in order to monitor for any ongoing call deficiencies.

Requirements: ACCESS AND INFORMATION REQUIREMENTS

The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f).

DHCS Finding D.VI.C

The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request.

While the MHP submitted evidence to demonstrate compliance with this requirement, four of five required DHCS test calls were not logged on the MHP's written log of initial request.

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f).

The MHP must comply with CAP requirement addressing this finding of partial compliance.

Repeat deficiency Yes

Corrective Action Description

To ensure proper logging of initial requests for service calls, the QI Manager convened a meeting with Access Program Managers and Optum leadership (7/29/21) to review call log requirements. Optum and Access staff will provide Call Log trainings to phone operators to ensure that all calls are logged appropriately.

Ongoing, the QI Manager will continue to conduct DHS-BHD test calls on a quarterly basis. Quarterly test call results will be reviewed and analyzed to determine training needs. The QI Manager will ensure trainings occur as necessary based on test call results.

Proposed Evidence/Documentation of Correction

1. Call log instructions
2. Evidence of Optum staff training on Call log Requirements
3. Evidence of DHS-BHD staff training on Call log Requirements

Ongoing Monitoring (if included)

1. Utilize existing quarterly test call monitoring (submitted to DHCS)
2. Ongoing review of monthly Optum Summary report

Person Responsible (job title)

1. QI Manager/ Access Program Manager/Optum Staff

Implementation Timeline:

The QI Manager convened a meeting with Access Program Managers (7/29/21) and Optum (7/27/21) leadership to review the current Call Log requirements. Within 30 business days from the July 2021 meeting, DHS-BHD Access Program Manager and Optum staff will conduct a Call Log training for all ACD and after-hours call operators. The QI Manager will obtain evidence of Call Log trainings (Access and Optum) within 10 business days of the ACD and after-hours call operators training.

Requirement: COVERAGE AND AUTHORIZATION OF SERVICES

The MHP shall have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(b)(2)(i-ii).)

DHCS Finding: Question E.I.A

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(b)(2)(i-ii). The MHP must have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP did not provide the authorized signature for one (1) Service Authorization Request (SAR) out of a sample of 50. During the facilitated discussion, the MHP described their authorization process and indicated they would follow up with more information on this SAR within the five (5) allotted days following the review. The MHP confirmed the SAR was missing the authorizing signature upon its review of the documentation, but stated that COVID-19 impacts had prevented its ability to locate the clinical documentation and file hard copies needed to demonstrate clinical necessity and validate delivery of services. Additionally, the MHP no longer employs the licensed mental health professional who authorized the SARs during the triennial review period.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(b)(2)(i-ii).

The MHP must comply with CAP requirement addressing this finding of non-compliance.

Corrective Action Description

To ensure compliance with the requirement that each SAR contains an authorizing signature; is authorized by the appropriately licensed staff; and is authorized within the required timeframes, the QI Manager will add to the SAR database a column for “date of signature.” This signature column will prompt the SAR/PT Clinicians to verify that the appropriate signature is obtained on the SAR. Additionally, this signature date column will be used as a point of reference to track SAR authorization timeframes. On a quarterly basis, the FYT Program Manager will run and review the SAR database report to monitor data entry accuracy and completeness, and SAR authorization timeframe compliance.

To support implementation of the revised SAR process, the QA Manager, YFS Section Manager and SAR/PR Clinician will revise the SAR/PT procedure to reflect the modified

SAR tracking and monitoring practices. The revised procedure will include the need for the SAR/PT Clinician to log into the SAR database the date of signature on the SAR. It will also outline FYT Program Manager SAR oversight, monitoring, and training responsibilities.

Proposed Evidence/Documentation of Correction

1. Revised SAR/PT procedure
2. Database template with Date of Signature column
3. SAR/PT procedure training documents
4. Quarterly SAR database report – when applicable, evidence of follow-up training

Ongoing Monitoring (if included)

1. Quarterly SAR database report review
2. When applicable, evidence of follow-up training

Person Responsible (job title)

1. YFS Section Manager/FYT Program Manager
2. YFS Section Manager/FYT Program Manager

Implementation Timeline:

The YFS Section Manager, FYT Program Manager, SAR/PT Clinician, and QA Manager will revise the SAR procedure by August 31, 2021. The QA Manager, QI Manager and SAR/PT Clinician will make necessary changes to the SAR database by August 31, 2021. The YFS Section Manager will ensure that the SAR/PT Clinician are trained on the new procedure by September 30, 2021. QA Manager will obtain evidence of SAR/PT procedure training within 10 business days of September training. The FYT Program Manager will commence quarterly review of the SAR database report by January 31, 2022 (to review 2nd quarter data). The FYT Program Manager will conduct any identified trainings, as necessary, subsequent to the first review of the quarterly report (January 2022).

Requirement: COVERAGE AND AUTHORIZATION OF SERVICES

The MHP must demonstrate compliance with Federal Code of Regulations, compliance with Federal Code of Regulations, title 42, section 438, subdivision 400.

DHCS Finding: E.IV.A1-6

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination under the circumstances listed below.

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.(Fed. Code Regs., tit.42, § 438, subd.400(b)(1)).
2. The reduction, suspension or termination of a previously authorized service. (Fed. Code Regs., tit. 42, § 438, subd.400(b)(2)).
3. The denial, in whole or in part, of a payment for service. (Fed. Code Regs., tit. 42, § 438, subd.400(b)(3)) .
4. The failure to provide services in a timely manner. (Fed. Code Regs., tit. 42, § 438, subd.400(b)(4)).
5. The failure to act within timeframes provided in Federal Code of Regulations, title 42, section 438, subdivision 408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (Fed. Code Regs., tit. 42, § 438, subd.400(b)(5)).
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. (Fed. Code Regs., tit. 42, § 438. subd.400(b)(7)).

While the MHP submitted evidence to demonstrate with this requirement, it is not evident that the MHP issued all relevant and required Notices of Adverse Benefit Determination to beneficiaries in all applicable circumstances. These include the denial of services, modifications and reductions made to service requests, and untimely access to services at times of initial requests for services and during the treatment authorization process. Documentation of these specific requirements, as shown below, were not included in any evidence provided by the MHP. During the facilitated discussion, the MHP indicated they would research their records, which includes scanned and original, hard copy formats, in an attempt to resolve the outstanding questions and gaps in documentation. The MHP explained they are in the process of updating their EHR and tracking system to streamline the procedures and bring them into one system to improve efficiency and data capabilities.

The MHP did not provide documentation necessary to support that it had issued NOABDs to 19 beneficiaries when medical necessity criteria had not been met during

assessments for initial requests for services; nor did the MHP issue NOABDs to 9 beneficiaries when the MHP failed to provide services in a timely manner upon initial requests for services (one (1) urgent and eight (8) non-urgent). Additionally, the MHP did not provide documentation necessary to support that it had issued NOABDs to (five) 5 beneficiaries when it was found that medical necessity criteria had not been met during the TAR review process; nor did the MHP issue NOABDs to 22 beneficiaries when the MHP denied in whole or in part, payment for service; nor did it provide evidence that it had issued two (2) NOABDs when it failed to provide services in a timely manner.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400(b)(1), (3), and (4). The MHP must comply with CAP requirement addressing this finding of non-compliance.

Repeat deficiency Yes

Corrective Action Description

To ensure compliance with Federal Code of Regulations, title 42, section 438, subdivision 400, efforts are currently underway to build a NOABD report in our Electronic Health Records (EHR) system (Avatar), which includes data points that allow for review and monitoring of accurate and timely NOABD issuance globally. Additionally, a review of the global NOABD report will be conducted quarterly at the Behavioral Health Plan Administration (BHPA) meeting to monitor compliance with NOABD issuance requirements.

Furthermore, to ensure compliance with NOABD issuance requirements related to timely access standards (initial appointments) and medical necessity determinations (delivery system determinations), efforts are currently underway to transition our appointment tracking from a database outside the EHR, to be conducted directly in our EHR. To achieve this, a Timely Access and Medical Necessity (CSI Assessment form) form and report (Timeliness Monitoring report) are being built in our EHR.

The Timely Access and Medical Necessity form will capture all metrics related to timely access standards and include information about appointment dispositions. The Timeliness Monitoring report will capture timeliness metrics and identify any that are outside of the timely access standards. Additionally, this report will flag dispositions where medical necessity criteria are not met for specialty mental health services. To allow for ease in NOABD issuance monitoring, we are exploring with our EHR vendor the option of adding to the Timely Access and Medical Necessity report an indication of when a NOABD was issued if it should have been.

To support NOABD compliance monitoring efforts, the Timeliness Monitoring report will be cross checked with the global NOABD report to verify timely and accurate NOABD

issuance. On a monthly basis, the QI Manager will conduct a review of the Timely Access and Medical Necessity report and provide NOABD data to the QA Manager. On a monthly basis, the QA Manager will incorporate the Timely Access and Medical Necessity NOABD data into the quarterly global NOABD monitoring report.

All Access program staff have been trained on how to use the new Timely Access and Medical Necessity form. Additionally, all DHS-BHD clinical staff will be trained on all NOABD issuance requirements, specifically those related to Timely Access and Delivery System NOABD issuance. This same training will be provided to DHS-BHD contracted network providers as well.

This corrective action plan will ensure compliance with NOABD issuance when appointment standards are not met at the time of initial request for services, and when services are denied based on medical necessity criteria not being met for specialty mental health services.

To resolve areas of non-compliance with Service Denial, Payment Denial, and Authorization Delay NOABD issuance requirements related to the Treatment Authorization (TAR) process, the MHP has already revised the Hospital Utilization and Review (Hosp UR) TAR workflow. This new workflow reflects a change in coordination between the Revenue Management Unit (RMU) and the Hosp UR team. This new workflow allows Hosp UR staff to issue necessary NOABDs immediately following a service authorization determination, or payment denial decision.

Additionally, on August 12, 2021 the QA Manager held a NOABD Q&A meeting with the Hosp UR team. During this NOABD Q&A meeting, the QA Manager reviewed general NOABD issuance requirements and provided specific clarification concerning the issuance of the Service Denial, Payment Denial, and Authorization Delay NOABDs.During this meeting, the Hosp UR team developed a process for routing NOABDs to the Hosp UR Senior Office Assistant (SOA) to ensure timely issuance. The Hosp UR team will also participate in one of the all staff NOABD trainings to occur by October 31, 2021.

To ensure timely and proper issuance of TAR related NOABDs, the UR Manager will conduct monthly reviews of the Hosp UR TAR database and monitor compliance with NOABD issuance requirements. On a monthly basis, the UR Manager will conduct a review of the Hosp UR TAR database and provide NOABD data to the QA Manager. On a monthly basis, the QA Manager will incorporate the TAR-NOABD data into the quarterly global NOABD monitoring report.

This corrective action will ensure that the Hosp UR team issues NOABD in a timely manner. It will also ensure that the Hosp UR team issues the correct NOABDs when there is a delay in making authorization decisions; when there is a denial of service

authorization requests; and when a request for service payment is denied in whole, or in part.

To resolve areas of non-compliance with NOABD issuance requirements related authorization delays associated with the Beneficiary Request for Service (BRS) process, the MHP will develop and use the aforementioned global NOABD monitoring report. As previously stated, efforts are currently underway to create a global NOABD monitoring report in our EHR. Additionally, the MHP recently revised the BRS procedure and all applicable staff have been trained on the new procedure. The revised procedure is intended to reduce authorization timeframes, thereby reducing the number of required Authorization Delay NOABDs.

To ensure timely and proper issuance of BRS related Authorization Delay NOABDs, the MHP QA Manager will conduct monthly reviews of the global NOABD report to monitor compliance with NOABD issuance requirements. Additionally, the MHP QA Manager will conduct quarterly reviews of the NOABD monitoring findings report at BHPA.

This corrective action will reduce BRS authorization timeframes and ensure more accurate and regular monitoring of compliance with Authorization Delay NOABD issuance requirements related to the BRS process.

To resolve areas of non-compliance with NOABD issuance requirements related to authorization delays associated with the Service Authorization Request (SAR), the QI Manager will modify the SAR database. Specifically, a “date of signature” column will be added to the database. This signature column will prompt the SAR/PT Clinicians to verify that the appropriate signature is obtained on the SAR. Correspondingly, a “count of days” column will be added to the database, which will include an auto populated count of days between the date of request on the SAR and the signature date. Lastly, a NOABD issuance requirement column will be added to the SAR database for tracking of service authorization timeframes. If SAR authorization timeframes are exceeded, the NOABD issuance requirements column will indicate a need to issue the Authorization Delay NOABD.

To allow for monitoring of compliance with Authorization Delay NOABD issuance requirements related to the SAR process, the QI Manager will build a SAR database report. On a monthly basis, the FYT Program Manager will run and review the SAR database report to monitor data entry accuracy and completeness, SAR authorization timeframe compliance, and compliance with NOABD issuance requirements. On a monthly basis, the FYT Program Manager will conduct a review of the SAR database report and provide NOABD data to the QA Manager. On a monthly basis, the QA Manager will incorporate the SAR-NOABD data into the quarterly global NOABD monitoring report.

To ensure overall compliance with timely and accurate NOABD issuance requirements, QA staff will provide periodic Technical Assistance (TA) and annual NOABD trainings for applicable DHS-BHD staff and contracted providers. QA staff will analyze NOABD quarterly reports and incorporate quarterly report review findings into ongoing TA and annual NOABD trainings provided to DHS-BHD staff and contracted providers.

Proposed Evidence/Documentation of Correction

1. BHPA meeting minutes with global NOABD issuance data
2. Monthly Timely Access and Medical Necessity NOABD data
3. Monthly TAR database NOABD data
4. Monthly SAR database NOABD data
5. Quarterly global NOABD findings report
6. Timely Access and Medical Necessity (CSI Assessment)
7. Timeliness Monitoring report
8. Timely Access and Medical Necessity (CSI Assessment) & training documents
9. DHS-BHD NOABD training documents
10. Contracted providers NOABD training documents
11. Revised NOABD Report (Avatar)
12. Revised Hosp UR workflow
13. Revised the BRS procedure
14. Evidence of BRS Training

Ongoing Monitoring (if included)

1. *Global NOABD Issuance*
   a. QA Manager to conduct quarterly review of global NOABD report (including data from reports in items 2-5 below).
   b. QA Manager to provide quarterly report out of global NOABD findings report to BHPA.
   c. QA Manager to conduct trainings based on analysis of NOABD monitoring reports (including findings from reports in items 2-5 below).
2. *Untimely Access and Delivery System NOABD Issuance*
   a. QI Manger monthly monitoring of Timely Access and Medical Necessity report and NOABD issuance cross check.
   b. QI Manager to provide monthly report out of Timely Access and Medical Necessity findings report and NOABD issuance cross check at BHPA.
3. *Hosp UR TAR NOABD Issuance*
   a. QA UR Manager to conduct monthly review of TAR database and NOABD issuance cross check.
   b. QA UR Manager to provide quarterly report out of TAR database and NOABD issuance cross check findings at BHPA.
4. *BRS Authorization Delay NOABD Issuance*
   a. QA Manager to conduct monthly review of global NOABD report.

   b. QA Manager to provide quarterly report out of global NOABD issuance findings to BHPA.
5. *SAR Authorization Delay NOABD Issuance*
   a. FYT Program Manager to conduct monthly review of SAR NOABD report.
   b. YFS Section Manager to provide quarterly report of SAR NOABD issuance to BHPA.

Person Responsible (job title)

1. QI Manager/QA Manager
2. QI Manager/QA Manager
3. UR Manager/QA Manager
4. QA Manager
5. FYT Program Manager/SAR/PT Clinicians

Implementation Timeline:

Global NOABD Issuance

The QI Manager will ensure that the revised NOABD report in available in Avatar by October 31, 2021. The QA Manager is currently conducting quarterly reviews of NOABD issuance and reporting on findings in the BHPA meeting, use of the modified global NOABD report will begin in March 2022 (covering FY 20/21 2nd quarter data). The QA Manager will ensure that all clinical staff and contracted providers are trained on NOABD issuance requirements by October 31, 2021.

Untimely Access and Delivery System NOABD Issuance

The QI Manager will ensure that all Access staff are trained on how to use the Timely Access and Medical Necessity form by October 31, 2021. The QI Manager will begin conducting the Timely Access and Medical Necessity and NOABD cross check quarterly report out at BHPA beginning March 2022 (covering FY 20/21 2nd quarter data).

Hosp UR TAR NOABD Issuance

The QA UR Manager is currently conducting quarterly report outs of the TAR database findings in BHPA. The TAR report out at BHPA will include NOABD monitoring results by September 30, 2021.

BRS Authorization Delay NOABD Issuance

The QA Manager will begin conducting monthly reviews of the global NOABD report for the purpose of monitoring issuance of Authorization Delay NOABDs related to the BRS process, beginning November 30, 2021. Findings for this report will be included

in the global NOABD report out to BHPA, which will begin in March 2022 (covering FY 20/21 2nd quarter data)

SAR Authorization Delay NOABD Issuance

The QI Manager will complete the SAR database modifications by September 30, 2021. The SAR/PT Clinicians will begin using the modified SAR database by October 1, 2021. The FYT Program Manager will being conducting monthly reviews of the SAR database and provide data and findings to the QA Manager by October 31, 2021. The YFS Section Manager will conduct quarterly SAR database report outs to BHPA beginning March 2022 (covering FY 20/21 2nd quarter data).