Tulare County Mental Health Services

Fiscal Year (FY) 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (42 C.F.R. § 438.206(c)(1)(i),CCR, tit. 28 § 1300.67.2.2 (c)(5)(D))

NOTE: Non-urgent and Non-physician appointments are monitored through the Network Adequacy data submission process. Triennial review will focus on timeliness of all urgent appointments and physician appointments.

- Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
- Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment

DHCS Finding 1.1.3

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services.
Triennial review will focus on timeliness of all urgent appointments and physician appointments.

1. Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment
2. Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy and Procedure 00-68 Timely Access
- Service Request Log
- Notice of Adverse Benefit Determination (NOABD)

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP meets timely access to care and services for urgent and physician appointments. There were 34 urgent and 27 physician appointments that did not meet the required timeliness standards. Per the

discussion during the review, the MHP stated a shortage of staff has caused timeliness issues in providing services.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

Corrective Action Description

Per the Adult and Child Crisis Response and Urgent Conditions policies and procedures Tulare County defines an Urgent Condition as “any crisis response that does not result in an acute psychiatric hospitalization will be coded as service code 50, making it an urgent condition and needs a follow-up mental health service within 48 hours”.

As of writing this, any consumer who experiences a psychiatric emergency not resulting in a hospitalization is provided a follow-up service within 48 hours. However, a large number of the Mental Health Plan’s (MHP) consumers are not immediately provided an assessment post crisis due to them already being enrolled and actively engaged in services within the MHP’s Mental Health Branch. As a result, several consumers may seem to be out of compliance with the 48-hour follow-up standard, when they have in fact have been provided a service within 48 hours. The Department of Health Care Services was initially provided a Service Request Log containing each consumer’s date of crisis, follow-up date, and next assessment service date regardless of how far out it was from the crisis date.

Additionally, the MHP will work with its contracted partners to recruit and retain psychiatrists for the youth population. (This has been an ongoing effort in relation a Network Adequacy Certification Tool Corrective Action Plan).

Proposed Evidence/Documentation of Correction

- Policy and Procedure 00-68 Timely Access
- Policy and Procedure 55-16 Adult Crisis Response and Urgent Conditions
- Policy and Procedure 55-14 Children’s Crisis Response and Urgent Conditions
- Service Request Log

Ongoing Monitoring (if included)

Review Urgent Condition Follow-up Timeliness and Psychiatry Timeliness on a monthly basis. Administer corrective action plans when necessary.

Person Responsible (job title)
Andrew Ruddy, Analyst III

Implementation Timeline: 12/01/22

Requirement

The MHP shall establish mechanisms 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)(v).)
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)(vi).)

DHCS Finding 1.1.6

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi). The MHP shall establish mechanisms to ensure that network providers comply with the below timely access requirements:

1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements.
2. The MHP shall take corrective action if there is a failure to comply with timely access requirements.

The MHP submitted the following documentation as evidence of compliance with this requirement:
• Policy and Procedure (P&P) 00-68 Timely Access
• Service Request Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP monitors and takes corrective action of network providers if they fail to comply with timely access requirements. Per the discussion during the review, the MHP stated timely issues are discussed during children and adult system improvement meetings, but no evidence of these meetings was submitted.

DHCS deems the MHP out of compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi).

Corrective Action Description

The MHP will email providers a set of graphs on a monthly basis containing their timely access averages for the following categories: outpatient services, psychiatry services, and urgent condition follow-up services. Tulare County's MHP will administer a CAP to each site determined to be out of compliance with timely access standards. Once a site receives an official CAP they will be required to send an updated version of the County supplied CAP Tool containing their response to the Quality Improvement Unit (QI Unit) within 14 days. Each site will then have 45 days from the date they supplied their CAP Tool response to the QI Unit to resolve their CAP and come into full compliance with

timely access standards. CAPs will be issued on a quarterly basis starting April 1, 2022.

Proposed Evidence/Documentation of Correction

- Revised Policy and Procedure (P&P) 00-68 Timely Access
- Updated Service Request Log
- Corrective Action Plan Email

Ongoing Monitoring (if included)

Review timely access to outpatient services, psychiatry services, and urgent condition follow-up services on a monthly basis. The average number of days/hours for each category will be monitored and followed-up on, if necessary, via a written corrective action plan.

Person Responsible (job title)
Andrew Ruddy, Analyst III

Implementation Timeline: 07/01/22

Requirement

The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need 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)

DHCS Finding 1.2.2

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth meet medical necessity criteria need ICC and IHBS.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P IA-002 ICC Policy
- ICC & IHBS POS Dashboard
- ICC Screening Tool
- ICC Caseload
- ICC Log
- ICC Service Delivery Flowchart

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth for medical necessity criteria for ICC services. During the clinical review of MHP's children service, it was determined that the MHP was not assessing children and youth for ICC services.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
The MHP will work with the Electronic Health Records (EHR) team to update the initial children's assessments/updated assessment to evaluate all children for ICC services as well as work on updating the initial/updated assessments for our adult clinics to ensure our transitional age youth being severed in our adult system of care are being evaluated for ICC.

Proposed Evidence/Documentation of Correction
- New Policy and Procedure (P&P)
- Copy of assessment questions from Avatar
- Samples of completed assessments

Ongoing Monitoring (if included)
Monthly UR

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 08/01/22

Requirement

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 1.2.7

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.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- TFC Memo
- TFC sample scope of work
- TFC withdrawal memo
- GSFS PSA request form

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP is providing TFC services to children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated is has been unsuccessful in securing a TFC provider.

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.

Corrective Action Description
Tulare County currently does not provide TFC. We continue to recruit during our FFA meetings. The MHP has scheduled a meeting with Child Welfare Services to discuss possibly requesting a conjoint Request for Proposal (RFP) for TFC providers.

Proposed Evidence/Documentation of Correction
- Minutes from FFA meeting
- Copy of the RFP (if initiated)
- Memo around meeting with CWS regarding the RFP
- Memo around ongoing efforts to obtain TFC and responses to RFP

Ongoing Monitoring (if included)
Quarterly

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 12/31/2022

Requirement

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

DHCS Finding 1.2.8

The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP

must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- TFC Memo
- TFC Sample Scope of Work
- TFC Withdrawal Memo
- GSFS PSA Request Form

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses all children and youth for medical necessity criteria for TFC services. Per the discussion during the review, the MHP stated that children and youth are being assessed for the TFC services, however, the MHP did not submit any evidence of actual practice or use of a screening tool assessment.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description
The MHP has scheduled a meeting with Child Welfare Services to discuss possibly requesting a conjoint Request for Proposal (RFP) for TFC providers.

Proposed Evidence/Documentation of Correction

- TFC Screening Tool Assessment

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 12/1/22

Requirement

The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).)

DHCS Finding 1.4.3

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a) (1). The MHP must comply with following;

- The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- New Provider Application

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP gives practitioners or groups of practitioners written notice of the reason for a decision not to contract with a practitioner or practitioner group. Per the discussion during the review, the MHP stated it would provide additional evidence do demonstrate compliance for this requirement. However no additional evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a)(1).

Corrective Action Description

Tulare County's MHP will supply DHCS with a sample letter sent out to a contractor not selected for a request for proposal (RFP) they applied for.

Proposed Evidence/Documentation of Correction

- Sample RFP Letter

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Andrew Ruddy, Analyst III

Implementation Timeline: Currently in place

Requirement

The MHP shall certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435. (MHP Contract, Ex. A, Att. 8)

DHCS Finding 1.4.4

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must certify, or use another MHP's certification

documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Sample Recertification Packet
- P&P 45-10-04 Certification/Recertification Requirements for Mental Health Plan Providers

INTERNAL DOCUMENTS REVIEWED:

- Provider Monitoring Report

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP consistently recertifies its subcontract providers. This requirement was not included in any evidence provided by the MHP. According to the Provider Monitoring Report, 11 of 34 providers were overdue for recertification. Per the discussion during the review, the MHP stated recertification has been difficult due staffing shortages and the COVID-19 pandemic.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

Corrective Action Description

The MHP will work on completing the 11 overdue recertifications and develop a log to monitor when sites are due for recertification and when said recertifications have been completed.

Proposed Evidence/Documentation of Correction

- Completed Overdue Recertification Packets
- Recertification Log

Ongoing Monitoring (if included)
A member of the MHP's QI/QA team will monitor the newly created log on a monthly basis.

Person Responsible (job title)
Betsy Ellis, QI Unit Manager

Implementation Timeline: 08/01/22

Requirement

The beneficiary shall be provided information on how to contact their designated person or entity. (MHP Contract, Ex. A, Att.10; 42 C.F.R. § 438.208(b)(1).

DHCS Finding 2.1.2

The MHP did not furnish evidence to demonstrate compliance with the MHP Contract, exhibit A, attachment 10, and Federal Code of Regulations, title 42, section 438, subdivision 208(b)(1). The MHP must provide the beneficiary information on how to contact their designated person or entity.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-13 Interface between Mental Health and Physical Health
- P&P 35-02-02 Post Acute Psychiatric Hospitalization
- Job Specifications-Clinical Social Worker I
- Job Specifications-Clinical Social Worker II
- Job Specifications-Mental Health Case Manager

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides the beneficiary information on how to contact their designated person or entity. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated the assigned clinician contacts the beneficiary via phone. The MHP did not submit evidence for this communication.

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

Corrective Action Description
The MHP will develop a document that will be a part of the informing materials to provide to the beneficiary with their assigned clinics name, phone number, and address. This document will be listed on the checklist that is scanned into the beneficiary's electronic health record.

Proposed Evidence/Documentation of Correction
- Notification document
- Updated intake checklist

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
QI Managed Care

Implementation Timeline: 08/01/22

Requirement

The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP. (CCR, title 9, section 1810.415(a).).

DHCS Finding 2.3.1

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 415(a). The MHP must make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-13 Interface between Mental Health and Physical Health Service Providers
- Quick Psych Guide

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides clinical consultation and training to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated prior to COVID-19, the MHP conducted monthly trainings and presentations. The MHP did not provide documented evidence of these trainings or presentations.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 415(a).

Corrective Action Description
Tulare County Medical Director and Integrated Services Manager will begin holding monthly trainings with health care providers. This stopped in March 2020 due to Covid, but will begin again in July 2022.
Currently, Tulare County employs a LMFT who is located at our Visalia Health Care Center and provides daily clinical consultation with health care providers. This LMFT also will continue to attend monthly provider meetings and is on the standing agenda as "Behavioral Health/Announcements".

Proposed Evidence/Documentation of Correction

- Agendas of past meetings (prior to 03/2020)
- Schedule of meetings that will be placed on calendar
- Redacted notes from LMFT who is located at the Visalia Health Clinic
- Agenda of monthly provider meetings that our LMFT attends the provider meetings

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Medical Director and Integrated Services Manager

Implementation Timeline: 07/01/22

Requirement

The MHP has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. (CCR Title 9 § 1810.370(a)(5)).

DHCS Finding 2.4.2

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, subdivision 370(a)(5). The MHP must has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. Also, when the dispute involves an MCP continuing to provide services to a beneficiary the MCP believes requires SMHS from the MHP, the MHP shall identify and provide the MCP with the name and telephone number of a psychiatrist or other qualified LMHP available to provide clinical consultation, including consultation on medications to the MCP provider responsible for the beneficiary's care.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Blue Cross of California Partnership Plan
- Blue Cross of CA-Mental Health Plan MOU Agreement
- Health Net Amendment
- Health Net MOU

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's Memorandum of Understanding (MOU) with Health Net includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while disputes are being resolved. Per the discussion

during the review, the MHP stated it would update the Health Net MOU to meet this requirement.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, subdivision 370(a)(5).

Corrective Action Description

The MHP will create a Policy and Procedure on resolving disputes between the MHP and MCPs it contracts with. MOU with MCP's are updated to reflect the requirement

Proposed Evidence/Documentation of Correction

- MHP and MCP Dispute Resolution Policy
- MHP and MCP Dispute Resolution Template
- Updated MOU's with MCPs

Ongoing Monitoring (if included)

The MHP's QI/QA Team will monitor the Team's shared email inbox on a monthly basis to ensure that all disputes are addressed and resolved as quickly as possible.

Person Responsible (job title)
Betsy Ellis, Unit Manager

Implementation Timeline: 07/01/22

Requirement

The MHP shall have mechanisms to detect both underutilization and overutilization of services. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(b)(3).)

DHCS Finding 3.1.4

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3). The MHP must have mechanisms to detect both underutilization and overutilization of services.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Tulare ACA Approved Claims CY17-19
- Tulare FC Approved Claims Report CY17-19
- Tulare TAY Approved Claims Report CY 17-19
- P&P 45-04-01 Annual Review of Quality Improvement Program and Utilization Management Activities by the Mental Health Plan

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a mechanism to detect both underutilization and overutilization of services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it does not have a mechanism in place for this requirement.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3).

Corrective Action Description

The Quality Improvement/Quality Assurance Team will resume using the existing over/underutilization report that exists within the AVATAR EHR System.

Proposed Evidence/Documentation of Correction

- De-identified sample of Over/Under utilization AVATAR Report

Ongoing Monitoring (if included)

The MHP's Quality Improvement/Quality Assurance Team will run the existing overutilization and underutilization AVATAR report on a monthly basis to ensure that all consumer records of concern are reviewed and followed up on if necessary.

Person Responsible (job title)
Andrew Ruddy, Analyst III

Implementation Timeline: 07/01/22

Requirement

The MHP has practice guidelines, which meet the requirements of the MHP Contract. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)

DHCS Finding 3.5.1

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must have practice guidelines, which meet the requirements of the MHP Contract.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 42-09 Practice Guidelines
- Documentation Manual

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP has practice guidelines which meet the requirements of the MHP contract. Per the discussion during the review, the MHP stated it would submit additional evidence post review to demonstrate compliance, however no additional evidence was submitted.

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

Corrective Action Description
The MHP will develop a formal document containing the MHP's practice guidelines.

Proposed Evidence/Documentation of Correction

Practice Guidelines Document

Ongoing Monitoring (if included)

The MHP will require all staff to log into the Relias system to review and attest to their review of the newly created practice guidelines document.

Person Responsible (job title)
- Policy and Procedure Committee and Clinical Supervisors

Implementation Timeline: 10/01/22

Requirement

The MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. ,
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)

DHCS Finding 3.5.2

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

The MHP submitted the following documentation as evidence of compliance with this requirement:
- P&P 42-09 Practice Guidelines
- Documentation Manual

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP disseminates practice guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. Per the discussion during the review, the MHP stated it would submit additional evidence post review to demonstrate compliance, however no evidence was submitted.

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

Corrective Action Description

The MHP will update policy and procedure 42-09 Practice Guidelines, create a formal practice guidelines document, and require all current and new providers to log into the Relias system to review and attest to their review of both documents.

Proposed Evidence/Documentation of Correction

- Updated P&P 42-09 Practice Guidelines
- Practice Guidelines Document

Ongoing Monitoring (if included)

Person Responsible (job title)
Clinical Supervisors and QI Managed Care

Implementation Timeline: 10/01/22

Requirement

The MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)

DHCS Finding 3.5.3

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 42-09 Practice Guidelines
- Documentation Manual

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has taken steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. Per the discussion during the review, the MHP stated it would submit additional evidence post review to demonstrate compliance, however no evidence was submitted.

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

Corrective Action Description

The MHP will update policy and procedure 42-09 Practice Guidelines to include language that the MHP will take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.

Proposed Evidence/Documentation of Correction

- Updated P&P 42-09 Practice Guidelines
- Practice Guidelines Document

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Policy and Procedure Committee

Implementation Timeline: 10/01/22

Requirement

The MHP shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. (42 C.F.R. § 438.10(f)(1).)

DHCS Finding 4.1.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(f)(1). The MHP must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 35-01-02 Termination of Tulare County Mental Health Plan Contract Provider

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides written notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice to each beneficiary who was seen on a regular basis by the terminated provider. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would update the policy and procedure to reflect the 15-calendar day timeline. The updated document was not received by DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(f)(1).

Corrective Action Description
The policy has been updated to reflect the 15-calendar day timeline.

Proposed Evidence/Documentation of Correction

- Updated policy 35-01-02 Termination of Contract Provider

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist; Decinda Allen, Supervising LCSW

Implementation Timeline: 2/1/2022

Requirement

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

1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.

3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.
5) 2) 3) 4)

(CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).) 1)

DHCS Finding 4.3.2

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

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

The seven (7) test calls are summarized below.

TEST CALL #1

Test call was placed on Monday, October 26, 2020, at 11:26 a.m. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in crisis. The caller responded in the negative. The caller explained that he/she has been feeling depressed and isolated because he/she is the sole caregiver for a sick parent. The operator asked the caller for his/her personal identifying information and the caller provided the requested information. The operator informed the caller he/she has reached the crisis line and proceeded to look up the nearest clinic to the caller's address with business hours, phone number, and service information. The operator transferred the caller to the adult clinic. The call was answered within one (1) ring via a live operator. The operator requested personal identifying information and the caller provided the information. The caller informed the operator he/she was feeling depressed and isolated. The operator provided information on how to receive mental health services including the assessment and intake process. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL #2

Test call was placed on Monday, November 2, 2020 at 3:18 p.m. The caller received a message stating that call did not go through. The caller attempted to call again at 3:20 p.m. for which the caller received the same message.

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

FINDING

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

TEST CALL #3

Test call was placed on Thursday, March 18, 2021, at 7:45 a.m. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in crisis and the caller replied in the negative. The caller explained that his/her son is having problems at school and has been more disruptive during distance learning. The operator asked for the caller's son's name, date of birth, city of residence, and if he has Medi-Cal. The caller provided the requested information. The operator proceeded to provide the caller with a clinic address and hours of operation. The operator explained to the caller to call the clinic after 8:00 a.m. to enroll his/her son in mental health services.

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

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

TEST CALL #4

Test call was placed on Friday, June 11, 2021 at 9:59 am. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in a crisis and the caller replied in the negative. The caller explained that he/she recently moved to the county and needs assistance in refilling his/her anxiety medication. The operator asked the caller for his/her name and date of birth which the caller provided. The operator

proceeded to ask if the caller has Medi-Cal and what area of the county the caller resides in. The caller provided the requested information. The operator provided the caller with the phone number for Visalia Adult Integrated Services and explained the process for getting his/her anxiety medication refilled.

The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.
The call is deemed *in compliance* with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).

TEST CALL #5

Test call was placed on Tuesday, July 13, 2021, at 12:02 p.m. The line rang seven (7) times and was not answered.

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

FINDING

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

TEST CALL #6

Test call was placed on Friday, April 2, 2021, at 4:18 p.m. The call was answered after two (2) rings via a live operator. The operator immediately asked if the caller was experiencing a crisis and the caller responded in the negative. The caller asked for information on how to file a complaint about a therapist. The operator asked the caller for personally identifying information so that the call could be logged and the operator could return the call if they were disconnected. The caller provided his/her first and last name, but declined to provide a phone number. The operator was thorough in providing instructions and details on the grievance, appeal, expedited appeal, and State Fair Hearing processes. The operator provided help line numbers, office locations, and hours of operation where the caller could pick up the grievance forms and information, as well as how to find the forms and information online.

The operator provided the caller with information about how to use the beneficiary problem resolution and fair hearing process.

FINDING

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

TEST CALL #7

Test call was placed on Friday, July 9, 2021, at 3:55 p.m. The call was answered after two (2) rings via a live operator. The operator asked if the caller was in crisis and the caller replied in the negative. The caller requested information about how to file a complaint against a therapist in the county. The operator asked the caller to provide his/her name and phone number. The caller provided his/her name, but declined to provide a phone number. The operator asked if the caller was a Medi-Cal beneficiary and the caller replied yes. The operator explained that the caller could pick up a packet to file a grievance in the office or file a complaint by phone. The operator explained the process of completing the form and the appeal process.

The caller was provided information on how to use the beneficiary problem resolution and fair hearing processes.

FINDING

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

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	IN	OOC	IN	IN	OOC	N/A	N/A	60%
3	IN	OOC	N/A	IN	OOC	N/A	N/A	50%
4	N/A	N/A	N/A	N/A	N/A	IN	IN	100%

Corrective Action Description

The MHP's Quality Improvement/Quality Assurance team will continue to send feedback to the Kings View 24/7 Access Line for each month if is deemed out-of-compliance.

Proposed Evidence/Documentation of Correction

- Test Call Communication Emails to 24/7 Access Line for several months
- Quality Improvement Indicators of Interest test call section for several months

Ongoing Monitoring (if included)

The MHP's Quality Improvement/Quality Assurance team will continue to monitor test call results on a monthly basis. Any calls reported as out of compliance will be documented and communicated to the Kings View 24/7 Access Line requiring a response in writing (email).

Person Responsible (job title)

Andrew Ruddy, Analyst III

Implementation Timeline: 07/01/22

Requirement

The written log(s) contain the following required elements:
a) Name of the beneficiary.
b) Date of the request.
c) Initial disposition of the request.
(CCR, title 9, chapter 11, section 1810.405(f).)

DHCS Finding 4.3.4

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.
The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 35-04-08 Procedure for Logging Every Request for Specialty Mental Health Services in Access Log
- Avatar Access Log

While the MHP submitted evidence to demonstrate compliance with this requirement, four (4) of five (5) required DHCS test calls were not logged on the MHP's written log of initial requests. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	10/26/2020	11:26 AM	IN	IN	IN
2	11/2/2020	3:18 PM	OOC	OOC	OOC
3	3/18/2021	7:45 AM	OOC	OOC	OOC
4	6/11/2021	9:59 AM	OOC	OOC	OOC
5	7/13/2021	12:02 PM	OOC	OOC	OOC
Compliance Percentage			20%	20%	20%

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

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

Repeat deficiency Yes

Corrective Action Description

The MHP's Quality Improvement/Quality Assurance team will continue to send feedback to the Kings View 24/7 Access Line for each month it is deemed out-of-compliance.

Proposed Evidence/Documentation of Correction

- Test Call Communication Emails to 24/7 Access Line for several months
- Quality Improvement Indicators of Interest test call section for several months

Ongoing Monitoring (if included)

The MHP's Quality Improvement/Quality Assurance team will continue to verify that all test calls are logged into AVATAR the County's EHR system on a monthly basis. Any calls that are identified as not being logged appropriately will be documented and communicated to the Kings View 24/7 Access Line requiring a response in writing (email).

Person Responsible (job title)
Andrew Ruddy, Analyst III

Implementation Timeline: 07/01/22

Requirement

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).)

DHCS Finding 5.1.3

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(c). The MHP must 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.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-02-02 Access to Specialty Mental Health Services
- P&P 45-04-01 Annual Review of Quality Improvement Program and Utilization Management Activities by the Mental Health Plan

- P&P 45-04-02 Utilization Review Committee Peer Review of Outpatient Medical Records
- P&P 45-06-06 Utilization Review of Inpatient Treatment Authorization Requests
- P&P 45-13 Prior Authorization for Outpatient Specialty Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP notifies the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no evidence was received by DHCS.

DHCS deems the MHP out of compliance with MHP contract; exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c).

Corrective Action Description
The MHP will provide blank NOABD and samples of termination and reduced treatment.

Proposed Evidence/Documentation of Correction
- Blank NOABD for termination and less than requested
- Samples of NOABD's provided to beneficiary's

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 07/01/22

Requirement

1) The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1).)
2) The acknowledgment letter shall include the following (MHSUDS IN18-010E):
    a. Date of receipt
    b. Name of representative to contact
    c. Telephone number of contact representative
    d. Address of Contractor
3) The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E)

DHCS Finding 6.1.5

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements:

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

The MHP submitted the following documentation as evidence of compliance with this requirement:

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Sample Acknowledgement Letters
- Grievances and Appeal Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by that the MHP acknowledges receipt of each grievance and appeal within five (5) calendar days.

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

	# of Sample Reviewed	Acknowledgement		Compliance Percentage
		# IN	# OOC	
Grievances	20	19	1	95%
Appeals	11	7	4	64%
Expedited Appeals	N/A	N/A	N/A	N/A

Corrective Action Description
PRC has not received letters or written request during covid and was not sending acknowledgment letters as she was working remotely and acknowledging by the phone call. PRC will ensure they will now send out acknowledgment letters within 5 days even if it is a phone call request. PRC will save as a PDF and use adobe pro for signature and email it to the OA to print and mail to the client.

Proposed Evidence/Documentation of Correction

- Copy of a letter

Ongoing Monitoring (if included)
Quarterly Monitoring

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 07/01/22

Requirement

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).)

DHCS Finding 6.2.1

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

The MHP submitted the following documentation as evidence of compliance with this requirement:

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Grievances and Appeal Log

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP records grievances and appeals in the log within one (1) working day of the date of receipt of the grievance and appeal. Of the grievances and appeals reviewed, one (1) out of the 20 grievances and zero (0) out of the four (4) appeals were logged within one (1) working day. Per the discussion during the review, the MHP stated due to previous staffing issues, the grievance and appeal log was not maintained correctly.
DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

Corrective Action Description

The Problem Resolution Coordinator (PRC) created a new Colum in the Grievance and Appeals log to show date logged.to reflect the timeliness of receipt. If the MHP receives a written request the document will be date stamped.

Proposed Evidence/Documentation of Correction

- Copy of the updated Log

Ongoing Monitoring (if included)
Quarterly

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: Immediately

Requirement

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).)

DHCS Finding 6.3.2

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision BH IN No. 19-041b)(1). The MHP must 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

The MHP submitted the following documentation as evidence of compliance with this requirement:

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Grievances and Appeal Log
- Resolution Letters

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP resolves each grievance as expeditiously as the beneficiary's health condition requires not to exceed 90 calendar days from the day the MHP receives the grievance. Per the discussion during the review, the MHP stated due to previous staffing issues, the grievance and appeal log was not maintained correctly

In addition, DHCS reviews grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below:

	Resolved Within Timeframes		

	# of Sample Reviewed	# In Compliance	# OOC	Required Notice of Extension Evident	Compliance Percentage
Grievances	20	18	2	N/A	90%
Appeals	11	11	0	N/A	100%
Expedited Appeals	N/A	N/A	N/A	N/A	N/A

DHCS deems the MHP partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1).

Corrective Action Description
The MHP will ensure that the Problem Resolution Coordinator (PRC) position remains staffed and have back-up clinicians if current PRC is out for any reason, vacant position, leave of absence, or vacation.

Proposed Evidence/Documentation of Correction
Updated grievance/appeals log

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 07/01/2022

Requirement

Resolve each appeal and provide notice, as expeditiously as the beneficiary's health condition requires, within 30 calendar days from the day the MHP receives the appeal. (42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(2).)

DHCS Finding 6.4.3

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

The MHP submitted the following documentation as evidence of compliance with this requirement:

- FY 18-19 Grievances
- FY 19-20 Grievances
- FY 19-20 Appeals
- Grievances and Appeal Log

- Appeal Memo-missing appeals

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP resolves each appeal and provides notice to the beneficiary within 30 calendar days from the day the MHP receives the appeal. Per the discussion during the review, the MHP stated that due to the resignation of staff, the MHP was unable to locate nine (9) appeals from fiscal year 2019-2020, therefore, the MHP was unable to resolve them within the required appeal timeframe. The MHP submitted a memo post review supporting this claim.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a); 408(b)(2).

Corrective Action Description
The MHP will ensure that any staff working with Problem Resolution Coordinator (PRC) related documents is instructed to save all documents, appeals, and grievances on the shared drive and update logs accordingly.

Proposed Evidence/Documentation of Correction
- Updated Log and samples of notice to beneficiaries

Ongoing Monitoring (if included)
Quarterly QIC the PRC will report on grievance and appeals with their log.

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: Immediately

Requirement

The MHP must continue the beneficiary's benefits if all of the following occur:
a) The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
b) The appeal involves the termination, suspension, or reduction of previously authorized services;
c) The services were ordered by an authorized provider;
d) The period covered by the original authorization has not expired; and,
e) The beneficiary timely files for continuation of benefits.

(42 C.F.R. § 438.420(b).)

DHCS Finding 6.5.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c). At the beneficiary's request, the

MHP must continue or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until all of the below listed occurs:

1. The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
2. The appeal involves the termination, suspension, or reduction of previously authorized services;
3. The services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired; and,
5. The beneficiary timely files for continuation of benefits.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-46 Beneficiary Problem Resolution
- Appeal Receipt Template
- Beneficiary Handbook
- Appeal Form
- NAR-Your Rights
- SFH Pamphlet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending and continues benefits until all the requirements are met as stated in the regulation. The evidence, including policies and procedures, as well as other documentation, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated that additional evidence would be submitted to demonstrate compliance for this requirement, however no evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c).

Corrective Action Description

Nothing needed. Currently in policy 35-17 NOABD regarding appeal, grievance process as well as in the informing materials. We supply a form called "What is an appeal"/"What is a grievance" with all other informing material at time of admission, which states the beneficiary has the right to ask that their services not be suspended or revised but beneficiary must file the appeal/grievance within 10 days of NOABD being issued. None of our appeals have been filed within 10 days of a NOABD being issued.

Proposed Evidence/Documentation of Correction

- 35-17 NOABD policy
- What is an Appeal form
- What is a Grievance form
- Informing material checklist
- Updated Grievance and Appeal Log

Ongoing Monitoring (if included)
Continuous

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: Immediately

Requirement

If, at the beneficiary's request, the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the following occurs:

a) The beneficiary withdraws the appeal or request for a State Hearing;
b) The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal;
c) A State Hearing office issues a hearing decision adverse to the beneficiary.

(42 C.F.R. § 438.420(c).)

DHCS Finding 6.5.2

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c). At the beneficiary's request, the MHP must continue or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until one of the below listed occurs:

1. The beneficiary withdraws the appeal or request for a State Hearing;
2. The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (e.g.), NAR) to the beneficiary's appeal;
3. A State Hearing office issues a hearing decision adverse to the beneficiary.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-46 Beneficiary Problem Resolution
- Appeal Receipt Template
- Beneficiary Handbook
- Appeal Form
- NAR-Your Rights
- SFH Pamphlet

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending and continues benefits until at least one requirement is met as stated in the regulation. This

requirement was not included in any evidence provided by the MHP. The evidence, including policies and procedures, as well as other documentation, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated that additional evidence would be submitted to demonstrate compliance for this requirement, however no evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 420(c).

Corrective Action Description
Beneficiary Problem Resolution Policy Update (if applicable)

Proposed Evidence/Documentation of Correction
- Updated Log

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Decinda Allen, Supervising LCSW

Implementation Timeline: 08/01/22

Requirement

The MHP, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the MHP Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to DHCS about the following:

1) Any potential fraud, waste, or abuse. (42 C.F.R. §438.608(a)(7); MHSUDS IN No. 19-034)
2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. §438.608(a), (a)(2); MHSUDS IN No. 19-034)

Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MHP. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(4).)

DHCS Finding 7.2.1

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 14, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(4). The MHP must ensure the MHP, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the MHP Contract, shall implement and maintain

arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to DHCS as listed below:

1. Any potential fraud, waste, or abuse.
2. All overpayments identified or recovered, specifying the overpayments due to potential fraud.
3. Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MHP.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly reports to DHCS when information about a change in a network provider's circumstances affects the network provider's eligibility to participate in the managed care program. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional documentation was provided.
DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 14, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(4).

Corrective Action Description
The MHP will revise the Fraud Waste and Abuse Prevention policy to include DHCS reporting requirements.

Proposed Evidence/Documentation of Correction

- Updated policy 00-11 Fraud Waste and Abuse Prevention

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Requirement

If the MHP identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying DHCS, the MHP shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed. (MHP Contract, Ex. A, Att. 13)

DHCS Finding 7.2.2

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. If the MHP identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying DHCS, the MHP must conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- P&P 45-04-03 Processing Disallowed Claims

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP notifies DHCS if the MHP receives notification of a complaint concerning an incident of potential fraud, waste, or abuse. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no evidence was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Corrective Action Description
The MHP will revise the Fraud Waste and Abuse Prevention policy to include DHCS reporting requirements.

Proposed Evidence/Documentation of Correction

- Updated policy 00-11 Fraud Waste and Abuse Prevention

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Requirement

As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the

level of screening based on risk of fraud, waste or abuse as determined for that category of provider. (42 C.F.R. § 455.434(a).)

DHCS Finding 7.4.2

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a). As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires its providers to consent to criminal background checks including fingerprinting as a condition of enrollment. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it was not aware of this requirement.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(a).

Corrective Action Description
The MHP will include this requirement in all provider contracts beginning FY 22/23. Updated Contracts with the following language: *As a condition of enrollment, the MHP must require providers to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider. (42 C.F.R. § 455.434(a).)*

Proposed Evidence/Documentation of Correction

- FY 22/23 provider contracts

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline:7/1/2022

Requirement

The MHP requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. (42 C.F.R. § 455.434(b)(1) and (2)).

1) The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104. (MHP Contract, Ex. A, Att. 13)

DHCS Finding 7.4.3

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13. The MHP must require providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable. The MHP shall ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations part 455.104.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures
- Provider contracts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP requires its network providers to submit updated disclosures to the MHP before renewing the network providers' contracts within 35 days of change of ownership and annually. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional evidence was received. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 455, subdivision 434(b)(1) and (2); 104, MHP Contract Exhibit A, Att. 13.

Corrective Action Description
The MHP will revise the Fraud Waste and Abuse Prevention policy to include DHCS reporting requirements

Proposed Evidence/Documentation of Correction
- Updated policy 00-11 Fraud Waste and Abuse Prevention

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Requirement

The MHP must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.

1. The ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request.
3. The MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

DHCS Finding 7.4.5

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions

totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures
- Provider contracts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosures and updated disclosures to DHCS as required per regulations. This requirement was not included in any evidence provided by the MHP. The evidence, including disclosure forms, as well as other documentation, was deficient in meeting the requirements. Per the discussion during the review, the MHP stated it would provide additional evidence, however no additional evidence was received.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 13.

Corrective Action Description
The MHP will revise the Fraud Waste and Abuse Prevention policy to include DHCS reporting requirements.

Proposed Evidence/Documentation of Correction

- Updated policy 00-11 Fraud Waste and Abuse Prevention

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Requirement

The MHP shall submit the following disclosures to DHCS regarding the MHP's management:

1. The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)
2. The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part 455.101.

DHCS Finding 7.4.6
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2). The MHP must submit disclosure to DHCS of identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 00-11 Fraud Waste and Abuse Prevention
- Compliance Plan
- Disclosure-Crestwood
- Disclosure-CTC
- Disclosure-ExMed
- Disclosure-Kern Bridges
- Employee Disclosure Form 700
- HHSA Exhibit G-Contract Provider Disclosures
- Provider contracts

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP submits disclosure to DHCS of identity of any person who has been convicted of a crime related to federal health care programs. This requirement was not included in any evidence provided by the MHP. The evidence, including disclosure forms, as well as other documentation, was deficient in meeting the requirements.

Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional evidence was received.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title.42, section 455, subdivision 101 and 106(a)(1), (2).

Corrective Action Description
The MHP will revise the Fraud Waste and Abuse Prevention policy to include DHCS reporting requirements.

Proposed Evidence/Documentation of Correction

- Updated policy 00-11 Fraud Waste and Abuse Prevention
- Tulare County has not experienced any provider fraud during the review period therefore have nothing to report.

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Requirement

The MHP has a process, at the time of hiring/ contracting, to confirm the identity and exclusion status of all providers (employees, network providers, subcontractors, person's with ownership or control interest, managing employee/agent of the MHP). This includes checking the:

a) Social Security Administration's Death Master File.
b) National Plan and Provider Enumeration System (NPPES)
c) Office of the Inspector General List of Excluded Providers and Entities(LEIE)
d) System of Award Management (SAM)
e) Department's Medi-Cal Suspended and Ineligible List (S&I List). MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438.602(b)(d) and 455.436)

DHCS Finding 7.5.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 602(b)(d) and section 455, subdivision 436 and MHP Contact Exhibit A, Att. 13. The MHP must has a process, at the time of hiring/ contracting, to confirm the identity and exclusion status of all providers (employees, network providers, subcontractors, person's with ownership or control interest, managing employee/agent of the MHP). This includes checking the:

1. Social Security Administration's Death Master File.
2. National Plan and Provider Enumeration System (NPPES)
3. Office of the Inspector General List of Excluded Providers and Entities(LEIE)
4. System of Award Management (SAM)
5. Department's Medi-Cal Suspended and Ineligible List (S&I List). MHP Contract, Ex. A, Att. 13; 42 C.F.R. §§ 438.602(b)(d) and 455.436)

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 45-10-15 Staff Credentialing
- Verification Log-Death Index
- Verification Log-Medi-Cal Ineligibility
- Verification Log-NPPES
- Verification Log-OIG
- Verification Log-SAM

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP has a process to confirm the identity and exclusion status of all providers at the time of hire. The policy and procedure submitted by the MHP only states that the Master Death Index is checked at the time of hire for all providers. Per the discussion during the review, the MHP stated it would submit additional evidence for this requirement, however no additional evidence was received by DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 602(b)(d); section 455, subdivision 436 and MHP Contact Exhibit A, Att. 13.

Repeat deficiency Yes

Corrective Action Description
The MHP will revise the Staff Credentialing policy to include language indicating when a provider's identity and exclusion status are confirmed at time of hire.

Proposed Evidence/Documentation of Correction

- Updated policy 45-10-15 Staff Credentialing
- Log to show identity and exclusions status are confirmed at time of hire

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Requirement

If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. §438.608(a)(2), (4).

DHCS Finding 7.5.3

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4). The MHP promptly notifies DHCS if the MHP finds a party that is excluded.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- P&P 45-10-15 Staff Credentialing

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that additional evidence would be submitted to demonstrate compliance for this requirement, however no additional evidence was received by DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4).

Corrective Action Description
The MHP will revise the Staff Credentialing and Fraud, Waste and Abuse Prevention policies to include DHCS reporting requirements. Tulare County has not had any party that has been on the exclusion list.

Proposed Evidence/Documentation of Correction

- Updated policy 45-10-15 Staff Credentialing
- Updated policy 00-11 Fraud Waste and Abuse Prevention

Ongoing Monitoring (if included)
N/A

Person Responsible (job title)
Debora Hutcheson, Administrative Specialist

Implementation Timeline: 8/1/2022

Tulare County Mental Health Services

Fiscal Year (FY) 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

Chart Review

Requirement

The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att. 9)

DHCS Finding 8.2.1

Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

One or more assessments were not completed within the initial timeliness and/or update frequency requirements specified in the MHP's written documentation standards. Per the MHP's policy, initial assessments are to be completed within 30 days of the episode opening date for all beneficiaries. The MHP's policy also indicates that assessments are to be updated every 3 years for all beneficiaries. The following are specific findings from the chart sample:

- **Line 19.** The initial assessment was due to be completed by 2/2/2020 given that the episode opening date was 1/2/2020; however, the initial assessment was not finalized until 2/14/2020.
- **Line 18.** The prior assessment was completed on 7/15/2017. The updated assessment was due to be completed every 3 years thereafter; however, the updated assessment was not finalized until 4/26/2021. The MHP was given the opportunity to locate a current assessment that covered the review period but was unable to locate any in the medical record. As such, there was no assessment in place covering the review period.

CORRECTIVE ACTION PLAN 8.2.1:

The MHP shall submit a CAP that describes how the MHP will ensure that assessments are completed in accordance with the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.

Corrective Action Description

All MHP staff providing, or supervising assessment services will receive re-training on the standard.

Proposed Evidence/Documentation of Correction

- Completion of documentation training will be verified via Relias.
- QI Memo outlining the requirement

Ongoing Monitoring (if included)
Clinical Supervisors and/or Managers will monitor staff completion of training. Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline: 08/01/22

Requirement

The MHP shall ensure the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed

1) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.
2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.
3) History of trauma or exposure to trauma
4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.
5) Medical History, including:
    a. Relevant physical health conditions reported by the beneficiary or a significant support person.
    b. Name and address of current source of medical treatment.
    c. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.
6) Medications, including:
    a. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.
    b. Documentation of the absence or presence of allergies or adverse reactions to medications.
    c. Documentation of informed consent for medications.
7) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.
8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).

9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.
10) Mental Status Examination
11) A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis.

(MHP Contract, Ex. A, Att. 9; CCR, tit. 9, §§ 1810.204 and 1840.112):

DHCS Finding 8.2.2

One or more of the assessments reviewed did not address all of the required elements specified in the MHP Contract. Specifically:

a) Medical History, including significant developmental history: **Line numbers 3 and 6.**
b) Medications, including medication for medical conditions, and documentation of adverse reactions: **Line numbers 3 and 6.**
c) Client Strengths: **Line numbers 5 and 6.**
d) A Mental Status Examination: **Line numbers 6 and 11.**

CORRECTIVE ACTION PLAN 8.2.2:

The MHP shall submit a CAP that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description
All MHP staff providing or supervising assessment services will receive re-training on the standard.

Proposed Evidence/Documentation of Correction

- Completion of documentation training will be verified via Relias.

Ongoing Monitoring (if included)
Clinical Supervisors and/or Managers will monitor staff completion of training. Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline: 08/01/22

Requirement

All entries in the beneficiary record (i.e., Assessments) include:

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding 8.2.3

One or more of the assessments reviewed did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, or the date the documentation was entered into the medical record. Specifically:

- The type of professional degree, licensure, or job title of person providing the service:
  - **Line number 6.**

CORRECTIVE ACTION PLAN 8.2.3:

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes the signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

Corrective Action Description
The initial assessment in Line number 6 was completed in 2015 and was missing the credentials for the assessing person. This was the result of a past error in the EHR system that has been subsequently fixed.

Proposed Evidence/Documentation of Correction

- The assessment update also submitted for Line number 6 was completed in 2017 and included the licensure of the person who completed the assessment. All other assessments submitted during the review also met this standard, as further evidence that the EHR problem was corrected several years ago.

Ongoing Monitoring (if included)
Monthly utilization chart reviews verify that appropriate licensure status and/or job title is included on assessments being reviewed.

Person Responsible (job title)
Utilization Review Coordinator

Implementation Timeline: Already implemented and monitored monthly.

Requirement

The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A, Att. 9)

DHCS Finding 8.3.1

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

1) **Line number 1, 3, 5, 8, 10, 15, 19, and 20**: There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*
2) **Line numbers 7, 14, and 16**: Although there was a written medication consent form in the medical record, there was no medication consent for each of the medications prescribed. *The MHP was given the opportunity to locate the medication consents in question but was unable to locate it/them in the medical record.*

CORRECTIVE ACTION PLAN 8.3.1:

The MHP shall submit a CAP to address actions it will implement to ensure the following:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

Corrective Action Description
The Medication Consent Policy and Procedure has been revised to reflect current requirements for medication consents. The revised policy and procedures will be reviewed with prescribing staff at medication motioning review committee.

Proposed Evidence/Documentation of Correction

- Reviewed during medication monitoring committee
- Updated Medication Consent Policy
- Updated Consent to Received Anti-Psychotics form
- Pages from the updated Medication Monitoring Plan, Process and Guidelines manual

Ongoing Monitoring (if included)
Ongoing monitoring of the standard will occur via monthly Medication Monitoring activities as this metric is a part of the Medication Monitoring review tool.

Person Responsible (job title)
Contracted Pharmacist for Medication Monitoring

Implementation Timeline:
8/01/22

Requirement

Written medication consents shall include, but not be limited to, the following required elements:

1) The reasons for taking such medications.
2) Reasonable alternative treatments available, if any.
3) Type of medication.
4) Range of frequency (of administration).
5) Dosage.
6) Method of administration.
7) Duration of taking the medication.
8) Probable side effects.
9) Possible side effects if taken longer than 3 months
10) Consent, once given, may be withdrawn at any time.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding 8.3.2

Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent form, and/or documented to have been reviewed with the beneficiary, and/or provided in accompanying written materials to the beneficiary:

1) The reason for taking each medication: **Line numbers 12 and 13.**
2) Type of medication: **Line numbers 12 and 16.**
3) Range of Frequency (of administration): **Line numbers 2, 4, 7, 12, 13, and 14.**
4) Dosage: **Line numbers 2, 4, 7, 12, 13, and 14.**
5) Method of administration: **Line numbers 2, 4, 7, 12, 13, and 14.**
6) Duration of taking the medication: **Line numbers 2, 4, 7, 12, 13, and 14.**
7) Probable side effects: **Line number 12.**
8) Possible side effects if taken longer than 3 months: **Line numbers 2, 4, 7, 12, and 14.**
9) Consent once given may be withdrawn at any time: **Line numbers 4, 7, and 14.**

CORRECTIVE ACTION PLAN 8.3.2:

The MHP shall submit a CAP that describes how the MHP will ensure that every medication consent process addresses all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description
The Medication Consent Policy and Procedure has been revised to reflect current requirements for medication consents. The revised policy and procedures will be reviewed with prescribing staff at medication motioning review committee.

Proposed Evidence/Documentation of Correction
- Reviewed during medication monitoring committee
- Updated Medication Consent Policy
- Updated Consent to Received Anti-Psychotics
- Pages from the most recent Medication Monitoring Plan, Process and Guidelines manual

Ongoing Monitoring (if included)
Ongoing monitoring of the standard will occur via monthly Medication Monitoring activities as this metric is a part of the Medication Monitoring review tool.

Person Responsible (job title)
Contracted Pharmacist for Medication Monitoring

Implementation Timeline:
08/01/22

Requirement

All entries in the beneficiary record (i.e., Medication Consents) include:
1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding 8.3.3

Medication Consents in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, job title, and/or the date the provider completed and entered the document into the medical record. Specifically:
- The signature of the person providing the service (or electronic equivalent)
  - **Line numbers 12, 13, 14, and 16.**
- The type of professional degree, licensure, or job title of person providing the service:
  - **Line numbers 13 and 16.**
- The date the documentation was completed, signed (or electronic equivalent) and entered into the medical record:

- **Line numbers 13 and 16.**

CORRECTIVE ACTION PLAN 8.3.3:

The MHP shall submit a CAP that describes how the MHP will ensure that all Medication Consents include the:

1) Provider's signature (or electronic equivalent).
2) Provider's signature (or electronic equivalent) that includes professional degree, licensure or title.
3) Date the signature was completed and the document was entered into the medical record.

Corrective Action Description
The Medication Consent Policy and Procedure has been revised to reflect current requirements for medication consents. The revised policy and procedures will be reviewed with prescribing staff at medication motioning review committee.

Proposed Evidence/Documentation of Correction

- Reviewed during medication monitoring committee
- Updated Medication Consent Policy
- Updated Consent to Received Anti-Psychotics
- Pages from the most recent Medication Monitoring Plan, Process and Guidelines manual

Ongoing Monitoring (if included)
Ongoing monitoring of the standard will occur via monthly Medication Monitoring activities as this metric is a part of the Medication Monitoring review tool.

Person Responsible (job title)
Contracted Pharmacist for Medication Monitoring

Implementation Timeline:
8/1/22

Requirement

The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
(MHP Contract, Ex. A, Att. 2)

DHCS Finding 8.4.2b

Services claimed and documented on the beneficiary's progress notes were not sufficient and consistent in amount, duration or scope with those documented on the beneficiary's current Client Plan. Specifically:

- **Line numbers 1, 4, 8, 11, 14, 15, 17, and 18.**
    - **Line number 1.** Per the Client Plan completed on 5/21/2020, TCM and Group Therapy, both with a frequency of 1-4 times monthly were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
    - **Line number 4.** Per the Client Plan completed on 12/16/2019, Group and Individual Rehabilitation and Group Therapy, all with a frequency of one time monthly were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
    - **Line number 8.** Per the Client Plan completed on 3/23/2020, Group Therapy, Individual and Group Rehabilitation, and TCM, all with a frequency of one time monthly; in addition to Collateral Services, were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
    - **Line number 11.** Per the Client Plan completed on 5/13/2020, Family Therapy, Rehabilitation Services, and TCM, all with a frequency of one time monthly; in addition to Medication Support Services, were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
    - **Line number 14.** Per the Client Plan completed on 8/20/2020, Group Therapy, Family Therapy, and Rehabilitation Services, all with a frequency of one time monthly, were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
    - **Line number 15.** Per the Client Plan completed on 8/9/2020, Family Therapy, with a frequency of “up to two times monthly,” was listed as a needed intervention. However, this service was not provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
    - **Line number 17.** Per the Client Plan completed on 5/18/2020, Family Therapy, Rehabilitation Services, and TCM all with a frequency of “up to” one time monthly, were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to

confirm that these services were provided at any time before or after the review period.

- **Line number 18.** Per the Client Plan completed on 7/14/2020, TCM and Rehabilitation Services, both with a frequency of one time monthly, were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.
- **Line number 19.** Per the Client Plan completed on 2/13/2020, Family Therapy, Rehabilitation Services, TCM, and Collateral Services all with a frequency of one time monthly, were listed as needed interventions. However, none of these services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.

CORRECTIVE ACTION PLAN 8.4.2b:

The MHP shall submit a CAP that describes how the MHP will ensure that services are provided in the amount, duration, and scope as specified in the Individualized Client Plan for each beneficiary.

Corrective Action Description
Review UR tool to make changes as necessary to ensure that the charts are reviewed for amount, duration, or scope for each beneficiary. Clinical staff will be instructed that beneficiaries need to receive the identified services described on the individual service plan

Proposed Evidence/Documentation of Correction

- Updated UR tool if necessary
- QI Memo outlining the requirement

Ongoing Monitoring (if included)
Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline:
8/1/22

Requirement

The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Att. 2)

DHCS Finding 8.4.3a

One or more client plan(s) was not updated at least annually and/or when there were significant changes in the beneficiary's condition. Specifically:

- **Line number 6**: There was a **lapse** between the prior and current Client Plans. However, this occurred outside of the audit review period.
    - **Line number 6**. Prior Client Plan expired on 10/19/2019; however, the current Client Plan was completed on 11/7/2019.

CORRECTIVE ACTION PLAN 8.4.3a:

The MHP shall submit a CAP that describes how the MHP will ensure that Client Plans are updated at least on an annual basis, as required by the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.

Corrective Action Description
All MHP staff providing, or supervising assessment services will receive re-training on the standard.

Proposed Evidence/Documentation of Correction

- Completion of documentation training will be verified via Relias.
- QI Memo outlining the requirement

Ongoing Monitoring (if included)
Clinical Supervisors and/or Managers will monitor staff completion of training. Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline: MHP direct services staff and clinical supervisors will complete the training by 7/01/22

Requirement

The MHP shall ensure that Client Plans:

1) Have specific, observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairment as a result of the mental health diagnosis.

2) Identify the proposed type(s) of interventions or modality, including a detailed description of the intervention to be provided.
3) Have a proposed frequency of the intervention(s).
4) Have a proposed duration of intervention(s).
5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.
6) Have interventions are consistent with client plan goal(s)/treatment objective(s).
7) Have interventions are consistent with the qualifying diagnoses.

DHCS Finding 8.4.4

Client Plans did not include all of the required elements identified in the MHP Contract. Specifically:

- One or more goal/treatment objective was not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments. **Line numbers 2, 3, 4, 5, 6, 9, 12, and 16.**
- One or more proposed intervention did not include an expected frequency or frequency range that was specific enough. **Line numbers 8, 11, and 17.**
  - **Line number 8**. Per the Client Plan completed on 3/23/2020, Collateral Services were listed as a needed intervention; however, there was no proposed frequency specified on the plan.
  - **Line number 11.** Per the Client Plan completed on 5/13/2020, Collateral Services, Family Therapy, and TCM, were listed as a needed interventions, all with a frequency of "up to once monthly", which is not a specific frequency.
  - **Line number 17.** Per the Client Plan completed on 5/18/2020, Collateral Services, Family Therapy, and TCM, were listed as a needed interventions, all with a frequency of "up to once monthly", which is not a specific frequency.
- One or more proposed intervention did not include an expected duration. **Line numbers 1, 2, 6, 12, 15, and 20.** o **Line number 1.** The Client Plan completed on 5/21/2020 does not include an expected duration for each of the proposed interventions listed.
  - **Line number 2.** The Client Plan completed on 8/11/2020 does not include an expected duration for each of the proposed interventions listed.
  - **Line number 6.** The Client Plan completed on 10/16/2019 does not include an expected duration for each of the proposed interventions listed.
  - **Line number 12.** The Client Plan completed on 8/20/2020 does not include an expected duration for each of the proposed interventions listed.
  - **Line number 15.** The Client Plan completed on 8/9/2020 does not include an expected duration for each of the proposed interventions listed.
  - **Line number 20.** The Client Plan completed on 9/24/2019 does not include an expected duration for each of the proposed interventions listed.

CORRECTIVE ACTION PLAN 8.4.4:

The MHP shall submit a CAP that describes how the MHP will ensure that:

1) Client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.
2) Mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

Corrective Action Description
All MHP staff providing, or supervising assessment services will receive re-training on the standard.

Proposed Evidence/Documentation of Correction
- Completion of documentation training will be verified via Relias.
- QI Memo outlining the requirement

Ongoing Monitoring (if included)
Clinical Supervisors and/or Managers will monitor staff completion of training. Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline: 08/01/22

Requirement

There is documentation in the Client Plan that a copy of the Client Plan was offered to the beneficiary.

DHCS Finding 8.4.11

Line numbers 1, 2, 5, 11, 12, and 16: There was no documentation on the current Client Plan that the beneficiary or legal guardian was offered a copy of the Client Plan.

CORRECTIVE ACTION PLAN 8.4.11:

The MHP shall submit a CAP that describes how the MHP will:
1) Ensure that there is documentation on the Client Plan substantiating that the beneficiary was offered a copy of the Client Plan.
2) Submit evidence that the MHP has an established process to document that each beneficiary is offered a copy of their current Client Plan.

Corrective Action Description
All MHP staff providing, or supervising assessment services will receive re-training on the standard.

Proposed Evidence/Documentation of Correction

- Completion of documentation training will be verified via Relias.
- QI Memo outlining the requirement

Ongoing Monitoring (if included)

Clinical Supervisors and/or Managers will monitor staff completion of training. Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)

Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline: 08/01/22

Requirement

Items that shall be contained in the client record (i.e., Progress Notes) related to the beneficiary's progress in treatment include all of the following:

1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions.
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.
4) The date the services were provided.
5) Documentation of referrals to community resources and other agencies, when appropriate.
6) Documentation of follow-up care or, as appropriate, a discharge summary
7) The amount of time taken to provide services.
8) The following:
    a. The signature of the person providing the service (or electronic equivalent);
    b. The person's type of professional degree, and,
    c. Licensure or job title.

(MHP Contract, Ex. A, Att. 2)

DHCS Finding 8.5.2

Progress notes did not include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically:

- **Line numbers 1, 2, 4, 5, 8, 9, 10, 12, 13, 15, 17, and 18.** One or more progress note was not completed within the MHP's written timeliness standard of 3

business days after provision of service. 74 (25.9 percent) of all progress notes reviewed were completed late (74.1% compliance).

CORRECTIVE ACTION PLAN 8.5.2:

The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document**:**

- Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.

Corrective Action Description
All MHP staff providing or supervising clinical services will receive re-training on the standard.

Proposed Evidence/Documentation of Correction

- Completion of documentation training will be verified via Relias
- QI Memo outlining the requirement

Ongoing Monitoring (if included)
Clinical Supervisors and/or Managers will monitor staff completion of training. Ongoing monitoring of the standard will occur monthly through URC activities.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline:
8/1/22

Requirement

The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs.
(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

DHCS Finding 8.6.1

1) The MHP did not furnish evidence that it has a standard procedure for providing and documenting individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs.
2) The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility

and need for ICC services and IHBS, and that if appropriate, such services were included in their Client Plan.
During the review, MHP staff indicated that they do not have a formal screening process in place for determining eligibility and need for ICC services and IHBS. MHP staff indicated that during the review period, not all youth beneficiaries were receiving an individualized determination of eligibility and need for ICC/IHBS services; however, they reported that they will begin the process of accurately capturing this determination within the medical records of all youth beneficiaries. *Lastly, it should be noted that the MHP was given the opportunity to locate evidence of any formal (or informal) determination for the need for ICC/IHBS services; however, the MHP was unable to locate it in the medical record.*

- **Line numbers 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20.**

CORRECTIVE ACTION PLAN 8.6.1:

The MHP shall submit a CAP that describes how it will ensure that:

1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.
2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.
3) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

Corrective Action Description
To address the correction systemically the ICC and IHBS policy has been created to more explicitly outline the MHP procedures to make and clearly document individualized determinations of all child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs. The Children's assessment process and form have been reviewed and are being updated to include more specific indicators for ICC/IHBS screening to support the clinical determination process. All MHP staff providing or supervising clinical services will receive training on the standard and updated policy and procedures. The MHP URC monitoring tool is being updated to support more thorough ongoing review for this standard.

Proposed Evidence/Documentation of Correction

- Completion of training will be verified via Relias.
- Developed ICC and IHBS policy.
- Updated assessment templates.
- Updated URC monitoring tool

Ongoing Monitoring (if included)
Clinical Supervisors and/or Managers will monitor staff completion of training.

Children and youth charts will continue to be randomly selected and reviewed using the updated UR tool to verify if determinations are clearly documented in children and youth charts.

Person Responsible (job title)
Clinical Supervisors/Managers
QI URC Coordinator and/or QI Analyst

Implementation Timeline:
8/1/22