DEPARTMENT OF HEALTH CARE SERVICES

TRIENNIAL REVIEW OF THE SAN LUIS OBISPO COUNTY MENTAL HEALTH PLAN

FINDINGS REPORT

Review Dates: November 7, 2018 - November 8, 2018

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EXECUTIVE SUMMARY

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

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

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

Below is an overview of DHCS' findings.

During the review, it was apparent that San Luis Obispo County MHP has developed a strong collaboration between mental health, health services, and social services organizations within their community that reduces the barriers to providing integrated care. The MHP should be commended for their processes to ensure that information sharing between delivery systems, such as bidirectional referrals, collaborated conference calls, coordinated meetings, and client access procedures have become effective and effortless. An example that was demonstrated as part of the review process included the active participation of the Managed Care Plan (MCP) in the discussion related to their coordination and commitment to providing the best possible services collectively with the MHP. The inclusion of the MCP allowed the DHCS team insight to a collaborative model that can be replicated in other counties.

The MHP has a similar relationship with Child Welfare (CW). The MHP has developed a shared database between DSS and the MHP, which allows the CW Social Worker to upload and share relevant case information, screening tools, mental health intake paperwork, and court orders. This process allows the MHP to receive and request information when needed. The synchronizing and sharing of information expeditiously allows the county to schedule assessments within the required timeliness standards.

Although we cannot list the variety of innovative projects that were discussed during the facilitated conversation, we want to recognize that the projects represent the concerted effort towards the MHP's ongoing pursuit of quality improvement.

The following information will focus on the areas in which additional training or process changes could improve the current practices the MHP has in place.

This report details the findings from the triennial system review of the **San Luis Obispo County** Mental Health Plan (MHP). The report is organized according to the findings from each section of the FY 2018/2019 Annual Review Protocol for Consolidated Specialty Mental Health Services (SMHS) and Other Funded Services, specifically Sections A-H and the Attestation. This report details the requirements deemed out of compliance (OOC), or in partial compliance, with regulations and/or the terms of the contract between the MHP and DHCS. The corresponding regulatory and/or contractual authority will be followed by the specific findings and required Plan of Correction (POC).

For informational purposes, this findings report also includes additional information that may be useful for the MHP, including a description of calls testing compliance of the MHP's 24/7 toll-free telephone access line and a section detailing information gathered for the "SURVEY ONLY" questions in the protocol.

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

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

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

RESULTS SUMMARY: SYSTEM REVIEW

SYSTEM REVIEW SECTION	TOTAL ITEMS REVIEWED	SURVEY ONLY ITEMS	TOTAL FINDINGS PARTIAL or OOC	PROTOCOL QUESTIONS OUT-OF-COMPLIANCE (OOC) OR PARTIAL COMPLIANCE	IN COMPLIANCE PERCENTAGE FOR SECTION
SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES	63	1	1	A.I.E	98%
SECTION B: CARE COORDINATION AND CONTINUITY OF CARE	17	1	1	I.D.1	94%
SECTION C: QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT	42	1	0		100%
SECTION D: ACCESS AND INFORMATION REQUIREMENTS	67	0	4	D.IV.15, D.VI.B.2, D.VI.B.3, & D.VI.B.4	94%
SECTION E: COVERAGE AND AUTHORIZATION OF SERVICES	42	1	1	E.IV.A.4	98%
SECTION F: BENEFICIARY RIGHTS AND PROTECTIONS	67	0	1	1.A.1	99%
SECTION G: PROGRAM INTEGRITY	43	0	0		100%
SECTION H: OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS	3	0	1	H.A.	67%
TOTAL ITEMS REVIEWED	**344**	**4**	**9**		

Overall System Review Compliance

Total Number of Requirements Reviewed	**344**			
Total Number of SURVEY ONLY Requirements	4 (NOT INCLUDED IN CALCULATIONS)			
Total Number of Requirements Partial or OOC	**9**		**OUT OF 344**	
OVERALL PERCENTAGE OF COMPLIANCE	**IN** (# IN/344)	97%	**OOC/ PARTIAL** (# OOC/344)	3%

FINDINGS

SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

1(E) Availability of Specialty Mental Health Services

FINDING

Title 42 of the Code of Federal Regulations 438.206(c) (1)(i). requires that the MHP meet, and requires that its providers meet, Department standards for timely access to care and services, taking into account the urgency of need for services. As part of the requested pre-review documentation process, the DHCS team reviewed the MHP's Service Request Log from January 9, 2018 thru January 31, 2018 for adult services and January 2, 2018 thru January 31,18 for children's services. Out of the eighty eight (88) calls received for adult services twenty four (24) declined services and two (2) out of the sixty four (64) remaining calls did not meet the timeliness requirements. One out of the two calls that were not timely was related to the clinician's error. Twenty nine (29) calls were made for children's services of those calls six (6) declined services. The remaining twenty three (23) calls all met timeliness standards. DHCS reviewed additional documents that included the Draft Implementation Plan, and Policy & Procedure 3.23 Network Adequacy, Access Timeliness, and Array of Services. However, this requirement is deemed OOC. The MHP must come into compliance with the provisions of (42 C.F.R. § 438.206(c)(1)(i).). Protocol requirement A.I.E is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with (42 C.F.R. § 438.206(c)(1)(i).)

SECTION B: CARE COORDINATION AND CONTINUITY OF CARE

IV.D.1 MOUs with Medi-Cal Managed Care Plans

FINDING

Title 9 of California Code of Regulations section 1810.370(a)(5) requires the MHP process for resolving disputes between the MHP and the MCP includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. The MHP provided their MOU with CENCAL Health, which has been actively in place since 2015. It outlines the service responsibilities of each agency and the delegation of mental health management to Holman Professional Counseling Centers, which has been approved by the Department of Managed Health Care. Holman is also accountable for monitoring of timely access standards.

In addition, The MHP submitted their Dispute Resolution Matrix and Narrative however, it failed to identify if beneficiaries would receive services including SMHS and prescription drugs, while the disputes is being resolved. The MHP was provided the opportunity to research if the information was included as a supplemental attachment however, the necessary information was not located. Protocol requirement B.IV.D.1. is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with (CCR Title 9 § 1810.370(a)(5)).

SECTION D: ACCESS AND INFORMATION REQUIREMENTS

IV.D.15 Provider Directory

FINDING

During the review, the MHP discussed their cultural competence trainings. All staff are to receive annual cultural competence training and the MHP has contracted with Relias Learning to offer this web-based service. The MHP provided their Current Training Plan Compliance dated 10/8/18 which included the various department and the percentage of compliance related to the annual requirements for cultural competence training. The DAS program identified that it was 97% in compliance. After further investigation and reviewing additional evidence of the trainings completed for contracted providers, it was clear that the contracted providers are required to take the annual training, and there are progressive steps to ensure that their employees complete the trainings. However, the documentation also showed that some employees did not complete the annual requirement that was to be completed by June 30, 2018. The MHP could not provide documentation that as of the date of the review any additional trainings were completed. The employees should currently be actively involved in trainings required for the 2018/19 FY. Therefore, this would require that the MHP to identify on its provider list that the contracted provider did not complete the required Cultural Competency Training. Protocol requirement D.IV.D.15 is deemed OOC.

The triennial that was conducted in FY 15/16 identified that the Provider Directory did not include specific alternatives and options for cultural services. Although this is separate category, the provider list being out of compliance is a repeat deficiency.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with (42 C.F.R. § 438.10(h)(1)(v), CCR, title 9, chapter 11, section 1810.410, MHSUD IN 18-020).

SECTION D: ACCESS AND INFORMATION REQUIREMENTS

VI.B 24/7 Access Line and Written Log of Requirements for SMHS

DHCS TEST CALLS

The DHCS review team made seven (7) calls to test the MHP's 24/7 toll-free line. The seven (7) test calls are summarized below:

Test Call #1 was placed on Tuesday, October 2, 2018, at 7:53 a.m. The call was answered after one (1) ring via a phone tree directing the caller to continue in English or select a Spanish language option, the MHP's threshold language. The message instructed the caller to dial 911 or go to the emergency room in an emergency. The phone tree offered the caller options for psychiatric services, mental health services, to schedule an appointment, and file grievances. There was also an option for hospitals. The caller selected the option for mental health services. A new answering machine message gave hours and operation and addresses of five (5) walk in clinics. The message stated the caller could get further information from the clinics, its website, the beneficiary booklet or by calling between 8am and 5pm. The caller was provided information for threshold language assistance and about how to access SMHS. The caller was provided information about how to access services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.1, D.VI.B.2, D.VI.B.3, and D.VI.B.4.

Test Call #2 was placed on Thursday, September 20, 2018, at 10:33 a.m. The call was answered after two (2) rings via a live operator. The caller described issues related to scenario 2, loss of appetite, crying, and the inability to sleep. The operator asked for some identifiable information: After trying to locate the caller in the system the operator was concerned about not being able to find the caller and put the caller on hold for about two (2) minutes. The caller explained that the issue could be that the caller just moved to the area and would need to get the Medi-Cal transferred.

The operator put caller on a brief hold and then transferred the caller to a therapist who identified herself as Diane. The therapist proceeded to ask another series of screening questions. After the caller responded. The therapist identified that the caller would be a good fit for the Holman group however, the callers Medi-Cal must be current. Another option would be that the caller could go to the Community Council Center, where they provide mental health services based on a sliding scale. The caller would be able to receive an assessment, therapy, and medication

support if needed. The caller was provided their number. The therapist also recommended that the caller contact the county office to get the Medi-Cal issues resolved and provided the number. After the issue is resolved, the caller has the option of contacting the Holman Group and if the caller needed assistance, the caller could call this same number and someone would be available to help or the called could contact the Holman Group directly. The operator provided the number. The caller thanked the therapist. The therapist stated that if the caller was feeling unsafe and felt like hurting him/herself he/she could call the SLO Hotline and provided the number. The caller thanked the therapist again and ended the call.

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 for protocol questions D.VI.B.2 and D.VI.B.3.

Test Call #3 was placed on Thursday, October 4, 2018, at 7:40 a.m. The call was answered after two (2) rings via a phone tree in English and then gave the option in Spanish to choose 4 for Spanish. The phone tree identified as San Luis Obispo County Mental Health Access Line and stated if it was a medical emergency to hang up and dial 9-1-1. A menu of options were given: press 1, for Mental Health Professional or an urgent matter, press 2, for how to get mental health services for yourself or a family member (obtain SMHS), 3, to reach a Patient Rights Advocate (appeal, grievance, etc.), and 5, For Psychiatric hospital admissions (SLO patient being admitted). The caller's script was to find out about specialty mental health services for the caller so, option #2 was chosen. The next phone tree gave options for the caller to obtain specialty mental health services as well as get more information about the county after hours which was the time of the call. The options included: leaving a message, call back during business hours, visit one of the counties clinics (names of multiple clinics were provided with addresses), as well as the website address (URL) with information the beneficiary could get from the website. The caller didn't speak to a live person and didn't leave a message for a call back. The caller disconnected the call at 7:43 a.m. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.1, D.VI.B.2, and D.VI.B.3.

Test Call #4 was placed on Monday, September 24, 2018, at 9:32 a.m. The call was answered after one (1) ring via a live operator. The caller explained to the operator that the caller is new to the county and is requesting information about how to fill an anxiety medication in San Luis Obispo County. The operator asked the caller what type of insurance the caller had. The caller replied, Medi-Cal. The operator asked for the caller's name, social security number (SSN), date of birth (DOB), and address. The caller provided their name, address (street name only) and DOB, but informed the operator that the caller was not comfortable in providing their SSN. The caller informed the operator that the caller is just wanting some information on what the process is to obtain a medication refill. The operator said she needed the information to see if the caller is in the system. The operator asked the caller to hold and that she would have the caller talk to a counselor. The caller spoke with the counselor and explained that the caller would like to know the process in obtaining a medication refill in their county. While counselor was talking to the caller, the counselor mentioned that you don't sound like you require urgent care and began to explain the process about how to obtain a medication refill with the county. After the explanation, the caller thanked the counselor for the information and ceased the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and was provided information about services needed

to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.2 and D.VI.B.3.

Test Call #5 was placed on Tuesday, October 9, 2018, at 8:37 a.m. The call was answered after (3) rings via an operator. The call was answered by a live operator identifying themselves as "this is San Luis Obispo Behavioral Health, how can I help you." They did not provide their name. The caller reported they can't seem to get any sleep; crying all the time; they don't have an appetite and that it's a struggle just to get out of bed every day. The operator asked for a name. The caller said their name is Shelia. Operator also asked for caller's last name. Caller stated they preferred not to provide last name. Operator explained it is confidential and its' information needed for the counselor. The caller provided their last name as "Johnson." Operator put the caller on hold for 2 minutes and 36 seconds. Before putting the caller on hold, operator explained they need to answer other calls coming in. The operator came back on the line and asked for more identifying information and referral source. They asked who referred you. The caller answered a friend referred them. Also, the operator wanted to know who the primary care physician was for the caller. The caller answered by stating they can't remember the physicians name right now. The operator asked for the social security number and Medi-Cal number. The caller reported, they do not feel comfortable giving their SSN and can't remember their Medi-Cal number. The operator replied, no counselor is available right now but one will call you within an hour. The operator ended the call by saying "thank you, Emily." The operator did not use the correct name or offer any information about how to access SMHS. They did not provide any information about services needed to treat a beneficiary's urgent condition. No crisis assessment was offered at any time during the call. The call is deemed out of compliance with the regulatory requirements for protocol questions D.VI.B.2 and D.VI.B.3.

Test Call #6 was placed on Tuesday, September 25, 2018, at 7:48 a.m. The call was answered after one (1) ring via a phone tree opening in English and then Spanish. After the language selection intro it opened up with San Luis Obispo County Mental Health Access Line. If this is a medical emergency please hang up and dial 9-1-1. Press 1 to talk to a mental health professional regarding a psychiatric crisis or for urgent matter. Press 2 for information on Mental Health Services for yourself or for a family member or to schedule an appointment for services. Press 3 for the Complaint Patient Right Advocate line about a complaint, appeal, expedited appeal, or the State Fair Hearing. Press 5 if you are calling from a psychiatric hospital of admission regarding admission to SLO medical beneficiary. The caller Pressed 3 and was put on hold for approximately 15-20 seconds. Answering machine picked up and provided intro in Spanish and English. If this is an urgent situation call 1-800-838-1381 or if this is an emergency please hang up and dial 9-1-1. To file a grievance, appeal, expedited appeal please leave a confidential message and we will return your call as soon as possible. Or if you need more information on the State Fair Hearing or how to Change a Provider we can discuss that in person or over the phone. There are 4 ways to submit in writing: Through our client information center where you can get information and forms in privacy. On their website and they provided URL. Leave your name and address and s/he will mail the form with a pre-paid self-addressed envelope. Or we can discuss the options over the phone. The recording then repeated the Patient Right Advocate information in Spanish. The caller re-called and didn't select an option and then the recording goes over several key informative details regarding the days and times they are open accompanied with a telephone number, the addresses for several locations, the County URL, and information regarding the provider handbook which is in English, Spanish or alternative formats. The call was deemed in compliance regarding providing

information to beneficiaries about how to access SMHS. The phone tree provided an option for Spanish and information related to treating an urgent condition and Information related to how to file a grievance. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B.1, D.VI.B.2, D.VI.B.3, and D.VI.B.4.

Test Call #7 was placed on Tuesday, September 18, 2018, at 10:07 a.m. The call was answered after one (1) ring via an operator directing the caller to a second operator whom is a patient rights advocate. The transfer from the first operator to the second operator was quick. The caller requested information about how to file a complaint in the county. The second operator asked the caller to provide their name and contact information and advised the caller their name was not in the county system. The caller asked again how they can file a complaint. The second operator informed the caller that they can file a complaint through the second operator or the program supervisor via phone. No additional information about how to file a complaint/grievance was provided to the caller, including how to physically file a grievance. The call is deemed out of compliance with the regulatory requirements for protocol question D.VI.B.4.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
D.VI.B.1	IN	N/A	IN	N/A	N/A	IN	N/A	100%
D.VI.B.2	IN	IN	IN	IN	OUT	IN	N/A	84%
D.VI.B.3	IN	IN	IN	IN	OUT	IN	N/A	84%
D.VI.B.4	IN	N/A	N/A	N/A	N/A	IN	OUT	66%

As part of the MHP's effort to improve the outcome of their test calls, they provide at least quarterly trainings in which their scripts and procedures are reviewed with their staff. In addition, the MHP conducts bimonthly test calls to test the staff on the information that is provided during the trainings. The policies provided included P&P 3.00 Access to Services, scripted responses for the Central Access line calls, and the MHP's detailed Action Plan for their Central Access Line. DHCS conducted seven (7) test calls; the Access line provided inconsistent information related to accessing SMHS and assessing a beneficiary's urgent condition. In addition, the information related to the grievance resolution process was inadequate and would require additional training on behalf of the MHP.

Protocol requirement D.VI.B.2, D.VI.B.3 and D.VI.B.4 is deemed in partial compliance. These requirements were in partial compliance in the previous triennial review and is now a repeat deficiency. This is an area needing immediate attention.

PLAN OF CORRECTION

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with CCR Title 9 1810.370(a)(5).

SECTION E: COVERAGE AND AUTHORIZATION OF SERVICES

IV.A.4 Notice of Adverse Benefit Determination (NOABD) Requirements

FINDINGS

DHCS' preliminary analysis of the MHP's Policy & Procedure 3.30 Notices of Adverse Benefit Determination and their NOABD log for 2017/2018 indicated that the MHP was sending the appropriate notices as required. The log identified that 597 NOABD's were sent in FY 2017/2018 and of those 173 were sent relating to lack to timely service. However, when reviewing the service request log from January 9, 2018 thru January 31, 2018 for adult services an NOABD for a beneficiary that was referred to the MCH (Holman Group for non-specialty MHS) was not provided as evidence. Protocol requirement IV.A.4 is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with (42 C.F.R. § 438.400(b)(4)).

SECTION F: BENEFICIARY RIGHTS AND PROTECTIONS

II.A.1 Handling Grievance and Appeals

FINDING

The MHP has implemented a problem resolution process that includes informing beneficiaries of their rights when beginning services and upon request. The review was at a location, which allowed the DHCS team to see posted Information explaining the grievance, appeal, and expedited appeal process. As part of their procedure available at each clinic is drop box to submit grievances and appeals. The MHP provided Policy & Procedures 4.07 Beneficiary Grievances, Appeals, & Expedited Appeals in addition to the Grievance/Appeal log from July 5, 2017 to June 29, 2018. The policy confirms that all grievances/appeals/expedited appeals will be directed to the Patients' Rights Advocate (PRA) for logging and to ensure confidentiality is maintained. However, this process requires that the grievances are not logged when received at each contracted provider site. The grievances/appeals must then be sent to the PRA which presents a delay related to the one day logging requirement. Protocol requirement F.1.A is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).)

SECTION H: OTHER REGULATORY AND CONTRACTUAL REQUIREMENTS

A. Annual Cost Reports

FINDING

As part of the pre review process DHCS reviewed the MHP's Cost Report information from July 1, 2016 thru June 30, 2017, in addition to email communications from the MHP to DHCS, and additional financial data. The boilerplate contract that was provided as evidence included the requirement that contractors collect and provide the MHP with all data and information necessary to satisfy state reporting requirements. However, Per WIC 14705 (c), the cost report is due to DHCS by December 31 following the close of the fiscal year. DHCS does not have the authority to alter this requirement. As such, the cost report is due regardless of the reason for delay (County and/or DHCS). If a county has any reason to believe that their cost report would not be filed by December 31, they should seek an extension to file from DHCS at least two weeks prior to the due date (IN 17-025). Cost reports received after December 31 with no extension requests on file are considered delinquent and subject to provisions contained in WIC 1412(e). This requirement is deemed OOC. The MHP must come into compliance with the provisions of W&I Code Sections 14705(c) and 14712(e). Protocol requirement H.A. is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with the requirement of W&I Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

SURVEY ONLY FINDINGS

The purpose of DHCS developing survey questions is to determine the status of implementation statewide prior to the inclusion as compliance requirements. Data is collected and reviewed by the DHCS team however; the information is not included in the overall compliance score.

SECTION A: NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

III. F. & G Children's Services

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

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P&P 6.11 Continuum of Care Reform/Pathways to Wellbeing: Subclass, Model, and Services, Snapshot identifying that the TFC service code is set up in Anasazi. The MHP currently has a contract with Family Care Network for FY 2018-2019 who is the TFC agency contractor.

SUGGESTED ACTION

No further action required at this time.

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

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P&P 6.11 Continuum of Care Reform/Pathways to Wellbeing: Subclass, Model, and Services. Policy identifies that SLO will provide all medically necessary SMHS and EPSDT supplemental services including ICC, IHBS, and TFC, to all Medi-Cal beneficiaries who meet medical necessity and eligibility criteria. In addition to collaborating with County of San Luis Obispo's Department of Social Services.

SUGGESTED ACTION

No further action required at this time.

SECTION B: CARE COORDINATION AND CONTINUITY OF CARE

III.C. Coordination of Physical and Mental Health Care

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

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: P&P Coordination and Continuity of Care which outlines the transitions from inpatient or residential to outpatient care, between levels of care within a San Luis Obispo Behavioral Health

Department (SLOBHD) program, to or from services provided by CenCal Health or other community health care providers, and between providers of services by multiple SLOBHD programs. In addition, the policy addresses if a beneficiary who was in treatment at a Physical Health Care Services (PHCS) or community provider level of care transitions to services at SLOBHD and requests to continue to receive services from their current provider and the provider is willing to continue to provide services.

SUGGESTED ACTION

No further action required at this time.

Section E: COVERAGE AND AUTHORIZATION OF SERVICES

H.1. Service Authorization Requirements

REQUIREMENT	
H.	**Survey Only:** 1) MHPs must review and make a decision regarding a provider's request for prior authorization within five (5) business days after receiving the request.

SURVEY FINDING

DHCS reviewed the following documentation provided by the MHP for this survey item: Service Authorization Request Form (SAR), SAR log – Out of County clients being served by San Luis Obispo (SLO), SAR Log-county youth placed out of county, and sample of SARs. After reviewing the twenty five (25) SARs it was determined that, each SAR was approved and signed the day received or the following day.

PROTOCOL REQUIREMENT		# PRIOR AUTHORIZATIONS IN COMPLIANCE	# PRIOR AUTHORIZATIONS OOC	COMPLIANCE PERCENTAGE
E.I.H.5	Prior authorization approved or denied within five (5) business days after receiving the request.	25	0	100%

SUGGESTED ACTION

No further action required at this time.