Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ **This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

_X_ **This is a renewal request.**

- __ **This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.**
- X **The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.**

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- Confirm **it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.**
- Summarize the results **or findings of each activity. CMS may request detailed results as appropriate.**
- Identify problems **found, if any.**
- Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.**
- Describe system-level program changes**, if any, made as a result of monitoring findings.**

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ **Yes**
___ **No. Please explain:**

Summary of results:

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Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

1. ***Monitoring Activity*: Consumer Self Report Data**

Strategy 1: Consumer Perception Survey (CPS)

Confirmation it was conducted as described:
__ X Yes
__ No. Please explain

Summary of results: **During waiver period seven, the CPS was conducted using the convenience sampling method. ~~The plan had been to conduct the surveys using a random sampling technique similar to that used during the pilot study done in FY 2009-10. However, the final evaluation of the pilot study revealed that the random sampling method used did not produce a sample much more representative than the convenience sample methodology.~~**

During a one week survey period, surveys were provided by counties to consumers and parent/guardians of child consumers who received services from ~~in~~ county-operated and contract providers. Please note that since the surveys were originally developed and used in compliance with Substance Abuse and Mental Health Services Administration (SAMHSA) requirements, the surveys were provided to all consumers who received services at the county level not just to consumers and parents/guardians of child consumers who received SMHS. The surveys obtained descriptive information from each consumer and included questions about consumer satisfaction with services and questions about whether the services consumers received improved their ability to function across several domains. Four types of forms were used during the survey period: Adult (for ages 18-59), Older Adult (for age 60+), Youth Services Survey (YSS) (for ages 13-17 and transition-age youth who still receive services in the child system), and Youth Services Survey for Families (YSS-F) (for parents/caregivers of youth under age 18). The forms were available in seven languages (English, Spanish, Chinese, Russian, Vietnamese, Tagalog, and Hmong).
The data was analyzed to adhere to the SAMHSA Scoring Protocols for the CPS. California's Adult and Older Adult Survey items were scored together to yield federal MHSIP results; and California's Youth and Caregiver Surveys were scored together to yield federal YSS/YSS-F results. Below are the results of the convenience sampling process.

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Percentage of Positive Responses
Adults and Older Adults Receiving Services in FY ~~2011-12~~ 2013-14

Domain	Adult/Older Adult % Positive
Access	85%
Quality and Appropriateness	88%
Outcomes	~~70%~~ 69%
Participation In Treatment Planning	78%
General Satisfaction with Services	90%
Functioning	~~67%~~ 70%
Social Connectedness	~~70%~~ 67%

Total Number of Responses (N)
Adults and Older Adults Receiving Services in FY ~~2011-12~~ FY 2013-2014

Domain	Adult/Older Adult Responses
Access	~~14,797~~25,988
Quality and Appropriateness	~~14,518~~ 25,585
Outcomes	~~13,972~~ 24,756
Participation In Treatment Planning	~~13,906~~ 24,725
General Satisfaction with Services	~~14,961~~ 26,402
Functioning	~~14,072~~ 24,893
Social Connectedness	~~13,773,~~ 24,430

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Percentage of Positive Responses
Youth Receiving Services in ~~SFY 2011-12~~ FY 2013-2014

Domain	Youth % Positive
Access	~~85%~~ 84%
General Satisfaction	~~87%~~86%
Outcomes	68%
Family Member Participation in Treatment Planning	85%
Cultural Sensitivity of Staff	94%
Functioning	~~72%~~ 73%
Social Connectedness	86%

Total Number of Responses (N) Youth Receiving Services in ~~FY 2011-12~~ FY 2013-2014

Domain	Youth Responses
Access	~~14,000~~22,985
General Satisfaction	~~14,247~~23,523
Outcomes	~~13,816~~ 2,735
Family Member Participation in Treatment Planning	~~13,985~~22,882
Cultural Sensitivity of Staff	~~13,274~~21,867
Functioning	~~13,895~~22,823
Social Connectedness	~~13,928~~22,721

***Problems identified*: None.**

***Corrective action (plan/provider level)* N/A**

***Program change (system-wide level)~~:~~* None**

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Strategy 2: Onsite Triennial Review: MHP Beneficiary Satisfaction Policies/procedures

Confirmation it was conducted as described:

_X_ Yes

__ No. Please explain:

Summary of results: **All MHP's are required to have mechanism(s) or activity(ies) in place whereby the MHP can regularly gather and measure beneficiary satisfaction. Such mechanisms include but are not limited to surveys, and client focus groups. MHPs are required to have baseline statistics with goals for each year. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. During the triennial onsite reviews, state staff reviewed the strategies used by the MHP related to beneficiary satisfaction including but not limited to beneficiary satisfaction surveys or focus groups.**

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:

4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities in the following work plan areas?

4c. Monitoring beneficiary satisfaction as evidenced by:

1) **A mechanism or activity is in place that regularly gathers and measures beneficiary satisfaction.**

In FY 2012/13, 2/17 (12%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by both counties.

In FY 2013/14, 1/19 (5%) County MHPs were found to be out of compliance with this requirement. A Plan of Correction was submitted by the MHP.

Problems identified: **The MHP's Quality Improvement work plans did not include evidence the MHP monitored beneficiary satisfaction nor did the MHP provide documentation of policies and procedures to provide a mechanism to measure beneficiary satisfaction.**

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with this requirement. DHCS' County Support Unit follows up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.**

Program change (system-wide level): **None**

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Strategy 3: Assess Feasibility of collecting and reviewing results of beneficiary satisfaction strategies

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results/Problems identified:
During waiver period 8, information was collected as to what strategies are used by MHPs to assess beneficiary satisfaction and whether it would be feasible to collect this information, review on a statewide basis and report on findings. However, since MHPS use a varity of strategies including focus groups and surveys it was determined that it would not be feasible to collate such data in any meaningful way.
***Corrective Action (plan/provider level):* None**

***Program change (system-wide level:* None**

2. _X_ Data Analysis (non-claims)

___ Denials of referral requests
___ Disenrollment requests by enrollee
___ From plan
___ From PCP within plan
_X_ Grievances and appeals data
___ PCP termination rates and reasons
_X_ Other (please describe) Fair Hearing Data

Strategy 1: Grievance and Appeals: Review and Analysis of MHP Annual Reports

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:
During waiver period 8, DHCS required each MHP to submit an annual report summarizing the number of grievances, appeals and state fair hearings by the general category of the complaint (e.g., access, denial of services, change of provider, quality of care, confidentiality or other). The grievance and appeals data was analyzed to identify potential trends and/or issues that should be addressed with the individual MHPs or that indicate statewide trends that may require technical assistance or policy clarification.

Summary of results/Problems identified:
County Support Unit (CSU) staff reviewed all incoming reports, which are submitted on the Annual Beneficiary Grievance and Appeal Report (ABGAR) form. Before accepting the reports as final, if the reported numbers appeared unusual, staff confirmed with the MHP if they were reporting correctly. Some problems and inconsistencies were noted in the way some MHPs reported grievance and appeals; for example, reporting numbers totals that did not match the sum of the individual

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categories, or the total listed under Disposition. Once the accuracy of the information reported was confirmed, CSU staff examined the statewide data and identified MHPs that had reported either unusually high or low numbers of grievance and appeals, in the grand totals or in individual categories. The staff contacted individual MHPs that were identified for follow up to obtain the MHP's perspective on the reasons for the high or low reported numbers.

The analysis of statewide trends and themes did not provide any conclusive information to base follow up activity, except that there was indication that some counties do not consistently understand the information they need to report under the general categories on the ABGAR form. Due to the number of MHPs with data that needed to be corrected, DHCS concluded that clarification should be made by revising the ABGAR form to include definitions and sub-categories to serve as examples of what should be reported under each general category.

Corrective Action (plan/provider level)
If an MHP reported high or low numbers of grievances and appeals, CSU staff contacted the MHP to better understand the reasons for the numbers reported. Depending on the MHP's perspective on the reasons for the numbers, CSU staff may provide technical assistance. For example, if the numbers reported are high, CSU staff ensure that the MHP is analyzing its local trends through their Quality Improvement Committee and developing strategies to improve the quality of services based on the grievance and appeal information. If a MHP has unusually low numbers reported, CSU staff work with the MHP to ensure that its beneficiaries are well informed about their rights to file a grievance or appeal, and the procedure and forms are understood. These technical assistance activities are provided by CSU staff on a case by case basis, and are occurring concurrently at the time of the submission of this waiver renewal request.

Program change (system-wide level
In the initial ABGAR forms submitted to DHCS, it was noted that some counties appeared to have inconsistent understanding about what information to report, and what general categories to enter the information under. For example under the category "Change of Provider," the intention is for MHPs to report grievances filed that are related to change of provider requests. Some MHPs reported all their change of provider requests, regardless of whether the request resulting in a grievance. This led to the need for CSU staff to clarify with MHPs what information should be included.

To address problems due to lack of clarity and inconsistent understanding of the information to be reported, DHCS staff developed a draft revised ABGAR reporting form during waiver period 8. The form still needs to be reviewed and finalized.

Strategy 2: Onsite Triennial Review: Grievances and Appeals Policies/procedures

Confirmation it was conducted as described:

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_X_ Yes
___ No. Please explain:

Summary of results: **All MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. During the triennial onsite reviews, state staff reviewed documentation of these strategies and evidence that the annual evaluation occurred. Staff also asked the MHP to provide 1-2 examples of grievances or appeals from receipt through resolution. Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:**

4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities in the following work plan areas?

4c. Monitoring beneficiary satisfaction as evidenced by:

2) Annual evaluation of beneficiary grievances, appeals, and fair hearings.

In FY 2012/13, 5/17 (29%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

Problems identified: **See above**

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with this requirement. DHCS' County Support Unit monitors Plans of Correction and collects evidence of compliance following the triennial reviews.**

Program change (system-wide level): **None**

Strategy 3 :Fair Hearing Data

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results: **In FY ~~2010-2011~~ 2012-2013, ~~69~~ 48State Fair Hearings concerning Mental Health issues were reported.**

In FY ~~2011-2012~~ 2013-2014, ~~56~~ 57 State Fair Hearings concerning Mental Health issues were reported.

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In FY ~~2012-13~~ 2014-2015, ~~24~~ 10 State Fair Hearings concerning Mental Health have been reported through ~~12/12~~ December 2014.

The summary results from the fair hearing database are provided below

	FY ~~10/11~~2012-2013	**FY ~~11/12~~ 2013-2014**	**FY ~~12/13 (to 12/12)~~ 2014-2015 (through December 2014)**
Number of Hearings Filed	**~~69~~ 48**	**~~56~~ 57**	**~~24~~ 10**
Case Granted	**~~7~~ 1**	**~~1~~ 10**	**~~1~~ 0**
Case Dismissed:	**~~17~~ 3**	**~~4~~ 12**	**1**
Case Denied	**~~8~~ 11**	**~~7~~ 5**	**~~6~~ 1**
Withdrawals	**~~50~~ 22**	**~~37~~ 22**	**~~8~~ 5**
Non-appearances	**~~9~~ 8**	**~~7~~ 9**	**~~3~~ 1**

The data illustrated in the table above is collected by the California Department of Social Services, State Hearing Division. The total number of filings does not represent the total activity in a given period because a request for a fair hearing can be filed in one month and be heard, postponed, withdrawn or adjudicated in the following month(s).

The results indicate that many fair hearing requests are withdrawn or dismissed for non-appearance of the beneficiary. According to CDSS this is not an atypical pattern.

During waiver period ~~7~~ 8, State staff were not contacted by the MHPs for technical assistance.

Problems identified: **None**

Corrective action (plan/provider level): **NA.**

Program change (system-wide level): **NA**

3. ***Monitoring Activity*:** **Measurement of any disparities by racial or ethnic groups**

Strategy 1: Review/Analysis of Data

Confirmation it was conducted as described:

_X_ Yes

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___ **No. Please explain**

Summary of results: **During waiver period 8 ~~7, the Office of Multicultural Services (OMS) continued to~~ DHCS worked with multiple partners at the state and local ~~and community and university~~ levels to address the disparities in ~~services to~~ California's ~~diverse racial, ethnic and cultural communities. As of July 1, 2012, The Office of Multicultural Services, formerly at DMH, transferred to the Office of Health Equity at the DPH. They will continue to track this data under the purview of DPH~~. During this time, the CA EQRO also looked at statewide mental health disparities. Within the APS EQRO report FY 2010-2013, the EQRO produced disparity data, measuring Race/Ethnicity and other aspects of discrepancies.**

The following series of figures present disparity inquiry from the perspective of gender, Race/Ethnicity and age group, based on identifying claims per beneficiary, penetration rates, ratios of penetration rate and of approved claims.

Figure 1 shows that approved claims appear higher for males than females for all measured service type categories.

Figure 1. Penetration Rates, Approved Claims, and Penetration Rate Ratios Comparison by Gender, CY10-CY12

Calendar Year	Penetration Rate		Approved Claims per Beneficiary Served		Ratio of Females vs. Males for:	
	Female	Male	Female	Male	Penetration Rate	Approved Claims
CY12	5.31%	6.66%	$4,593	$5,640	0.80	0.81
CY11	5.21%	6.49%	$4,379	$5,418	0.80	0.81
CY10	5.34%	6.61%	$4,213	$5,249	0.81	0.80

Figure 2 shows approved claims per beneficiary served, broken down by Race/Ethicity. CAEQRO Annual Statewide Reports have previously noted progress in reducing disparities in average approved claims between race/ethnicity groups. However, both Asian/Pacific Islander and Hispanic beneficiary access to services, based on their percentage of the eligible population, remains a key disparity when compared to White beneficiaries.

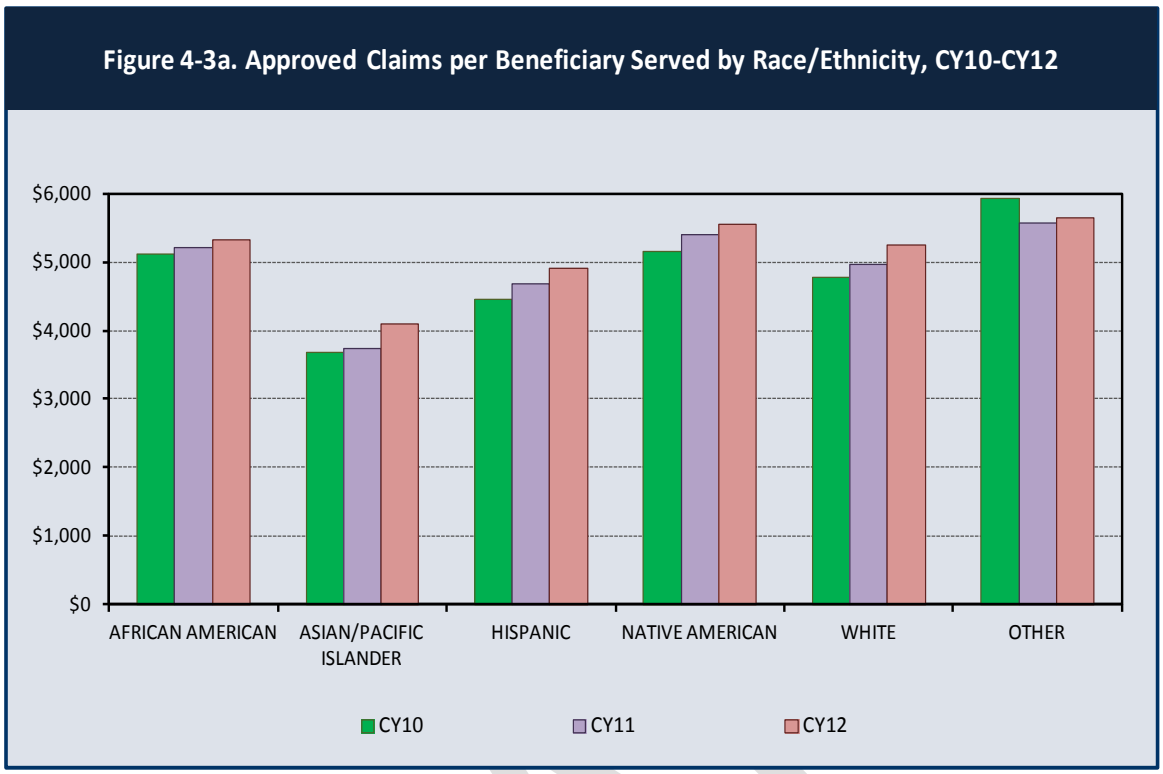

Figure 3 displays statewide trends in average approved claims based on age. Consistent with findings in previous CAEQRO Annual Statewide Reports, Youth 6-17 have the highest average annual claims and Older Adults 60+ have the lowest annual claims.

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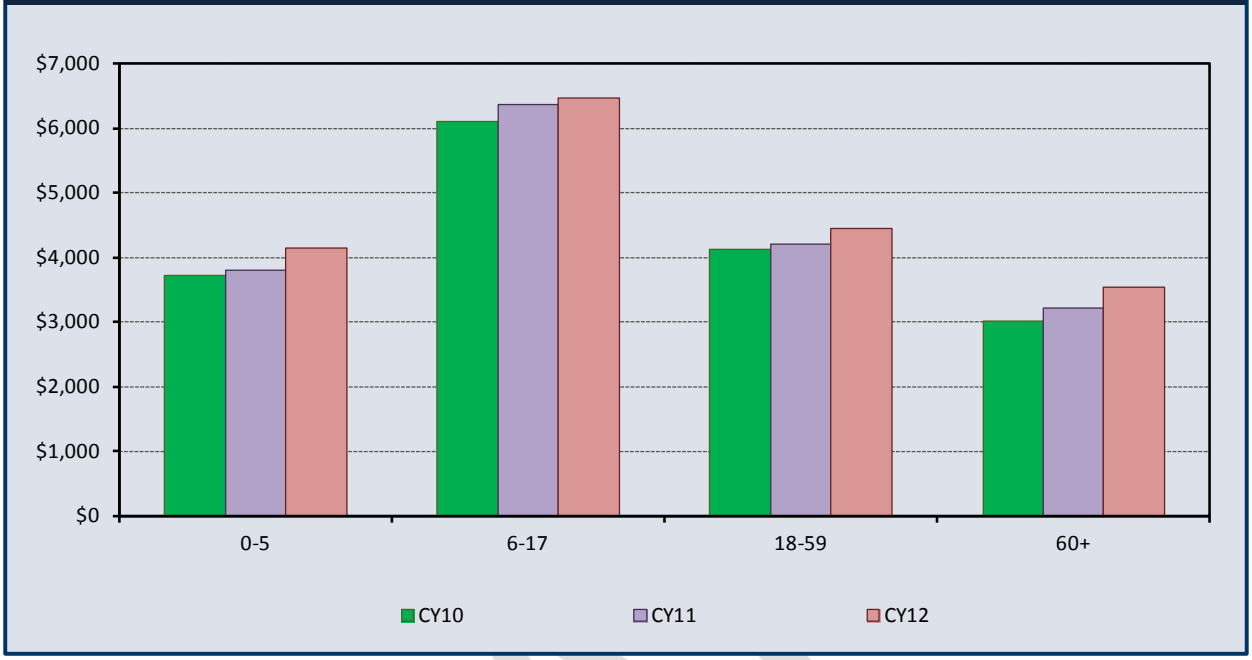
Figure 4-4a. Approved Claims per Beneficiary Served by Age Categories, CY10-CY12



Figures based on APS HealthCare claims data: websitewww.caleqro.com:

Figure 4 shows the distribution of the total state populations in 2012. The demographic table below can be used to compare reported data above to assess mental health service disparities in California.

Figure 4. California population in 2012 by Race and Age Group

Race/Ethnicity	Total	Age Group 0-17	Age Group 18-64	Group65+
Total	37,826,161	9,170,526	24,111,486	4,544,149
White	14,953,617	2,504,870	9,681,137	2,767,610
Hispanic	14,501,606	4,716,718	8,944,926	839,962
Asian/Pacific Islander	5,157,029	1,000,576	3,525,845	630,608
Black	2,203,540	507,530	1,459,910	236,100
American Indian	164,382	36,590	109,035	18,757
Multi Race	967,414	404,243	512,059	51,112

Based on Department of Finance figures accessed at

website:http://epicenter.cdph.gov

The following table shows the distribution of clients served in the State during.CY 2011. The client population reflects the diversity of the State population although not all groups are represented proportionally to the State population.

Race/Ethnicity/Culture	Total	0-5	6-17	18-59	60+
Total	447,585	25,608	164,499	218,874	38,604
White	155,835	6,344	43,415	88,558	17,518
Hispanic	158,486	13,904	83,904	54,613	6,065
Asian/Pacific Islander	29,822	597	4,294	18,626	6,305
Black	75,231	3,799	25,101	41,362	4,969
American Indian	3,730	149	1,214	2,102	265
Multi Race	24,481	815	6,571	13,613	3,482

Figures based on APS HealthCare claims data: websitewww.caeqro.com:

In comparison, the following table shows the distribution of the total state populations in 2011.

TOTAL STATE POPULATION 2011 BY RACE AND AGE GROUP				
		AGE GROUP		
RACE/ETHNICITY	Total			
Total	37,560,774	9,105,044	24,107,257	4,348,473
White	14,577,131	2,407,796	9,531,036	2,638,299
Hispanic	14,493,180	4,751,089	8,939,227	802,864
Asian/Pacific Islander	5,275,655	1,036,263	3,618,375	621,017
Black	2,142,188	508,691	1,408,038	225,459
American Indian	155,574	39,356	100,326	15,892
Multi Race	917,046	361,848	510,255	44,942

Based on Department of Finance figures accessed at website:http://epicenter.cdph.gov

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Performance Measures
Review of performance measures data includes analyzing indicators by race/ethnicity to determine potential disparities. Information on recent performance measures data on the use of specialty mental health services by race/ethnicity can be found on section 8 page 121. For more specifics see "Summary of Department of Mental Health Specialty Mental Health Services by Race/Ethnicity" (attachment 17).

~~**Cultural Competence Plans**~~
~~**Due to the suspension of all activity related to review of the CCPs in the context of transitioning activities formerly under DMH's purview to other state departments, the CCP could not be used as a source of information for this monitoring activity during waiver period 7.**~~

Problems identified: **None**

Corrective action (plan/provider level: **NA**

Program change (system-wide level): **NA**

Strategy 2 Onsite Triennial Review: MHP's Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate Services

Confirmation it was conducted as described:

X **Yes**
__ No. **Please explain**:

Summary of results: **In the Cultural Competence Plan Requirements (DMH Information Notice 10-02), MHPs are required to address and update strategies and efforts for reducing disparities in access to SMHS and quality and outcome of these services in the context of racial, ethnic, cultural, and linguistic characteristics. Further, all MHPs are required to have mechanism(s) or activity(ies) in place whereby the MHP can assess the availability of appropriate cultural/linguistic services within the service delivery capacity of the MHP. Such mechanism(s) include but are not limited to:**

- **A list of non-English language speaking providers in the beneficiary's service areas by category;**
- **Culture-specific providers and services in the range of programs available;**
- **Beneficiary booklet and provider list in the MHPs identified threshold languages;**
- **Outreach to under-served target populations informing them of the availability of cultural/linguistic services and programs;**
- **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 that will provide information to beneficiaries about access, services and the use of beneficiary problem resolution/fair hearings;**
- **Interpreter services;**

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In addition to reviewing the CCPR submissions, DHCS staff monitor MHPs' compliance with the Cultural Competence Plan Requirements during the triennial onsite reviews. During these onsite reviews, DHCS staff reviewed information provided by the MHP to ensure that the above mechanisms were implemented by the MHPs. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted.

Problems identified: **The Annual Review Protocol, Section A "Access" (see attachment 11) covers many of the mechanisms required in the Cultural Competence Plan Requirements. While some counties continue to have challenges related to specific protocol items, DHCS found statewide improvement in the compliance findings for the Access Section of the Annual Review Protocol. For both FY2012/13 and FY2013/14, many of the questions in this section had high compliance rates with only 1-2 counties being out of compliance with specific requirements. The biggest area of concern is the continued challenge for MHP's to provide a statewide toll-free 24/7 access line. The findings related to the 24/7 access line are described in detail in Waiver Section C, Monitoring Activity "Onsite System Reviews", Stategy "Systems Review."**

The following are examples of items in the Annual Review Protocol, Access Section A, (see attachment 11) directly related to the monitoring of the Cultural Competence Plan Requirements:

Section A, Question 11. Is there evidence that Limited English Proficient (LEP) individuals are informed of the following in a languages they understand: a) LEP individuals have a right to free language assistance services;

In FY 2012/13, 1/17 (6%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 0/19 (0%) County MHPs were found to be out of compliance with this requirement.

Section A, Question 13. Has the MHP developed a process to provide culturally competent services as evidenced by: a) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing SMHS employed by or contracting with the MHP, to provider interpreter or other support services to beneficiaries; b) Implementation of training programs to improve the cultural competence skills of staff and contract providers; and c) A process that ensures the interpreters are trained and monitored for language competence.

In FY 2012/13, 2/17 (12%) County MHPs were found to be out of compliance with these requirements. Plans of Correction were submitted by the MHPs.

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In FY 2013/14, 1/19 (5%) County MHPs were found to be out of compliance with requirement 13a and 3/19 (16%) County MHPs were found to be out of compliance with requirement 13c. Plans of Correction were submitted by the MHPs.

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with these requirements. DHCS' County Support Unit follows up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.**

Program change (system-wide level): **None**

***4. Monitoring Activity*: Network adequacy assurance submitted by plan**

Strategy 1: MHP Contract

Confirmation it was conducted as described:

_X_ Yes

No. Please explain:

Summary of results: **In accordance with their contract (Exhibit A, Attachment 1, Item 2), MHPs are required to report to the Department when a significant change occurs in the MHPs operation that could impact network adequacy. Significant change is defined as a change in the MHP's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries or a reduction of an average of 25 percent or more in outpatient provider rates. No MHP reported any such change in operations during the ~~7th~~ 8th waiver period i.e. July 1, 2013 – June 30, 2015 ~~July 1 2011-June 30, 2013~~.**

Problems identified **None**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA**

Strategy 2: Onsite Triennial Review: MHP's Policies/Procedures Regarding Numbers and Types of Providers

Confirmation it was conducted as described:

X **Yes**

__ **No**. Please explain:

Summary of results: **Each MHP is required to have a Quality Improvement Work Plan that includes its plan to monitor its service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system. Further, the plan must include**

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goals established for the number, type, and geographic distribution of mental health services. During the triennial onsite reviews, state staff reviewed each MHP's QI Work Plan and Work Plan Evaluation to verify that goals have been established regarding the number, type and geographic distribution of mental health services within the MHP's delivery system.
In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. Items specific to this issue in the System Review Protocol, Quality Improvement (QI) section (see attachment 11) are the following:

4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities to meet the following work plan areas?
4a Monitoring the service delivery capacity of the MHP as evidenced by:

1) **Goals are set for the number, type, and geographic distribution of mental health services.**

In FY 2012/13, 5/17 (29%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 7/19 (37%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

Problems identified: **In some cases, there was evidence the MHPs were reviewing data related to number, type and geographic distribution of mental health services with the Quality Improvement Committee; however, County MHPs found to be out of compliance with this requirement did not specifically have goals set for the number, type, and geographic distribution of mental health services in the QI work plans.**

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with this requirement. DHCS' County Support Unit follows up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.**

Program change (system-wide level): **None**

***5. Monitoring Activity*: Ombudsman**

Confirmation it was conducted as described:

_X Yes
__ No. Please explain:

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Summary of results: **Note: Although the Ombudsman Unit continued its primary function to be a bridge between the mental health system and individuals and family members providing information and presenting options to consumers in accessing mental health services, the data base used to record calls and their nature as originally designed has proved to be insufficient as volume increased. Therefore information as to numbers and nature of the calls received during this waiver period are estimates. ~~DHCS is reviewing and may pursue updating the data base during waiver period eight.~~**

For the period July ~~2011~~2013 through December ~~2012~~ 2014it is estimated that the Ombudsman toll free number received approximately ~~3000~~ 6767 calls. Approximately ~~1/3~~ ½ of all the calls were related to Medi-Cal and of those calls approximately ~~half~~ a quarter were in the nature of complaints primarily regarding providers and patient's rights advocates.

Other relatively high volume areas were calls requesting information and/or access to non Medi-Cal and/or Medicare related service and calls administration related. In those cases, callers were referred to other units/divisions within the department, to counties or to other state agencies.

In about ~~20~~ 9 percent of calls, the caller either hung up before the staff could answer the phone or the call was routed to voicemail and the caller left no follow up information. ~~However, since December 2012, the Ombudsman Unit has been relocated and has access to a new phone system which allows for simultaneous bell ring for all Ombudsman staff. Since calls received during business hours will no longer be routed to an answering machine staff estimate that this will result in a significant increase in calls which are connected to a staff member.~~

Problems identified: **None ~~Due to the number of monthly calls received, as well as the types of calls received, the Ombudsman database is not adequate to store all of the information gathered and to accommodate the additional reports requested by management.~~**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA ~~As mentioned above, DHCS plans to pursue updating the data base in the upcoming waiver period~~.**

6. *Monitoring Activity:* **Onsite System Reviews**

Confirmation it was conducted as described

X **Yes**

___ No Please explain:

There were three ~~components~~ strategies that together constituted the State's on site review activities during waiver period ~~7~~ 8.

1 Systems Reviews

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2) Non-Hospital Services Outpatient Chart Review/EPSDT Chart Reviews
3) SD/MC Hospital Reviews

Results for each component are described below

Strategy 1. Systems Review

***Summary of Results*: ~~In FY 2010-2011, there were 18 onsite MHP reviews conducted. In FY 2011-2012, there were 20 onsite MHP reviews conducted~~. The findings obtained from FY ~~2010-2011~~ 2012-2013 and FY ~~2011-2012~~ 2013-2014 ~~Program Oversight and Compliance~~ Annual R~~r~~eviews for Consolidated Specialty Mental Health Services and Other Funded Services are summarized below. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted.**

***Problems identified*: ~~For the two FYs reviewed, the two sections of the Protocol with the highest items out of compliance are in Access and the Chart sections. These two areas have been noted in the prior waiver period. Access items include the availability of information regarding SMHS and providers of services; availability of a 24/7 toll free number, maintenance of a written log of initial requests for specialty mental health services, availability of information regarding how a beneficiary might change providers etc. No items stand out as being notable in the chart review.~~**

~~FY 2010-2011~~
~~In the Access section, 17 out of the 18 MHP's reviewed were out of compliance with 1-5 items.~~

~~Of possible 21 chart items, all of the 18 MHPs had between 7-17 items out of compliance in this area.~~

~~FYs 2011-2012~~
~~In the Access section, 18 out of the 20 MHPs reviewed were out of compliance with 1-14 items out of compliance with questions 9a and 10 being the highest tally of items out of compliance. These items relate to the availability of a toll free telephone number 24/7 with linguistic capability in all languages spoken by beneficiaries in that county.~~

~~Of a possible 21 chart items, 6-17 items were out of compliance during FY 2011-2012.~~

For each Fiscal Year in this reporting period, the highest out-of-compliance areas across MHPs fall into three critical categories: (1) 24/7 toll-free telephone access (Protocol, Section A: Access, Question 9a1-4); (2) the written log of initial requests for SMHS (Protocol, Section A: Access, Questions 10a-c);and, (3) the MHP's ongoing monitoring system to ensure contracted organizational providers and county owned and operated providers are certified and recertified (Protocol, Section G: Provider Relations, Question 2),

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For FY12/13:

1. **71% (12) MHPs were out of compliance on Section A 9a 1-4 which is relevant to test calls made by the department: 1) whether the MHP's statewide, toll free number has language capability in all languages spoken by beneficiaries in the county; 2) whether the number provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met; 3) whether the number provides information to the beneficiaries about services needed to treat a beneficiary's urgent condition; and 4) whether the number provides information to beneficiaries about how to use the beneficiary problem resolution process.**
2. **76% (13) MHPs were out of compliance on Section A 10 regarding the written log of initial requests for SMHS containing the name of the beneficiary, the date, and the initial disposition of the request.**
3. **76% (13) MHPs were out of compliance on Section G2 regarding whether the MHP has an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified per Title 9 regulations.**

For FY13/14:

1. **84% (16) MHPs were out of compliance on Section A 9a 1-4 (See description above under FY 12/13, number 1)**
2. **95% (19) MHPs were out of compliance on Section A 10 (See description above under FY 12/13, number 2)**
3. **68% (13) MHPs were out of compliance on Section G2 (See description above under FY 12/13, number3)**

In FY 2014~~2~~-2015~~3~~, ~~there are 17~~ 20MHPs are scheduled for review. ~~There were five MHP reviews completed from October 2012 through December 2012 in this reporting period.~~ Data will be available after the completion of the reviews for FY 2014~~2~~-2015~~3~~ ending June 2015~~3~~.

***Corrective action (plan/provider level)*: ~~During onsite reviews, DHCS staff provide feedback about critical issues such as the MHP's 24/7 toll free lines and lack of written log documentation. It is recommended that MHPs regularly conduct their own test calls for compliance and provide regular training to their Access teams to reduce and eliminate these problems.~~**

~~On a more general level,~~ Following the onsite review, MHPs are notified in writing of all out of compliance items. MHPs are required to submit a Plan of Correction (POC) for all out of compliance items which is due within 60 days after receipt of the Final Report. If the MHP wishes to appeal any of the out of compliance items, the MHP may do so by submitting an appeal in writing within 15 working days after receipt of the Final Report. Once the POC is received, the MHP works with Program Oversight and Compliance Branch and DHCS Quality Assurance Section, County Support Unit staff to implement the POC.

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In addition, during onsite reviews, DHCS staff provide feedback and technical assistance to MHP's related to out of compliance issues, as well as other critical issues for which performance can be improved. The DHCS County Support Unit has started participating in the triennial system reviews in order to establish consistency between the compliance findings and the follow up and technical assistance provided by the Department.

During FY 2012~~0~~-2013~~1~~, Program Compliance received 17 ~~18~~ Plan of Corrections (POCs) from the MHPs. In FY 2013~~1~~-2014~~2~~, 18 ~~16~~ Plan of Corrections have been received.

Program change (system-wide level): **~~None~~** ***):*** **In 2014, the Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services was revised to include an indication of partial compliance, as appropriate, for select items on the protocol which was effective beginning with the FY 14/15 review cycle. For example, DHCS conducts test calls of the MHP's 24/7 Access line to determine compliance with the regulations. In many cases, the MHP is found to be in compliance with some of the test calls, while others are found to be out of compliance. The designation of partial compliance allows the State, as well as the MHP, to have a fuller understanding of the compliance issues by specifying the exact nature of the problem (i.e. time of calls out of compliance, staff taking calls, etc.). The revisions to the protocol will allow DHCS to establish benchmarks related MHP compliance in key areas, including those areas identified above as having the highest out of compliance rates across MHPs.**

Strategy 2: Non-Hospital Services Outpatient Chart Review/Adult and EPSDT Chart Reviews

Summary of results**: Results are reported for July 1, 2012~~0~~ – December 31, 2015~~2~~. The chart review team, consisting of licensed mental health clinicians, review the MHP's non-hospital services provided to Medi-Cal beneficiaries both adult and children/youth on a triennial basis. The principal focus of these reviews is to ensure federal and state requirements are being met along with MHP contractual requirements. The State provides oversight to ensure that the SD/MC claims submitted by the MHPs meet medical necessity criteria for reimbursement.**

DHCS Program Compliance and Oversight Branch completed ~~18~~ 20 MHP outpatient chart reviews in FY 2010~~-~~-2201~~1~~3; ~~20 reviews in FY 2011-2012 and 5 reviews were completed from October-December, 2012. There are 15 remaining reviews scheduled for FY 2012-2013. As of December 12, 2011, the separate EPSDT outpatient chart review based on extrapolation were suspended for FY 2011-2012 and review of charts for EPSDT beneficiaries were integrated into the outpatient chart reviews of non-hospital services.~~ For FY 2013 – 2014, 19 chart reviews were completed. For FY 2014-2015, 8 of 20 scheduled reviews have been completed. Half of the claim sample is adults and the other half is EPSDT.

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***Problems identified*: The primary reasons for disallowances is that the chart documentation failed to meet medical necessity.**

***Corrective action (plan/provider level):* A written Plan of Correction (POC) for all out of compliance items found in the chart reviews is required from the MHP within 60 days of the receipt of the report of the audit findings. The POC must specify the corrective actions taken to address the items out of compliance. The DHCS County Support Unit reviews the POCs, ~~and~~ provides follow and technical assistance and ensures the POCs are implemented. POCs were required for all reviews completed within waiver period 8~~7~~.**

A disallowance is taken for each claim line for which there is insufficient documentation. Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings.

***Program change (system-wide level):* None**

Strategy 3. On-site Reviews -SD/MC Hospital Reviews

***Summary of results*: Findings from the FY 2012-2013 ~~2010-2011~~ and FY 2013-2014 ~~2011-2012~~ reviews of SD/MC psychiatric inpatient hospitals are provided in attachment 16.**

***Problems identified*: The principal deficiencies identified during the FY ~~2010-2011 and FY 2011-2012~~ FY2012-2013 and 2013-2014 reviews were: (1) Documentation which failed to meet medical necessity criteria for continued stay services; and (2) Documentation which failed to meet criteria for administrative day services.**

***Corrective action (plan/provider level*): MHPs are notified of all deficiencies identified during the inpatient review. FFP for all disallowed hospital days is recouped and returned to DHCS. MHPs are also required to submit a Plan of Correction (POC) which addresses all identified deficiencies. These POCs are reviewed by DHCS staff and, when adequate, are approved. If POCs are determined to be deficient, the MHPs are required to revise and resubmit them.**

During FY ~~2010-2011, seven (7)~~ FY 2012-2013 six (6) inpatient reviews were conducted, and all ~~seven~~ six of these hospitals were required to submit POCs.

During FY ~~2011-2012~~ 2013-2014 , six (6) inpatient reviews were conducted, and all six of these hospitals were required to submit POCs.

***Program change (system-wide level :)* None**

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Strategy 4

Monitoring Activity: **Provider Certification On-Site Reviews**

Confirmation it was conducted as described:

__X_ Yes

____ No. Please explain:

Summary of results: **-Results are reported for July 1 2013-December 31, 2014. ~~July 1, 2010 – December 31, 2012~~. DHCS has conducted ~~63~~ 112 provider onsite reviews of county owned and operated providers, and certified or re-certified ~~385~~ 369 providers as eligible to bill for the provision of specialty mental health services from July 1, 201~~0~~ 3through December 31, 2014 ~~2~~. The number of onsite certification reviews of county owned and operated providers, has ~~decreased~~ nearly doubled from the last waiver report period which may be due in part to the increased need for services resulting from the ACA Medicaid Expansion in California. ~~i.e. October 1 2009-June 30 2011 because, in accordance with DMH Letter #10-04 (see attachment 15) effective July 8, 2010 the State was required to certify/recertify only a limited number of county owned and operated sites.~~**

MHPs monitor and track the recertification for their contracted organizational providers. During the review period, July 1, 2013-December 31, 2014, DHCS has processed 1, 278 certifications and recertifications from the MHPs for their contracted providers. As specified in the contract between the DMH and MHPs, the MHP/contractor shall comply with CCR, Title 9, Section 1810.435 in the selection of providers and shall review its providers for continued compliance with standards at least once every three years, except as otherwise provided in the contract. (Refer to Exhibit A-Attachment 1 Item 4 Provider Selection and Certification of the Boilerplate MHP Contract).

Problems identified: **There were no problems identified.**

Corrective action (plan/provider level) **Any Plans of Corrections (POCs) issued as a result of an onsite review (see section 6 page 118) are reviewed and out of compliance items must be resolved prior to certifying and/or re-certifying a provider's eligibility to bill Medi-Cal for the provision of specialty mental health services. An MHP has 30 days from receipt of the written request for POCs (which in most cases is the date of the site review) to submit their POCs. ~~About 20 percent of the providers needing certification/recertification have POCs with items that need resolution. .~~**

Program change (system-wide level): **None**

7. *Monitoring Activity:* **Performance Improvement Projects**

Confirmation it was conducted as described:

_X_ Yes
__ No Please explain:

Summary of results: **The EQRO reviews two PIPs (one clinical, one non clinical) during their reviews of MHPs. The EQRO also provides DHCS with information regarding the PIPs: including topics, activity level, and status of interventions. Lastly, the EQRO, reports to DHCS on MHP compliance with the PIP requirement. 25 of the PIPs submitted in FY 2013-2014 are in the areas of Access (20) and Timeliness (5).**

For more information regarding the EQRO process and results see section 11 pages 126-128.

Problems identified: **N/A**

Corrective action (plan/provider level): **N/A**

Program change (system-wide level): **N/A**

8. ***Monitoring Activity***: **Performance Measures**

Strategy 1: Measurement of Indicators of Mental Health System Performance on an Ongoing and Periodic Basis

Confirmation it was conducted as described:
_X_ Yes
__ No. Please explain:

Summary of results:
Expenditures and Penetration Rates for Medi-Cal Recipients
As seen in data from the report, "Summary of Department of Health Care Medi-Cal Specialty Mental Health Services by Race/Ethnicity", (see attachment 17) from FY2006/07 to FY2012/13 California served between 191,810 to 232,483 Medi-Cal clients with specialty mental health services each month. More adults were served than children until the last two quarters of Fiscal Year 12/13. For the third quarter of FY 12/13, more children (115,132) received specialty mental health services than adults (111,046). For the fourth quarter of FY 12/13, more children (120,866) received specialty mental health services than adults (111,617) as well.

The Medi-Cal penetration rates fluctuated slightly from 6.2% to 6.9% between FY 2006/07 to FY2012/13. The number of individuals enrolled in Medi-Cal and clients served increased during this seven year period. Penetration rates were highest for the White population through Fiscal Year 2011/12. The penetration rate was lowest for the Hispanic population through Fiscal Year 2010/11. The penetration rate for the Asian/Pacific Islander population was almost similar to the Hispanic population

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beginning in Fiscal Year 2011/12. The penetration rate for the Other category shows an increase beginning in Fiscal Year 2010/11. The drop in the penetration rate for the Asian/Pacific Islander population may be due to an error in coding.

The mean annual client cost had a gradual and moderate increase between FY2006/07 and FY2012/13 for all races.

Reporting for clients and services for Fiscal Year 2012/2013 was more than 99% complete at the time of this report.

~~**California served between 200,000 and 220,000 Medi-Cal beneficiaries with specialty mental health services each month between FY 2006/07 to FY 2011/12. More adults received services until the last two quarters of FY 2011/12. Approximately, the same number of children and adults received services in the last two quarters of FY 2011/12.**~~

~~**The Medi-Cal penetration rate decreased slightly from 7.1% to 6.9% between FY 2006/07 to FY 2011-2012. The number of individuals enrolled in Medi-Cal and the number of beneficiaries increased during this six year period. Penetration rates were highest for the White population through FY 2008/09. The penetration rate for the Native American population spiked in FY 2009/10 and remained high through FY 2011/12. The penetration rate for the Hispanic population was lowest through FY 2009/10. The penetration rate for the Asian/Pacific Islander population dropped below the Hispanic population in FY 2010/11 and remained lowest through FY 2011/12. The penetration rate for the Other category showed a similar increase beginning in FY 2010/11 through FY 2011/12, which suggests that the race of Asian/Pacific Islander beneficiaries may have been miscoded as Other during this period of time .**~~

~~**The mean annual beneficiary cost had a gradual and moderate increase between FY 2006/07 and FY 2011/2012 for all races.**~~

Consumer perception of care indicators
The results of the consumer perception indicators are reported above under item 1 Consumer Self Report Results page-111.

***Problems identified*: None.**

***Corrective action:* None.**

***Program change*: None**

Strategy 2:Implementation Plans
***Confirmation it was conducted as described*:**

_X_ Yes
___ No._Please explain:

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Summary of results: **The Implementation Plan is required by state regulation when an MHP begins operation. The State has approved the Implementation Plans for all current MHPs. State regulations require MHPs to submit proposed changes to their Implementation Plans to the State in writing. The State ~~approved~~ reviewed Implementation Plan updates received during the waiver period in accordance with CCR Title 9 section 1810.310(c).**

Problems identified: ***None***

Corrective action (plan/provider level): **NA**

Program change (system-wide level): -**NA**

Strategy 3: Onsite Triennial Review: MHP's Quality Improvement (QI) Program

Confirmation it was conducted as described:

X **Yes**

__ **No. Please explain**:

Summary of results: **Each MHP is required (in accordance with the MHP/DHCS contract (Exhibit A, Attachment 1, Section 23), CCR, title 9, Section 1810.440 and CFR Title 42 Section 438.204, 240 and 358) to have a Quality Improvement (QI) program. The purpose of the QI program is to review the quality of specialty mental health services provided to beneficiaries by the MHP. The QI Program must have active participation by the MHP's practitioners and providers, as well as beneficiaries and family members. During the triennial System Reviews, state staff reviewed each County MHP's QI work plan for evidence of QI activities that the MHP has engaged in including recommending policy changes, evaluation of QI activities, instituting needed actions, and ensuring follow-up of QI processes and previously identified issues. The MHPs also provided evidence of mechanisms in place to evaluate the effectiveness of the QI program and how QI activities have contributed to improvements in clinical care and beneficiary services. The MHP's are required to review the QI Work Plan and revise as appropriate on an annual basis. During the triennial System Review state staff reviewed both the QI Work Plan itself and evidence that activities identified in the Work Plan were implemented.**

In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. Specific protocol items related to this issue can be found in the Annual Review Protocol Section I, Quality Improvement (see attachment 11).

Problems identified: **The findings from the reviews for FY2012/13 and FY2013/14 are summarized below:**

1. **Is the QIC involved in or overseeing the following QI activities:**

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a. **Recommending policy decisions?**

In FY 2012/13, 2/17 (12%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 0/19 (0%) County MHPs were found to be out of compliance with this requirement.

b. **Reviewing and evaluating the results of QI activities?**

In FY 2012/13, 3/17 (18%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

c. **Instituting needed QI actions?**

In FY 2012/13, 3/17 (18%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 0/19 (0%) County MHPs were found to be out of compliance with this requirement.

d. **Ensuring follow up of QI processes?**

In FY 2012/13, 3/17 (18%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

2. **Regarding the annual QI Work Plan, Does the MHP evaluate the effectiveness of the QI program and show how QI activities have contributed to improvement in clinical care and beneficiary service?**

In FY 2012/13, 4/17 (24%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with these requirements. DHCS' County Support Unit follows up with the county MHPs to**

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monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level): **None**

9. *Monitoring Activity*: **Periodic comparison of number and types of Medicaid providers before and after waiver**
03/15/2015: Updated Information will be provided shortly
Confirmation it was conducted as described:
_X_ Yes
__ No. Please explain:
Summary of results:
Please note: While transferring the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions from DMH to DHCS there have been significant difficulties migrating the data associated with the SMHS program such that staff have been unable to date to access certain data. Therefore some of the data provided in previous wavier periods is not available and this has been so noted in the following charts and information by NA – not available.

Table 1 Hospitals

FISCAL YEAR:	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	9/10	10/11
TOTAL FFS/MC HOSPITALS	204	191	189	184	186	194	194	192	187	185	185	180	170	NA	NA
FFS/MC HOSPITALS PROVIDING SERVICE	121	122	118	113	105	95	99	92	93	92	93	91	83	75	77
FFS/MC CONTRACT HOSPITALS	103	101	101	96	98	82	82	74	75	70	71	69	67	69	70
SD/MC HOSPITALS	29	27	23	23	23	24	24	21	21	23	21	20	20	20	22

As shown in table 1 above, the total number of FFS/MC psychiatric inpatient providers decreased from FY 1996-97 (prior to the first waiver period) through FY 2008-09. Research during prior waiver periods indicated that this is in part due to a number of hospitals statewide who, as a component of their restructuring efforts, closed their psychiatric units. Since data is unavailable at this time for FY 09/10 and FY 10/11 it is not possible to determine if this trend has continued.

The number of FFS/MC hospitals actually providing psychiatric inpatient hospital services to Medi-Cal beneficiaries has continued an overall decrease from FY 1996-97 to FY 2010-11. One hundred and twenty one (121) FFS/MC psychiatric inpatient hospitals provided services in FY 1996-97, while 77 FFS/MC psychiatric inpatient hospitals provided services in FY 10-11. The slight increase in the number of FFS/MC hospitals providing service between FY 2001-2002 and FY 2002-03 can be

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attributed to the identification of out-of-state non-border hospitals providing inpatient mental health services to Medi-Cal beneficiaries.

In FY 1996/97, 103 FFS/MC hospitals were under contract with MHPs. This number has shown a small increase in FY 09-10 and FY 10-11 from a low of 67 in FY 08-09. There were 70 FFS hospitals under contract to the MHPs in FY 10-11.

As shown below, recent paid claims data shows that, despite the decrease in the number of FFS/MC hospitals under contract and/or providing services, the number of unduplicated clients receiving care in those facilities rose in the years between FY 2006/2007 and FY 2011-2012.

FFS/MC Hospitals Psychiatric Inpatient Hospital Services

Fiscal Year	Total Claims	Total Beneficiaries
FY 06/07	$154,544,462	20,867
FY 07/08	$149,146,681	20,762
FY 08/09	$156,111,674	22,057
FY 09/10	$163,635,421.	22,794
FY 10/11	$175,815,037.	23,901
FY 11/12	$188,168,445	23,228

The number of Short-Doyle/Medi-Cal (SD/MC) hospitals has also decreased from 29 in 1996-97 to 22 in FY 2009-10. However, the number of SD/MC hospitals has stayed fairly consistent since FY 1998/99 ranging between 20 and 24. Recent paid claims data shows that the number of unduplicated clients has varied only slightly between FY 2006/2007 and FY 2011-12.

SD/MC Psychiatric Inpatient Hospital Services

Fiscal Year	Total Claims	Total Beneficiaries
FY 06/07	$78,461,862	8343
FY 07/08	$71,106,397	7638
FY 08/09	$73,009,647	8320
FY 09/10	$70,535,824	8211
FY 10/11	$68,055,913	8135
FY 11/12	$67,893,065	8200

Table 2
Professional and Rehabilitative Service Providers

FISCAL YEAR:	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
TOTAL SD/MC ORGANIZATIONAL PROVIDERS	1014	1225	1401	1649	1882	2101	2369	2527	2645	2952	3125	3195	3318	3387	3604
SD/MC ORGANIZATIONAL PROVIDERS	939	1072	1154	1309	1491	1548	1852	1915	1913	2187	2271	2395	2435	NA	NA

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FISCAL YEAR:	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
PROVIDING SERVICE															
FFS/MC PRACTITIONERS	3314	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	NA

As can be seen in table 2, the total number of SD/MC Organizational providers showed a steady increase from 1,014 in FY 96/97 to 3,604 in FY 10/11. The number of SD/MC organizational providers actually providing services -increased from 939 in FY 1996-97 to 2,435 in FY 2008-09. Numbers are not available at this time for FY 09-10 and FY 10/11. It should be noted that SD/MC organizational providers consist of a varying number of actual practitioners who serve Medi-Cal beneficiaries. Information is not available at the State as to the actual total number of SD/MC practitioners who are employed by SD/MC organizational providers.

Data on paid claims for FFS/MC psychiatrists and psychologists for FY 1996-97, prior to the first waiver renewal period, revealed that 3,314 psychiatrists and psychologists received Medi-Cal payments during that year. It should be noted that since FY 1996-97 was prior to Medi-Cal Specialty Mental Health Services Consolidation, some of these claims may be for services to beneficiaries who would not have met medical necessity criteria developed for consolidation, so the number may be somewhat inflated.

The Medi-Cal SMHS Consolidation waiver enabled MHPs to expand the range of practitioner types in their individual provider networks to include MFTs, LCSWs and RNs. This allows for greater ability to increase the number of available network practitioner providers and may account for some of the increase seen in the number of organizational providers. State Medi-Cal oversight reviews that were conducted during the past and present waiver periods found that, in general, MHPs had maintained or increased the number of practitioner providers compared to those available to beneficiaries under FFS/MC.

Problems identified: **None**

Corrective action (plan/provider level): **None**

Program change (system-wide level): **None**

10. ***Monitoring Activity***: **Utilization review**

Strategy **MHP Utilization Management Plan**

Confirmation it was conducted as described:

_X_ Yes

__ No Please explain:

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***Summary of results*: All MHP's Utilization Management Plans reviewed during waiver period ~~7~~ 8contained requirements related to consistent application of medical and service necessity in payment authorization systems.**

***Problems identified*: None**

***Corrective action (plan/provider level):* NA**

***Program change (system-wide level):* NA**

11. *Monitoring Activity*: External Quality Reviews (EQR)

Confirmation it was conducted as described:

_X_ Yes
___ No Please explain:

***Summary of results:* FY ~~2011~~-2012-2013**
***Note:* Information regarding FY ~~2012~~-2013 -2014 is not yet available**

FY ~~2011~~-2012-2013 EQR activities focused its activities on three monitoring areas:

- **Access**
- **Timeliness**
- **Quality**

A variety of factors was used in analyzing these three areas including factors associated with the three overarching principles of cultural competence, wellness/recovery and consumer/family involvement.

PIPs

- **~~PIPs continue to be an area where MHPs have only partial success. While 70~~ 66 percent of MHPs had two active PIPs as required, only half of those or ~~20~~ 31 percent of all MHPs had PIPs that had study results which include the interpretation of the findings and the extent to which the study demonstrates true improvement. ~~active interventions and had measured the impact of those interventions.~~**
- **~~32~~ 29 PIPs reached completion in FY 2012-2103.~~, largely a function of the sunset of the formerly required EPSDT PIP. While PIPs were completed, they did not necessarily conclude successfully with demonstrated improvement in care.~~**
- **In cases where the MHP had struggled with the same issue over a number of years they were provided technical assistance in selecting a new PIP topic for which the infrastructure needed to support successful setup and follow through was available.**
- **MHPs may contact the department's County Support Unit to initiate meetings with EQRO staff and resolve issues with developing and implementing PIPs.**

Performance Measures

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The Performance Measure for ~~Year Eight~~ FY 13-14 ~~11-12~~ focused on psychiatric inpatient follow-up services and readmission (CY~~10~~12 data). The following results were found.

- **In terms of total claims dollars, ~~I~~inpatient services alone accounted for ~~13~~11.5 percent of claims dollars, providing inpatient services to 7.~~5~~ 6 percent of beneficiaries.**
- ~~**13 percent of all claims dollars were for Inpatient services while 7.5 percent of beneficiaries received Inpatient services**~~
- **There was an increase in the number of beneficiaries receiving inpatient services, though the average approved claims for inpatient services decreased.**
- **Rehospitalization rates were ~~8~~ 6 percent within seven days and ~~18~~ 14 percent within thirty days.**
- **For youth 6-17, rehospitalization rates were lowest and outpatient follow-up highest.**

ISCA

CMS mandates administration of an ISCA each year at each MHP for which the ~~The~~ EQRO is responsible. ~~for the independent review of the health information systems of each MHP in California. As part of this process, CMS also mandates administration of an ISCA each year at each MHP.~~

During this period there have been many changes to legacy systems, and consequently in the selection, acquisition and implementation status of new enterprise systems. With all of the newer systems offering modules specific to electronic health records (EHR) the presence of various EHR functionalities at different MHPs has also changed.

- **Most MHPs have moved to newer systems or are currently implementing them. Most of the MHPs with no plans for new systems are those that have had a new system in place for more than five years.**
- **The system changes and adjustments that emerged throughout FY10-11 and FY11-12 are reported as largely resolved.**
- **During FY12-13, timely submissions of claim files by most MHPs substantially improved. However, a small number of counties continued to experience some level of operational challenges in claim submission during the past year.**
- **DHCS claim processing lag issues seen in FY11-12 were resolved during FY12-13 by improving system capacity to process claims in a timely manner.**

- ~~**New and ongoing implementations of information systems continue to create extensive demands on MHP staff resources. Implementation time is therefore often longer than anticipated.**~~
- ~~**State changes in Medi-Cal billing processes added additional complications which impacted timely claims, denials, and impeded cash flow.**~~

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- ~~**Electronic Health Records (EHR): The year showed significant advancement in electronic health record implementation. Electronic progress notes have been implemented in 30 MHPs. Assessments are in place in 27 MHPs, and treatment plans in 22 MHPs.**~~

In addition to those activities described in the monitoring plan for the ~~7th~~ 8th waiver period focus groups were used to gain valuable information. Findings of the focus groups are included in EQRO reports. Beneficiary feedback continues to be an important aspect of the EQRO process. The CFM focus groups allow site reviewers to gain valuable perspectives concerning:

- **Underserved racial/ethnic and other demographic groups**
- **Experiences acquiring services initially**
- **Utilization of acute care services or outpatient modes of service delivery**
- **Consumer involvement in decision making, progress through levels of care, and discharge**
- **Family member participation in treatment as well as system planning**
- **Consumer career opportunities both within and beyond the service delivery system**
- **Interface between mental health care systems and medical, alcohol/drug, or other service delivery systems**

- **During FY13-14, 625 individuals participated in 85 focus groups. Interpreters were included in 32% focus groups**
- **39% of the consumer/family member focus group participants were Latino, an increase from 31% in FY12-13.**
- **Of the Latino participants, 57% identified Spanish as their preferred language.**

- ~~**752 individuals participated in 95 focus groups. 39 percent of the participants were Latino and 37 percent of groups conducted included an interpreter.**~~
- **Spanish-speaking beneficiaries generally reported longer wait times to access services.**
- ~~**Longer wait times were also more common among children seeking services, particularly for psychiatry**~~

Problems identified: **The overall results of the site review process were presented to the State and MHPs in the individual and statewide reports based on comparative analysis of claims data for CY~~10~~12. Some key findings include:**

- **Changes in the size of the average monthly Medi-Cal eligibles population significantly affect penetration rates. Increased Medi-Cal program enrollment resulted in decrease in penetration rates, despite increases in the number of beneficiaries served.**
- **Females continue to have lower penetration rates. Approved claims continue to be higher for males than females for all measured service type categories i.e. TBS, Crisis Intervention, Medication Support, Mental Health Service, Case Management, Day Treatment, Crisis Stabilization, Residential Services, Inpatient Services**

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- **Both Asian/Pacific Islander and Hispanic beneficiary access to services, based on their percentage of the eligible population, remains a key disparity when compared to White beneficiaries. Asian Pacific Islanders and Hispanics have the lowest approved claims per beneficiary among the race/ethnicity categories.**
- **Consistent with findings in previous reports, Youth 6-17 have the highest average annual claims and Older Adults 60+ have the lowest annual claims**
- **High cost beneficiaries (greater than $30,000 in services in the CY) continue to consume a disproportionate amount of services, slightly increased over prior years. High cost beneficiaries were more likely to be male and child.**
- **While approved claims per beneficiary for foster care population increased and the number of eligibles increased, the number of foster care beneficiaries receiving services decreased. The combination of increasing numbers of eligibles and decreasing beneficiaries served is reflected in the downward trend in the penetration rate for the foster care population.**
- **As noted above, Spanish –speaking beneficiaries generally reported longer wait times as did children seeking particularly psychiatric service**
- ~~**Statewide penetration rate dropped slightly due to an increase in beneficiaries and decrease in numbers served.**~~
- ~~**Females continue to have lower penetration rates and average approved claims. The greatest disparity is in the adult 18-59 age group.**~~
- ~~**Hispanic penetration rate increased but remains significantly disparate from White penetration rates or overall average penetration rates. However, the claims disparity previously existing for Hispanic beneficiaries no longer exists. Equal dollars are spent for Hispanic and white beneficiaries.**~~
- ~~**Youth 6-17 continue to have the highest average claims.**~~
- ~~**Foster care penetration rate continued to increase; however there was a decrease in numbers served and a more significant decrease in the population.**~~

Corrective Action (plan/provider level): **Every MHP is given 5 recommendations of strategies to consider for improvement. Those items are then reviewed during the following year's review. Opportunities and Recommendations for MHP improvement note are:**

- **Increase stakeholder involvement in quality monitoring and improvement processes.**
- **Increase and improve the quality of consumer and family member employment within the MHP.**
- **Increase the use of outcome data, including implementation of evaluation tools.**
- **Increase consumer and family member involvement in system and program planning.**
- **Develop more collaborative processes with primary care.**
- **Evaluate consumer satisfaction with service delivery.**

~~**MHPs implemented activities in response to EQRO recommendations made in the prior year. 87**~~**72 percent of all recommendations were either fully addressed or partially addressed.** ~~**Recommendations associated with improving access to**~~

~~**underserved populations were most significantly addressed at 94 percent of the time.**~~

Program change (system-wide level) **None**

12. ***Monitoring Activity***: **Cultural Competence Plans**

Confirmation it was conducted as described:

___ Yes

_X_ No Please explain: See *Summary of Results* below

Summary of Results

Summary of Results: **Title 9, CCR, Section 1810.410 requires each MHP to complete and submit a Cultural Competence Plan (CCP) including annual updates to the department. Previously, the 2010-2011 CCP requirements were included in the former DMH Information Notices No 10-02 and 10-17. They can be found now on the DHCS website at:**
http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf (see Attachment 9)
http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf. (see Attachment 10)

The last submission of CCPs to DMH occurred between July 28, 2010 and March 15, 2011. Shortly thereafter, Assembly Bill (AB) 102 was signed into law which required that Medi-Cal related mental health functions be transferred from DMH to DHCS by July 1, 2012. Consequently, DMH staff who were initially assigned to review and score the CCPs were reassigned to other functions that supported the inter-departmental transfer efforts.

This action resulted in the staff dedicated to the review and scoring of the CCPs (submitted to DMH between July 28, 2010 and March 15, 2011) being reassigned to other functions and the suspension of the review and scoring of the CCPs. DHCS records indicate that 57 CCPs were submitted and 26 CCPs from mid and large size MHPs were reviewed and fully to partially rated. The 26 CCPs have not been fully scored and the remaining 31 plans have not been reviewed at all.

During the last Waiver renewal period, the department has worked with subject matter experts and stakeholders including staff from the Office of Health Equity (OHE) to revise and streamline the previous requirements in order to provide MHPs with guidance to ensure appropriate access for beneficiaries from ethnically, culturally and linguistically different backgrounds. To that end, DHCS hired two (2) employees who are dedicated to cultural competence tasks. Also, DHCS executed an Interagency Agreement (IA) with the California Department of Public Health's (CDPH) Office of Health Equity (OHE). As part of the agreement, OHE staff provided their technical expertise to the CCPR revisions. The revisions were geared toward addressing mental health disparities to vulnerable communities. The collaboration of the two departments facilitated the provision of appropriate CCPRs

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to achieve appropriate access to mental health care for individuals from different cultural, ethnic and linguistic backgrounds including those that live in geographically isolated communities. The requirements were updated and only minor changes were made to the previous requirements. The revisions included removal of references to former Department of Mental Health (DMH), the inclusion of tables to display demographic information, and references to the nationally published 2013 Cultural and Linguistic Appropriate Services (CLAS) standards. The revised requirements will be implemented in the beginning of 2015,

~~**DMH Information Notices Nos. 10-02 and 10-17 Cultural Competence Plan Requirements (CCPR) were issued respectively for mid-size and large counties on January 25, 2010 and for small counties on August 17, 2010 (see attachments 9 and 10). DMH had planned to convene review panels to review and score all the CCPR submissions during Spring and Summer 2011.**~~

~~**However, due to activities required by Assembly Bill (AB) 102, which transferred the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions from DMH to DHCS, DMH-OMS staff were redirected to perform a number of transition activities. Thus, the functions of the CCPR, including training, webinars, review and scoring of plans were postponed until completion of the transfer of cultural competence functions to DHCS and CDPH, including the transfer of the CCPR.. In addition, the majority of counties requested extensions ranging from 1-15 months, often requesting third and fourth extensions. Consequently, the review team had to wait for the cost benefit threshold to be reached (i.e., there had to be a pool of plans large enough to review before the team would convene a four hour Reviewer Training).**~~

~~**DMH established an interim plan and informed counties to implement their submitted CCPR plans, per language incorporated in the MHP contract, (Exhibit E, Item 5) which states, "*Contractor may implement the plan 60 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.*" In addition, submitted CCPRs were monitored during the triennial Compliance Review.**~~

***Problems identified*: NA (since the plans could not be reviewed as planned)**

***Corrective action (plan/provider level)* NA**

***Program change (system-wide level)*:** ~~**DHCS is currently developing an implementation plan to move forward with the CCPRs. For more information please see Section s2 page 105.**~~ **None**

13. ***Monitoring Activity*: Advisory Groups**

***Confirmation it was conducted as described*:**

X Yes

__ No Please explain:

Strategy 1~~a.~~ Compliance Advisory Committee (CAC)

***Summary of result*: The Compliance Advisory Committee (CAC) offers stakeholders an invaluable opportunity to provide feedback and recommendations relative to DHCS' compliance protocol and review process. The~~is~~ ~~continuation of the~~ ongoing relationship between ~~the State~~ DHCS and the CAC ensures ~~that~~ stakeholders have a significant voice in how quality and access are monitored. The CAC meeting for FY2014/15, held in August 2014, resulted in the stakeholder approval of critical revisions to the Annual Review Protocol. These revisions, recommended initially by the County Behavioral Health Directors Association of California (CBHDA), include an indication of partial compliance, as appropriate, for select items on the protocol. For example, DHCS conducts test calls of the MHP's 24/7 Access line to determine compliance with the regulations. In many cases, the MHP is found to be in compliance with some of the test calls, while others are found to be out of compliance. The designation of partial compliance allows the State, as well as the MHP, to have a fuller understanding of the compliance issues by specifying the exact nature of the problem (i.e. time of calls out of compliance, staff taking calls, etc.). The CAC's feedback and recommendations helped shaped the discussion around the proposed changes to the protocol and determined the process for implementing the recommended changes.**

***Problems identified*: ~~None~~ The revisions to the protocol approved by the CAC will allow DHCS to establish benchmarks related MHP compliance in key areas.**

***Corrective action (plan/provider level):* NA**

***Program change (system-wide level):* Changes implemented with significant input from the CAC include revisions to the Compliance Review Protocol, which is used by the State to review MHPs on-site for system compliance with the relevant state and federal regulations and contractual ~~program~~ requirements.**

~~**b. Cultural Competence Advisory Group (CCAC)**~~

~~***Confirmation it was conducted as described:***~~

~~**_X_ Yes**~~

~~**__ No. Please explain:**~~

~~***Summary of result:* During the 7th waiver period, Cultural Competence Advisory Group meetings continued until June 30, 2012 and were then put on hold pending the transfer of responsibility for the group to CDPH in accordance with legislation which transferred DMH functions to various other state departments, primarily DHCS.~~~~

~~**Effective July 1, 2012, The Office of Multicultural Services (OMS), formerly at the DMH was, transferred to the Office of Health Equity (OHE) at the California**~~

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~~Department of Public Health (CDPH). At that time, responsibility for the Advisory Group was also transferred to CDPH.~~

~~However, DHCS staff, particularly staff involved with the Cultural Competency Plan continued to have contact with stakeholder groups such as the CCAC and OHE staff, thus facilitating stakeholder voice in the conduct of mental health programs.~~

~~*Problems identified:* None.~~

~~*Corrective action (plan/provider level):* NA~~

~~*Program change (system-wide level):* NA~~

Strategy 2 ~~c.~~ California Mental Health Planning Council (CMHPC)

***Confirmation it was conducted as described*:**

_X_ Yes
___ No. Please explain:

Summary of results:

A. **The CMHPC is working closely with the California Association of Local Mental Health Boards and Commissions (CALMHB/C) to monitor access through an annual ~~updating~~ data ~~workbook~~ notebook development and training.**

B. **The CMHPC staff has participated on reviews of County Cultural Competence Plans to ensure compliance with Plan requirements.**

C. **The CMHPC represented the interest of stakeholders in meetings held by the state during the transition from DMH to DHCS.**

D. **As part of our commitment to rehabilitative services the CMHPC actively opposed legislation to continue involuntary outpatient services. The Council takes positions on legislation and advocates for community-based care in lieu of institutional care.**

E. **The CMHPC holds quarterly meetings, open to the public, and encourages robust stakeholder input.**

Problems identified: **None**

Corrective action (plan/provider level) **NA**

Program change (system-wide level): **NA**

14~~6~~. ***Monitoring Activity*:** **Provider Appeals Inpatient Services and EPSDT Services**

***Confirmation it was conducted as described*:**

__X_ Yes
____ No. Please explain:

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Strategy 1: Provider Appeals Inpatient Services: FFS Hospitals

***Summary of results*: Results are reported for July 1, 2010~~2~~3-December 31, 2012 4. MHPs are required to have a provider problem resolution process pursuant to CCR, title 9, section 1850.305. When an appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, ~~and that service has been provided at a FFS Hospital,~~ the providers may appeal to the State if the MHP denies the appeal in whole or in part. Such appeals to the State are generally referred to as "State/second-level TAR appeals".**

In FY 2012/13, DHCS received 119 State/second level TAR appeals from providers. During this time period, a majority of second level TAR appeals were filed by a single provider. DHCS upheld the MHP's decision for 98% of days appealed through the State/second level TAR appeal process. DHCS rejected 21 of the appeals received because they did not meet criteria for a second level TAR appeal.

In FY 2013/14, DHCS received 349 State/second level TAR appeals from providers. During this time period, a majority of second level TAR appeals were filed by a single provider. DHCS upheld the MHP's decision for 87% of days appealed through the State/second level TAR appeal process.

~~Decisions on State second-level TAR appeals were rendered at a rate of 8.5 per month in FY 2009-2010. Decisions were rendered July 1, 2010 through December 31, 2012 on an average of 16 decisions per month. The percentage of TAR appeal decisions upholding the MHP's original denial is above 90 percent.~~

***Problems identified*: The high percentage of 2nd level TAR appeal denial decisions is primarily based upon the failure of providers to meet documentation standards related to medical necessity criteria for acute and administrative days. ~~DHCS has determined that the high percent of the second-level TAR appeals denied by the State indicates that there is a continuing problem at the provider level with understanding documentation of medical necessity criteria for acute and administrative days.~~**

***Corrective action (plan/provider level)*: Feedback via the State/second level TAR appeals process to the providers on medical necessity criteria.**

***Program change (system-wide level)*: None**

Strategy 2: Provider Appeals: ~~EPSDT~~ Specialty Mental Health Services

***Summary of results*: Overall, the number of provider appeals have been low within the last two years. From July 1, 2013~~1~~ - -January 31, 2015~~3~~, ~~33~~ three inpatient appeals were filed, fourteen outpatient appeals were filed; and two AB 1780 EPSDT informal appeals were filed; ~~however, in 24 of those cases the legal entities chose to~~**

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~~drop the appeal and four MHP subcontractors have requested formal appeals. A~~ The resolution of one informal appeal is still pending. One provider has inquired about a formal hearing but the process to handle formal appeals is in development. As of January 201~~3~~5, no new requests for either informal or formal appeals have been filed.

Problems identified **None**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA.**

17. ***Monitoring Activity~~:~~*** **County Support Unit (formerly County Technical Assistance Section)**

***Confirmation it was conducted as described*:**

_X_ Yes
___ No. Please explain:

***Summary of results*: During ~~the~~ waiver period 8, the County Support Unit (CSU) ~~(formerly the County Technical Assistance Section)~~ has functioned as the central point of contact for the MHPs, provided resources and technical assistance for the administration and provision of community mental health service programs. CSU staff are assigned as the liaison to specific counties. Beginning in January 2014, CSU staff has participated in the Program Oversight and Compliance Branch triennial system review in their assigned counties that were scheduled for reviews. CSU staff provided technical assistance to MHP contact staff on the development of the Plans of Correction (POCs) in response to review items that were out of compliance with standards.**

Prior to upcoming system reviews, CSU staff contacted MHPs to request updates on evidence of correction from the previous triennial review. Based on MHP status, CSU staff offered consultation and technical assistance as the MHP prepared for the review. CSU staff continued to regularly follow up with MHP staff until the time of the system review.

***Problems identified*: After submission of the POC, CSU staff worked with MHPs to obtain evidence of correction for POCs in priority areas including Access, Beneficiary Protection, Quality Improvement, Program Integrity, and any repeat POCs from the previous review. After evidence of correction was submitted, CSU staff continued to interact with MHPs and request evidence of continued correction as needed to confirm continued implementation of POCs~~The County Support Unit contacted MHPs as needed following their Medi-Cal Oversight System Review conducted by the Program Oversight and Compliance Branch to monitor the status of implementing plans of correction and offer technical assistance and resources.~~**

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Follow up activities placed the greatest priority on 24/7 access lines, grievance and appeal process, timeliness of access to services, Treatment Authorization Requests, and provider certification, as well as quality improvement activities. Staff tracked MHP progress in these specific areas.

***Corrective action (plan/provider level)*: -The County Support Unit collaborated with the Program Oversight and Compliance Branch to conduct a focused review on one county that needed additional assistance to maintain compliance with state requirements. The technical assistance in the form of regularly schedule contacts continued ongoing for several months.and CSU staff worked with the county to obtain evidence of correction and ensure that requirements are met. The MHP was found to have made significant improvement. ~~Additionally County Support staff assisted the county to prepare for and accompanied Program Oversight and Compliance on the system review in June 2013.~~**

Based on CSU analysis of statewide trends from the system reviews during the last three years, we have identified 24/7 access line requirements as an area for focused statewide technical assistance. As a result, DHCS has conducted a survey of the 24/7 access line mechanisms used in each county to meet the linguistic access requirements, both during business hours and after hours. We have used this information to develop draft training materials to assist MHPs to meet requirements, including information and recommended strategies on linguistic capability, answering mechanisms during business hours and after hours, access line scripts, and MHP internal test call frequency and scripts.

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