County of Orange Mental Health Plan

System Review and Chart Review

Corrective Action Plan

Review December, 2019

This is the Corrective Action Plan (CAP) for the Department of Health Care Services' (DHCSS) 2019-20 review of the Orange County Mental Health Plan. This CAP addresses both system review findings and chart review findings. This CAP is being developed and implemented during the unusual times associated with the COVID-19 pandemic. Because of the many adaptations to the situation, the implementation of the CAP is heavily impacted by MHP internal communications, distance conferences, and distance learning by the providers. In addition, a number of the corrective actions, especially to the chart review findings, require modifications to the electronic health record (EHR) of the County MHP and to the multiple EHRs of contract providers. Changes to these complex systems must go through multiple change management processes to ensure that they do not impact compliant billing and claiming of services.

Finding Number 1

Requirement

The MHP shall offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county.

Finding

While the MHP submitted evidence to demonstrate compliance with the requirement, it is not evident that the MHP offers an appropriate range of SMHS that is adequate for the number of beneficiaries in the county. In addition to the evidence submitted by the MHP, DHCS reviewed the most recent Network Adequacy Findings Report and the Corrective Action Plan Remediation Tool. The MHP received a conditional pass on the Corrective Action Plan Remediation Tool for Provider Capacity for Adult and Children Youth.

DHCS deems the MHP out-of-compliance with Federal Code of Regulation, Title 24, Section 438, subdivision 207(b)(1). The MHP must comply with the CAP requirements per the Network Adequacy Findings Report addressing this finding of non-compliance.

Citation

Federal Code of Regulation, title 24, section 438, subdivision 207(b)(1)

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Steps to implement:

Step 1: MHP will comply with the DHCS-approved Network Adequacy Findings Report CAP. Evidence will be the DHCS CAP acceptance letter.

Plan for providers/contractors:

NA

Evidence of correction/improvement:

Evidence for Step 1 will be DHCS acceptance letter of 4/2/20 that the CAP has been completed.

Ongoing Monitoring Plan:

The MHP will continue to submit the required quarterly Network Adequacy Report and review for compliance with the CAP at the time of submission.

Measure(s) of effectiveness

Network Adequacy submission will be deemed adequate by DHCS.

Person Responsible

Kathleen Murray

DHCS Response

Finding Number 2

Requirement

The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services.

Finding

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

While the MHP submitted evidence to demonstrate compliance with the requirement, it is not evident that the MHP is meeting the standards for timely access to care and services taking into account the urgency of need for services. In addition to the evidence submitted by the MHP, DHCS reviewed the most recent Network Adequacy Findings Report and the Corrective Action Plan Remediation Tool. The MHP received a conditional pass on the Corrective action Plan Remediation Tool for reported service requests meeting threshold.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section438, subdivision 206(c)(1)(i). The MHP must comply with CAP requirements per Network Adequacy Findings Report addressing this finding of non-compliance.

Citation

Federal Code of Regulations, title 42, section438, subdivision 206(c)(1)(i).

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Steps to implement:

Step 1: MHP will comply with the DHCS-approved Network Adequacy Findings Report CAP. This item is completed. Evidence will be the DHCS CAP acceptance letter dated 4/2/20.

Plan for providers/contractors:

NA

Evidence of correction/improvement:

Evidence for Step 1 will be DHCS' acceptance letter of 4/2/20 that the CAP has been completed.

Ongoing Monitoring Plan

The MHP will continue to submit the required quarterly Network Adequacy Report and review for compliance with the CAP at the time of submission.

Measure(s) of effectiveness

Network Adequacy submission will be deemed adequate by DHCS.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 3 (A3A)

Requirement
The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC.

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

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP does not have a TFC provider at the time of this review, therefore it does not have capacity to provide TFC services to those children and youth who meet medical necessity criteria for TFC.

DHCS deems the MHP out of compliance with Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must complete a CAP addressing this finding of non-compliance

Citation
Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Correction to be made: The ultimate goal is for Orange MHP to have TFC services available. Because the development of the Intensive Services Foster Care homes where TFC is to be provided is under the control of SSA, the steps which the MHP can take to contribute to the ultimate goal are limited. Those steps that are currently underway or are planned are listed in this corrective action.

Steps to implement:

Step 1: CYP staff will continue to work closely in partnership with SSA to facilitate the development of ISFCs and TFCs. This will be through participation in the SSA led FFA partner meetings monthly and in the FFA forums meetings quarterly. SSA coordinates the meetings and does not capture participation or minutes. The evidence of participation that is available will therefore limited to the meeting notes of the CYP staff. This activity will be ongoing until TFC services are in place.

Step 2: CYP is adding slots to an existing Full Service Partnership to provide 24/7 support for ISFCs, such as assistance with all services including TFC. 20 client slots are designated for this FSP. This item is scheduled to go to the Board of Supervisors in April, but faces possible delay depending on Board priorities related to the current public health situation of COVID 19. The evidence for this item will be the approved Board of Supervisors action.

Plan for providers/contractors: Multiple steps are currently made to engage contracted providers. Support for providers, once contracted, is addressed in the contracting discussed under Step 2.

Evidence of correction/improvement:

Evidence for Step 1 will be minutes to the meetings.
Evidence for Step 2 will be documentation of Board of Supervisor passage of this agenda item.

Ongoing Monitoring Plan:
AQIS will coordinate with CYP to develop a quarterly status report on this item to DHCS.
Measure(s) of effectiveness:
The ultimate measure of effectiveness is the availability of TFC services.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 4 (A3B)

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

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

While the MHP submitted evidence to demonstrate compliance with this requirement, they did not submit evidence that they determine if children and youth meet medical necessity criteria need TFC. The MHP's P&P Pathway to Well Being and Intensive Services does not address the need for TFC.

DHCS deems the MHP out of compliance with Medi-Cal Manual for ICC, IHBS and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must complete a CAP addressing this finding of non-compliance.

Citation Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Steps to implement: The MHP will assess children and youth to determine if children and youth who meet medical necessity criteria need TFC.

County and contracted MHP providers will assess children and youth.

Steps that will be taken:

Step 1: The MHP through Children, Youth and Prevention (CYP) Division will create a TFC assessment protocol/form. Because there is not currently a TFC provider, form will remain in draft form until a TFC provider is added. The draft form will be submitted as evidence.

Step 2: The TFC assessment requirement will be put into Policy and Procedure, either through inclusion in the Pathways to Well Being P&P or through its own P&P. Because there is not currently a TFC provider, the P&P will remain in draft form until a TFC provider is added. The P&P draft will be submitted.

Plan for providers/contractors:

The subcontractors are required to follow the same P&P and will be provided with information and training on the required assessment.

Evidence of correction/improvement:
Evidence of completion of Step 1 will be the draft TFC assessment form.
Evidence of completion of Step 2 will be the draft Pathways to Wellbeing P&P.

Ongoing Monitoring Plan
AQIS will include an update on this item in its quarterly status report described for Finding 4.
Measure(s) of effectiveness
The ultimate measure of effectiveness is the assessment of children and youth meeting medical necessity for the need for TFC services.
Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 5 (A6D10)

Requirement
All contracts or written agreements between the MHP and any network provider specify the following:

A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable available at any time for inspection, examination or copying by the Department, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (Fed. Code Regs., tit. 42, §438, subd. 3(h).)

This audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (Fed. Code Regs., tit. 42, § 438, subd.230(c)(3)(iii).) The Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk, then. (Fed. Code Regs., tit. 42, § 438, subd. 230(c)(3)(iv).)

Finding
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 230 and the MHP Contract, exhibit A, attachment 1. The MHP must ensure that all contracts or written agreements between the MHP and any network provider specify all aspects listed above.

While the MHP submitted evidence to demonstrate compliance with this requirement, the current contracts did not include that the audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. The MHP did not submit evidence of amendment of those contracts. The MHP submitted the new unsigned copy of the Telecare Corporation agreement, which now has this requirement in it. While the unsigned copy of the contract included this requirement, there was no evidence of compliance for currently executed contracts.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 230 and MHP Contract, exhibit A, attachment 1.

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

Citation
Federal Code of Regulations, title 42, section 438, subdivision 230 and the MHP Contract, exhibit A, attachment 1.

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement;

Corrections to be made: At the time of the on-site review, the contract boilerplate had already been amended to include the required language and HCA Contracts provided an executed contract showing that language. However existing contracts do not yet have that language in them. All contracts being renewed in July 2020 will have that language and those contracts not up for renewal will be amended to include the language. In addition, for those community providers who are contracted through an Administrative Services Organization (ASO), Beacon, this language has already been in those contracts.

Steps to implement:
Step 1: Contracts Department to modify boilerplate to include complete required language in the Records Retention section. Boilerplate will be submitted as evidence.

Step 2: Contracts to include the required language in all new and renewed MHP contracts moving forward. This is already under way and will be completed during the contract renewal period by November 1, 2020. For evidence an example of a newly executed contract with the required language will be submitted.

Step 3: HCA Contracts Department will prepare and implement amendments to those contracts not being renewed in July 2020. The amendments will be in place by November 1, 2020.

Plan for providers/contractors:
Providers/contractors will be subject to the contract change and will be notified by Contracts as part of the renewal and amendment process.

Evidence of correction/improvement:
Evidence for Step 1 will be the contract boilerplate, already completed.
Evidence for Step 2 which is already completed will be examples of newly executed contracts with the required language.

Evidence for Step 3 will be the amendment and two amended contracts. These will be submitted by November 1, 2020.

Ongoing Monitoring Plan:
Contracts will do the ongoing monitoring as part of their routine contracting processes.
Measure(s) of effectiveness:
The language will be in all MHP subcontracts.

Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 6 (C2F)

Requirement
The Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence

Finding
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must ensure the Quality Assessment and Performance Improvement (QAPI) Work Plan includes evidence of compliance with the requirements for cultural competence and linguistic competence.

While the MHP submitted evidence to demonstrate compliance with this requirement, the QAPI Work Plans submitted did not include evidence of compliance with the requirement for cultural competence and linguistic competence.

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

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

Citation
(MHP contract, Ex. A, Att. 5)

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement;

Steps to implement:
Step 1: A goal will be added to the 2020-2021 QAPI reflecting the ongoing compliance with the requirement for cultural competence and linguistic competence. The goal will be consistent with all the required elements related to development, oversight and reporting of the QAPI.

Plan for providers/contractors:
The goal will include performance by providers/contractors.

Evidence of correction/improvement:
Evidence of completion of Step 1 will be the 20-21 QAPI including the new goal which will be submitted to DHCS.

Ongoing Monitoring Plan:
AQIS managers responsible for coordinating the development of the QAPI will be responsible to ensure that this requirement continues to be met.
Measure(s) of effectiveness:
The QAPI will continue to address the cultural competence and linguistic competence of MHP providers.

Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 7 (4D14-15)

Requirement
The MHP provider directory must contain the following required elements:

California license number and type of license.
An indication of whether the provider has completed cultural competence training

Finding
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(h)(1)(v), California Code of Regulations, title 9, chapter 11, section 1810, subdivision 410, and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-020. The MHP provider directory must contain all the elements required above.

The MHP submitted the Provider Directory including the license number and type of license for the contracted providers. However, while the MHP submitted evidence to demonstrate compliance with this requirement, the Provider Directory did not include the license number and type of license for the county owned and operated providers as required by Information Notice 18-020. In addition, the cultural competence training information was missing for all providers on the directory.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(h)(1)(v), California Code of Regulations, title 9, chapter 11, section 1810, subdivision 410, and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-020. The MHP must complete a CAP addressing this finding of non-compliance

Citation
Fed. Code Regs., tit. 42, § 438, subd.10(h)(1)(v), Cal Code Regs., tit. 9, chap. 11, §1810, subd. 410, MHSUDS, IN, No. 18-020).

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors
Correction to be made: The Provider Directory will include license number, license type and cultural competence training information for each provider. Authority and Quality Improvement Services (AQIS) staff will coordinate the collection and entry of the required data into the Provider Directory. The majority of deficiencies were in the community provider network which is managed through an Administrative Services Organization (ASO).

Steps to implement:

Step 1: The ASO was instructed to provide the missing information brought to light during the Triennial Review. This step was completed shortly after the Triennial Review. Evidence will be the communication from the MHP to the ASO.

Step 2: The ASO complied with provision of the required information shortly after receiving the communication from the MHP and has continued to provide the information since that time. Evidence will be the response communication from the ASO.

Step 3: AQIS data entry of the provider information is proceeding. This step is complete. As evidence, the MHP will provide the link to the Provider Directory.

Step 4: A more formal approach when a provider does not respond to the request for updated information will be developed to include

a. A formal communication from AQIS staff to the manager of the provider and to the County contract liaison and the County Program Manager.
b. An escalation process if a provider fails to respond to the request for two consecutive months.

Plan for providers/contractors:
The steps related to the contractor are completed as noted above.

Evidence of correction/improvement:
Evidence of Step 1 will be the communication from the MHP to the ASO.
Evidence of Step 2 will be the communication response from the ASO to the MHP.
Evidence of step 3 will be the evidence of completion of correction will be the MHP Provider Directory.
Evidence of step 4a will be the evidence of completion will be the sample communication to providers.
Evidence of Step 4b will be the escalation process.

Ongoing Monitoring Plan:
AQIS staff, other than those responsible for maintaining the directory, will review the Provider Directory quarterly.
Measure(s) of effectiveness
Provider Directory will have all required information

Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 8 (D6B3-4)

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

The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.

The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing recesses.

Finding

Test Call 2:

Test call #2 was placed on Friday, September 27, 2019, at 8:47 a.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the caller was directed to select from the following options: Press 1 for Alcohol and Drug Related, Press 2 for Other Mental Health Services or Press 3 if you are a Health Professional. The caller pressed option 2 and the caller was transferred to a live operator who answered the call as Beacon Health. The caller requested information about how to file a complaint against a therapist. The operator asked the caller to provide his/her name and the caller responded. The therapist asked if the caller is now seeing another therapist with Orange County Mental Health. The caller replied in the negative. The operator provided the number to call about grievances which is 866-308-307 4. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

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

Test Call 5:

The call was answered after one (1) ring via a phone tree directing the caller to dial 911, select #1 or stay on the line if the caller is having a medical emergency. Another recording came on

providing instructions in other languages and stated if the call is for routine business matter to call back during business hours and it provided the hours of operation or select #2 for mental health services. The caller selected #2 and the phone rang one (1) time and remained silent for approximately 10 seconds. After the 10 seconds, a recording stated that the call will be forwarded to an automated answering service #6572360121 and that it is not available, then the call disconnected on its own. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. However the caller was provided information about services needed to treat a beneficiary's urgent condition.

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

Test call #6

Test call #6 was placed on Tuesday, October 1, 2019, at 12:59 p.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the DHCS test caller then heard a recorded greeting and instructions to call 911 in an emergency. The caller was then placed on hold for two (2) minutes and fifty-six (56) seconds while the call was transferred to a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide their name and contact information, and advised the caller that she/he was not in the county system. The operator advised the caller that someone from the county would contact the caller later in the week to schedule an assessment. No additional information about SMHS was provided to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition.

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

Test Call #7

Test call #7 was placed on Wednesday, October 30, 2019, at 7:31 am. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The caller was then placed on hold for one (1) minute while the call was transferred to a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide his/her name and contact information, and advised the caller that he/she needed to be located in the county system for appropriate service provision. The operator also requested the caller's contact number or any number where the caller could be reached, in the event the call was disconnected. The caller asked if the information requested was required before he could get information regarding how to access SMHS. The operator explained again, that the identifiers requested from the caller were to locate the caller with appropriate services. Further, the operator inquired if the caller was in crisis. The operator informed the caller that he should call the same number during business hours, after which he will be assessed over the phone and linked with appropriate services. Operator did not provide information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition.

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

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The MHP must complete a CAP addressing this finding of partial of compliance. This is a repeated deficiency identified in the previous triennial review.

Citation
Cal. Code Regs., tit. 9, chap. 11, § 1810, subd.405(d) and 410(e)(1).

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Correction to be made: All calls will be handled in compliance with requirements. Although the logging requirement was split out as a separate finding by DHCS (see Finding Number 9, below) the corrective actions and monitoring apply to both Finding Number 8 and Finding number 9.

Target audience: 24/7 Access Line

Steps to be implemented:

Step 1: County's ASO Liaison will meet with ASO management (i.e. 24/7 line management) to:

- Review results of all Access Line related finding in detail
- County's ASO Liaison will meet with ASO management and communicate a verbal warning to which a corrective action plan from the ASO will follow should routine test call results fall below 100% compliance. This step will be completed by June 1, 2020

Step 2: Call scripts will be revised to address the issues identified in the state report.

Step 3: Train the 24/7 staff.

Plan for provider/contractor:
The CAP for this finding addresses the ASO contractor.

Evidence of correction/improvement:
Evidence for Step 1 will be the quality improvement meeting minutes.
Evidence for Step 2 will be the revised scripts for the 24/7 line (ASO)
Evidence for Step 3 will be the training materials for the ASO staff answering the 24/7 line.

Ongoing Monitoring Plan:
Test calls will continue with additional focus on the items in these findings.
Measure(s) of effectiveness:
The actions will be considered effective when 100% compliance is maintained.

Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 9 (D6C2)

Requirement
The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) contain the following required elements

Name of the beneficiary.
Date of the request.
Initial disposition of the request.

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

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged in the MHP's written log of initial requests. The table below summarizes DHCS' findings pertaining to its test calls:

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f). The MHP must complete a CAP addressing this finding of partial compliance.

Citation
Cal. Code Regs., tit. 9, chap. 11, §1810, subd.405(f).

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors:

Corrections to be made: The goal is that all calls shall be logged consistent with requirements. The corrective actions noted above for the other findings related to the test calls will include the appropriate logging of calls as part of the corrective actions and follow up monitoring. ***All steps and follow-up set out under Finding Number 8, above, relate to both that item and this.***

Steps to be implemented:

Step 1: County's ASO Liaison will meet with ASO management (i.e. 24/7 line management) to:
- Review results of all Access Line related finding in detail
- County's ASO Liaison will meet with ASO management and communicate a verbal warning to which a corrective action plan from the ASO will follow should routine test call results fall below 100% compliance. This step will be completed by June 1, 2020

These actions were completed on May 8, 2020.

Step 2: Call scripts will be revised to also address the logging requirements more clearly.

Step 3: Train the 24/7 staff.

Target audience: 24/7 Access Line

Evidence of completion:
Evidence of Step 1 will be the minutes of the ASO QI meeting.
Evidence of Step 2 will be the revised scripts.
Evidence of Step 3 will be the training materials for the ASO staff.

Plan for provider/contractor:
The CAP for this finding addresses the ASO contractor.

Evidence of correction/improvement:

100% of County and ASO test calls are handled in compliance with requirements for 3 consecutive months.

Ongoing Monitoring Plan:
Test calls will continue with additional focus on the items in these findings.
Measure(s) of effectiveness:
The actions will be considered effective when 100% compliance is maintained.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 10 (E4A)

Requirement
The MHP must provide beneficiaries with a NOABD under the following circumstances:

The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.

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

While the MHP submitted evidence to demonstrate compliance with this requirement, four (4) denied TARS did not have the required NOABD. The MHP was provided the opportunity to submit the NOABD's after the review. The evidence was not provided.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. The MHP must complete a CAP addressing this finding of non-compliance.

Citation
Fed. Code Regs.,tit.42, § 438, subd.400(b)(1)

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Corrections to be made: NOABD shall be issued in accordance with regulations. The errors were isolated to the Inpatient Unit. The issue was discovered and corrected prior to the DHCS onsite review, however had not been in place during the audit period reviewed.
Steps to be taken:

Target audience: Inpatient unit

Steps to implement:
Step 1: Revise Inpatient NOABD workflow. Evidence will be the revised workflow to be submitted by 12-31-20.

Step 2: Inpatient shall implement issuance of NOABDs as required. This step was completed 9-9-19. Evidence will be the inpatient training power point with implementation date on slide 8.

Step 3: AQIS will randomly select 5 TARS with denials or reductions and review the NOABD log to ensure appropriate completion. This step to be completed by 12-31-20.

Plan for providers/contractors:
NA

Evidence of correction/improvement:
Evidence for Step 1 will be the revised NOABD workflow.
Evidence for Step 2 will be the inpatient training PowerPoint.
Evidence for Step 3 will be submission to DHCS of a report on the outcome of the AQIS review.

Ongoing Monitoring Plan:
A follow up review of 5 TARS will be completed in the 4th quarter of 20-21.
Measure(s) of effectiveness:
Inpatient TARS resulting in denials or reductions will be found on the NOABD log.

Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 11 (F2A1)

Requirement
The MHP shall adhere to the following record keeping, monitoring, and review requirements:

Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal.

Finding
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must adhere to the record keeping, monitoring, and review requirements as listed above

While the MHP submitted evidence to demonstrate compliance with this requirement, the log reflected that seven (7) grievances were not logged within one (1) working day of the date of the receipt.

DHCS deems the MHP out-of-compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. The MHP must complete a CAP addressing this finding of non-compliance

Citation
Fed. Code Regs., tit. 42, § 438, subd. 416(a); Cal. Code Regs., tit. 9, § 1850, subd .205(d)(1).

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Correction to be made: All grievances shall be logged within one working day of receipt. The omission of this requirement from the P&P and process was noted prior to the on-site visit.

Steps to implement:

Step 1: Amend P&P 09.02.01 to reflect one business day logging requirement for grievances. This step was completed 11/6/19. Evidence will be submission of the P&P.

Step 2: Advise Grievance Log support staff of one business day logging requirement. This step was completed. Evidence will be the email directing support staff on the one business day requirement.

Step 3: Update grievance log to include a column for capture of the date logged. This step was completed. Evidence will be a blank log page and a completed log page

Evidence of correction/improvement
Evidence for Step 1 will be the updated grievance P&P.
Evidence for Step 2 will be the email reminding grievance support staff of one business day requirement.
Evidence for Step 3 will be the updated grievance log with date logged column and a completed page from the updated log.

Ongoing Monitoring Plan
AQIS Managers of the AOABH and CYPBH support teams shall conduct a review of the grievance log at the end of 20-21 to ensure that the requirement has been consistently met.
Measure(s) of effectiveness
100% of grievances are logged within one business day.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 12 (F4B1-3)

Requirement
The MHP includes in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. (Fed. Code Regs., tit. 42, § 438, subd.408(e)(1)).

The MHP includes in the NAR the beneficiary's right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. (Fed. Code Regs., tit.42, § 438, subd. 408(e)(2)(i)).

The MHP includes in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request. (Fed. Code Regs., tit.42, § 438, subd.408(e)(2)(ii)).

Finding
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, subdivision 408(e)(2). The MHP must include in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. The MHP must include in the NAR the beneficiary's right to a State fair hearing and the procedure to request one if the appeal resolution is not wholly in favor of the beneficiary. Also, the MHP must include in the written notice of the appeal resolution the beneficiary's right to request and receive benefits while the State fair hearing is pending, and how the beneficiary makes this request

While the MHP submitted evidence to demonstrate compliance with this requirement, the written notice of the appeal resolution did not include the beneficiary's right to request a State fair hearing, and receive benefits while the State fair hearing is pending, and how the beneficiary makes those requests.

DHCS deems the MHP out-of-compliance with Federal Code of Regulations, title 42, subdivision 408(e)(2). The MHP must complete a CAP addressing this finding of non- compliance.

Citation
Fed. Code Regs., tit. 42, § 438,subd 408(e)(1). Fed. Code Regs., tit.42, § 438, subd. 408(e)(2)(i). Fed. Code Regs., tit.42, § 438, subd.408(e)(2)(ii).

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Correction to be made: The finding from DHCS does not provide information on the specific item that resulted in the finding. County has re-reviewed all of the items submitted for F IV B 1-3. All of the NARs submitted for the on-site review use the required state-developed NAR and the state-developed "Your Rights" forms. However, on one of the NARs (a file labeled "NAR CYPBH" in the original submission for F IV B 2) the sentence regarding SFH and how to obtain one is cut off part way through the sentence. This is the only thing that County is able to identify as possibly resulting in this finding. Therefore, it is this item that the corrective action addresses.

Steps to implement:
Step 1: Staff preparing the response to appeals shall be re-trained to use the state-developed forms and to ensure that the required verbiage is not inadvertently changed in the preparation of the response. Evidence will be training communication for all staff preparing appeals responses and staff acknowledgement of the training.

Evidence of correction/improvement:
Evidence for Step 1 will be the training communication for all staff preparing appeals responses and the training staff acknowledgement of receipt.

Ongoing Monitoring Plan:
The Administrative Managers responsible for reviewing all appeals responses prior to the response being sent specifically include this paragraph in their review to ensure it is not inadvertently changed.
Measure(s) of effectiveness:
All NARs sent out shall contain the required language.

Person Responsible:
Kathleen Murray

DHCS Response

Finding Number 13 (G4A)

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

Disclosures must include:
Date of birth and Social Security Number (in the case of an individual).

Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest)

Finding
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must ensure that its subcontractors and network providers submit the disclosures below to the MHP regarding the network providers' (disclosing entities') ownership and control. The MHP's network providers must be required to submit updated disclosures to the MHP upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under Federal Code of Regulations, title 42, section 455, subd.104. Disclosure must include all aspects listed above.

While the MHP submitted evidence to demonstrate compliance with this requirement, the disclosure forms submitted do not include all of the required items, specifically missing date of birth, social security number, and other tax identification number.

DHCS deems the MHP out-of-compliance with MHP contract, exhibit A, attachment 13. The MHP must complete a CAP addressing this finding of non-compliance.

Citation
Federal Code of Regulations, title 42, section 455, subd.104. (MHP contract, Ex. A, Att. 13)

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement;

Corrections to be made: The Orange MHP process for collecting disclosure information relative to this item did not include the date of birth, social security number, or other tax identification number. Following review of the item it was decided that the most appropriate method for insuring the collection of the required information was to modify one step for new contracts and a separate step for renewing contracts.

Step 1: For each new MHP contract, AQIS requires the contractor to submit a Medi-Cal Certification Application which includes a disclosure of ownership grid. AQIS will add to that grid required fields of DOB, SSN, and other tax ID # as appropriate to each disclosing party/entity. This will be implemented 7/1/20.

Step 2: Each year HCA Contracts requires MHP subcontractors to submit a packet of Annual Administrative Documents that address multiple requirements. The requirements for ownership disclosure with all required elements as per CFR 42, section 455, subd. 104 will be re-stated and an amended disclosure statement, or a statement that there have been no changes since the prior submission, will be required. . This item will be required in the Annual Administrative Document requirement that will be circulated by Contracts by 11/1/20.

Plan for providers/contractors:
Existing providers/contractors will be informed of this requirement at the time the Annual Administrative Document notification is distributed. New providers/contractors will be required to submit with the Contract Application submission.

Evidence of correction/improvement:
Evidence of Step 1 will be the modified Contract Application and example of a new application that includes this information. These items will be submitted by November 1, 2020.

Evidence of Step 2 will be the communication from HCA Contracts to renewing providers/contractors that includes on the list of required documents the new disclosure information. Evidence will also include an Annual Administrative Document submission from a provider/contractor that includes the required information.

Ongoing Monitoring Plan:
The Contracts department will be responsible for ensuring the required language is included.
Measure(s) of effectiveness
The required information for the disclosures, including the DOB, SSN, and tax ID number, is collected annually and at the time of any changes.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 14 (G4F1-2)

Requirement
The MHP must submit disclosures and updated disclosures to the Department of Health and Human Services including information regarding certain business transactions within 35 days, upon request. (MHP contract, Ex. A, Att. 13) The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

Finding
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 13. The MHP must submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request. The MHP must ensure the ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request, and the MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request..

While the MHP submitted a policy as evidence to demonstrate compliance with this requirement, evidence of practice and/or implementation of the policy to demonstrate compliance was not submitted. The policy did not include the details of this requirement.

DHCS deems the MHP out-of-compliance with the MHP contract, exhibit A, attachment 13. The MHP must complete a CAP addressing this finding of non-compliance.

Citation

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement;

Corrections to be made: The 35 day notification requirement will be added into the contract boilerplate and existing contracts amended.

Step 1: The MHP contract boilerplate will be amended to reflect the 35 day requirement. This will be completed by November 31, 2020. The evidence will be the amended boilerplate.

Step 2: New contracts will reflect the 35 day requirement by November 31, 2020. The evidence will be an executed contract with the required language.

Step 3: Existing contracts will be amended to reflect the 35 day requirement. This will be completed by November 31, 2020. The evidence will be an amended contract with the required language.

Plan for providers/contractors:
The requirement will be in new contracts. Existing contracts will be amended with notification to the provider/contractors.

Evidence of correction/improvement:
Evidence of Step 1 will be the contract boilerplate.
Evidence of Step 2 will be an example of an executed contract with the revised language.
Evidence of Step 3 will be an example of an amended contract with the revised language.

Ongoing Monitoring Plan:
The Contracts department will ensure the language is in all MHP contracts moving forward.
Measure(s) of effectiveness:
The requirement will be in all MHP contracts.

Person Responsible:
Kathleen Murray

DHCS Response

Chart Review

Most of the corrective actions related to the chart review include additional training for staff on the various finding items. As specified below for each finding, the relevant slides and sample pages of the training logs will be provided as evidence. The primary training referenced will be the Annual Provider Training (APT) which has both a children's (CYP) version and an adults' (AOABH) version. Both County and contract providers take the APT. Due to the COVID 19 pandemic issues, the APT is anticipated to be completed somewhat later than usual this year, but should be complete by December 31, 2020.

Finding Number 2A

Requirement

The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation.

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

Finding

Assessments were not completed within the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.

The following are specific findings from the chart sample:

Line number 20: The Initial Assessment was not completed within 60 days of the beneficiary's Episode Opening Date, as specified in the MHP's written standards.

Line numbers 2, 6, 8 and 9: Updated Assessments were not completed within 365 days of completion of the previous Assessment, as specified in the MHP's written standards.

Citation

MHP Contract, Ex. A, Att.9

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; plan for providers/contractors.

Correction to be made: The goal is for initial and annual assessments to be completed within required timelines. Upon review and discussion with QI staff and providers, it appeared that there was not a consistent understanding of the criteria for identifying the relevant signature date to indicate the date of the assessment. The findings from DHCS indicate that it is the date of the provider signature that DHCS used to determine the date of the assessment and the date of prior assessments. This understanding will be communicated across all providers and will be used in internal audits and reviews.

Steps to implement:
Step 1: The March QRTips (the AQIS monthly provider update) for CYPBH and AOABH provides training for all providers regarding provider signature is the relevant date rather than the client signature.

Step #2. The Annual Provider Training for CYPBH and AOABH will include training for all providers regarding requirement for timelines for initial and annual assessments, including the provider signature date as the date of the assessment. This item to be completed 1st half 2020-21. Evidence to be provided is relevant training slides and "attendance tracking" log pages.

Plan for providers/contractors
The trainings listed above and the audits listed below include contracted providers.

Evidence of correction/improvement
Evidence for Step 1 will be the QRTips training for March.
Evidence for Step 2 will be the Annual Provider Training slide and "attendance tracking" log pages.

Ongoing Monitoring Plan
Ongoing audits will continue and timeliness assessed with feedback to individual and group providers.
Measure(s) of effectiveness
Initial and annual assessments will be completed in compliance with required timelines. The end of the year summary of audit results will show at least 90% of Care Plans reviewed completed within required timelines.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 2B

Requirement

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

a. Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
b. Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
c. History of trauma or exposure to trauma;
d. Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions;
e. Medical History, including: Relevant physical health conditions reported by the beneficiary or a significant support person; Name and address of current source of medical treatment; for children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history;
f. Medications, including: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment; Documentation of the absence or presence of allergies or adverse reactions to medications; Documentation of informed consent for medications;
g. Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over- the-counter drugs, and illicit drugs;
h. Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s);
i. Risks. Situations that present a risk to the beneficiary and others, including past or current trauma;
j. Mental Status Examination;
k. A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent
    a. with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis

Finding

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

d) Mental Health History: Line number 9.
e) Medical History: Line number 9.
f) Medications: Line numbers 9 and 13.
g) Client Strengths: Line numbers 5 and 7.
h) History of Trauma: Line numbers 6, 7 and 9.

Citation

MHP Contract, Ex. A, Att. 9; CCR, title 9, §§ 1810.204 and 1840.112

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Correction to be made: The goal is for all initial and annual assessments to include the required eleven elements of an assessment as specified by DHCS.

Target audience: All providers

Steps to implement:

Step 1: All county-operated and contract organizational providers shall amend their initial and annual assessment forms to include all eleven required elements and prompt indicating that the fields are all required regardless of whether or not there has been a change since prior assessment. Evidence for this step will be the assessment formats, to be completed by the end of 2020-21.

Step 2: All county-operated and contract organizational providers shall be re-trained on the requirement that all required fields must be completed regardless of whether or not there has been a change since prior assessment. Evidence for this step will be the relevant Annual Provider Training slides and a page from the "Attendance Log". This step to be completed during the first quarter 20-21.

Plan for providers/contractors
Providers and contractors take the same annual provider training as do county providers. AQIS will coordinate the modifications to the forms.

Evidence of correction/improvement
Evidence for Step 1 will be the County and organizational provider initial and annual assessment formats which will be submitted showing all eleven elements and prompt indicating they are required.

Evidence for Step 2 will be the slide from the CYPBH and the AOABH Annual Provider trainings, and a page of the "attendance" log of the training, which is required for all providers.

Ongoing Monitoring Plan
The AQIS chart audit protocol will be amended to specify that all 11 items are present. Every provider is audited and is given feedback on the results. Results will now specify if any of the 11 items are missing.
Measure(s) of effectiveness
Annual summary of the results of the year's audits will show at least 90% compliance with this requirement.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 3A:

Requirement
The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication.

Finding

The provider did not obtain and retain a current written medication consent form signed by the

beneficiary agreeing to the administration of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

1) **Line number 3:** There was no written medication consent form found in the medical record. *During the review, MHP staff was given the opportunity to locate the missing medication consent form but was unable to locate it in the medical record.*
2) **Line numbers 4 and 5:** Although there were one or more medication consent forms in the medical record, medication consent was not obtained for all of the medications prescribed. *During the review, MHP staff was given the opportunity to locate the medication consents in question but were unable to locate them in the medical record.*

Citation
MHP Contract, Ex. A., Att.9

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Corrections to be made: The lines that failed this item were for services provided by psychiatrists in an inpatient setting. When hospitals provide TARs for the inpatient stay days, they currently submit the medication consents as part of the packet, but the consents are not retained or reviewed to ensure that they contain the required elements. MHP staff collecting the data for the chart reviews did not ensure that all existing medication consents were obtained from the inpatient providers.

Target audience:
Inpatient hospital providers and the physicians providing services to those clients.

Steps to implement:
AQIS will audit a sampling of services provided in this setting. For each sampled provider claim submitted in this category, AQIS in conjunction with Inpatient Services and Patients' Rights and Advocacy Services will pursue from the inpatient provider the necessary medication consents, review the consents for necessary requirements, and develop corrective actions should the consents not be present/complete.

Plan for providers/contractors:
The corrective actions are specifically shaped to the providers providing services to the inpatients.

Evidence of correction/improvement
Medication consents will contain the required items.

Ongoing Monitoring Plan
AQIS will annually review a sampling of TAR submissions from the hospital providers to ensure that all required consents are present and include the required items.
Measure(s) of effectiveness
Annual review of the results of the audits will show at least 90% compliance with this requirement.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 3B

Requirement

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

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

Finding

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

1) The reason for taking each medication: **Line number 1.**
2) Reasonable alternative treatments available, if any: **Line number 1**.
4) Frequency or Frequency Range: **Line number 20.**
7) Duration of taking each medication: **Line numbers 1, 10 and 20.**
9) Possible side effects if taken longer than 3 months: **Line number 6.**

Citation
MHP Contract, Ex. A, Att. 9

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Corrections to be made: The goal is for all medication consents to include all of the elements required by DHCS. Discussion with QI staff and providers suggest that there is a lack of clarity regarding the field "duration". The DHCS finding indicated that "TBD" is not an acceptable response. Duration that is a range, for example "up to two years" is acceptable according to DHCS feedback.

Target audience: All providers

Steps to implement:

Step 1: All county-operated and contract organizational providers shall ensure that their medication consent forms include all ten required elements and prompt indicating that the fields are all required. This step to be completed by September 1, 2020.

Step 2: The Annual Provider Training will include training for all county-operated and contract organizational providers on the requirement that all fields must be completed. This training will occur in the first half of 20-21.

Plan for providers/contractors:
Providers and contractors take the same Annual Provider Training as do county providers. AQIS will coordinate the modifications to the form.

Evidence of correction/improvement
Evidence for Step 1 will be the county form and organizational provider forms submitted showing all ten elements and prompt indicating they are required.

Evidence for Step 2 will be the relevant Annual Provider Training slide and an "attendance" log page.

Ongoing Monitoring Plan
The AQIS chart audit protocol will be amended to specify that all 10 items are present. Every provider is audited and is given feedback on the results. Results will now specify if any of the required elements are missing.

Measure(s) of effectiveness
Annual summary of the results of the year's audits will show at least 90% compliance with these requirements.

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 3C

Requirement

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

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

Finding

One or more Medication Consents in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, and job title. Specifically:

- The type of professional degree, licensure, or job title of person providing the service:
  - **Line numbers 1 and 20.**

Citation
MHP Contract, Ex. A, Att. 9

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Correction to be made: The goal is for all medication consents to include the required elements specified by DHCS for this item. Medication consents shall include: Date of service; the signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title of the person providing the service; relevant identification number (e.g., NPI number), if applicable; the date the documentation was entered in the medical record. Legibility of the signature seems to have been an issue in DHCS not finding the licensure in one of the two line items.

Target audience: All prescribers

Steps to implement:

Step 1: The Annual Provider training for County and contract providers will include re-training regarding these requirements. The Annual Provider Training will be completed in the first half of 2020-2021.

Plan for providers/contractors:

The trainings listed above and the audits listed below include contracted providers.

Evidence of correction/improvement:

Evidence for Step 1 will be the relevant slide in the Annual Provider Training and a page from the "attendance" log.

Ongoing Monitoring Plan

In addition to the items from finding 3B, above, the AQIS audit protocol will be amended to include that a passing signature must have these items.

Measure(s) of effectiveness

Annual summary of the results of the year's audits will show at least 90% compliance with these requirements.

Person Responsible

Kathleen Murray

DHCS Response

Finding Number 4A

Requirement

Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan.

Finding

The Initial Client Plan was not completed in compliance with the MHP's written timeliness standard of no more than 60 days following the beneficiary's Episode Opening Date.

Therefore, treatment services were not provided or delayed, due to an incomplete client plan. Specifically:

- **Line number 1.** Episode Opening Date, 3/13/2018; Initial Client Plan completed on 6/27/2018. Note - the beneficiary did not receive any planned treatment service prior to completion of the Initial Client Plan.

Citation

MHP Contract, Ex. A, Att. 2)

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors

Corrections to be made: The goal is for all Care Plans to be completed within required timelines.

Steps to implement:

Step 1: Annual Provider Training will retrain all MHP providers on the requirements for Care Plan timeliness. The evidence for this step will be the Annual Provider Training slides and a page from the "Attendance Log". The training will be completed during the first quarter of 2020-21.

Step 2: Retrain all MHP providers of the expectation that when a client is unavailable the outpatient provider should complete the plan as best as possible, documenting the reason the client was unavailable, and gain the client participation as soon as possible. The evidence to be submitted for this step will be the relevant slides from the Annual Provider Training and a page from the attendance log for the Annual Provider Training to be completed during the first quarter of 2020-21.

Plan for providers/contractors:

The trainings listed above and the audits listed below include contracted providers.

Evidence of correction/improvement:

Evidence for Step 1 will be the relevant Annual Provider Training slide and a page from the attendance log.
Evidence for Step 2 will be the relevant Annual Provider Training slide and a page from the attendance log.

Ongoing Monitoring Plan:

AQIS will to monitor this item during the routine audits.
Measure(s) of effectiveness
Annual summary of the results of the year's audits will show at least 90% compliance with these requirements.

Person Responsible

Kathleen Murray

DHCS Response

Finding Number 4A-2a

Requirement

The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

Monitoring and follow up activities [shall] ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's individual needs.

Finding

Services claimed and documented on the beneficiary's progress notes were not consistent in amount, duration or scope with those documented on the beneficiary's current Client Plan. Specifically:
Line number 15. While the Care Plan indicated the need for "Collateral Therapy" sessions weekly, the beneficiary was actually seen only four times during the three month review period.

- Eight other Collateral services claimed were provided by phone with the parent, without the participation of the beneficiary, and targeted the parent's issues/problems without addressing the beneficiary's behavior. For example, progress notes described the intervention as, "engaged mother in emotional check-in ...." Reflected back mother's

feelings/experiences and validated mother responses/experiences" ... "processed with mother her recent [medical] recovery."

Citation
MHP Contract, Ex. A, Att. 2
MHSUDS IN No.17-040

Corrections to be made: The goal is to ensure that all clients receive services as needed within a timely manner as established in a client plan informed by assessment. The County MHP reviewed the chart for Line number 15 thoroughly following receipt of the audit finding. The review indicates that while services were provided, they were not actually collateral services as listed in the Plan as planned services. This appears to be a misuse of the collateral code potentially reflecting a misunderstanding of what collateral services actually are.

Steps to implement:

Step 1: Retrain all MHP providers of the expectation that services listed in the Client Plan must be provided and if not, the reason why must be clearly documented and/or the Plan revised. This training to occur in the Annual Provider during the first quarter of 2020-21. The evidence to be submitted for this step will be the relevant slides from the Annual Provider Training and a page from the attendance log for the Annual Provider Training.

Step 2: Retrain all MHP providers on the specifics of what collateral services actually are and are not. The evidence to be submitted for this step will be the relevant slides from the Annual Provider Training and a page from the attendance log for the Annual Provider Training, to be completed during the first quarter of 2020-21.

Plan for providers/contractors:

The trainings listed above and the audits listed below include contracted providers.

Evidence of correction/improvement:

Evidence for Step 1 will be the relevant Annual Provider Training slide and a page from the attendance log.
Evidence for Step 2 will be the relevant Annual Provider Training slide and a page from the attendance log.

Ongoing Monitoring Plan:

An item will be added to the routine AQIS chart review protocol to identify any significant discrepancies between the planned services and the services actually provided.
Measure(s) of effectiveness
Annual summary of the results of the year's audits will show at least 90% compliance with these requirements.

Person Responsible

Kathleen Murray

DHCS Response

Finding Number 4B

Requirement

The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition.

Finding

One or more client plan was not updated at least annually. Specifically:

- **Line numbers 2, 6, 8 and 9:** There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period. Specifically:
  - Line number 2. Prior Client Plan expired on 8/15/2018; current Client Plan completed on 10/26/2018.
  - Line number 6. Prior Client Plan expired on 8/16/2018; current Client Plan completed on 8/30/2018.
  - Line number 8. Prior Client Plan expired on 4/11/2018; current Client Plan completed on 4/15/2018.
  - Line number 9. Prior Client Plan expired on 2/27/2018; current Client Plan completed on 3/14/2018.

Citation

MHP Contract, Ex. A, Att. 2

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement;

Corrections to be made: The goal is for all Care Plan annual updates to be conducted within required timelines.

Target audience: All MHP providers

Steps to implement:

Step 1: Retrain all providers regarding annual Care Plan timeline requirements. Training to occur in the Annual Provider Training which will occur in the first half of 2020-21. Evidence will be the relevant training slide and a page of the "Attendance log".

Plan for providers/contractors:

The training listed above and the audits listed below include contracted providers.

Evidence of correction/improvement:

Evidence for Step 1 will be the relevant Annual Provider Training slide and a page from the attendance log.

Ongoing Monitoring Plan:

The AQIS chart review protocol already identifies any late annual Care Plans, ensures that any services improperly claimed during the time that there was no care plan in place are repaid, and provides feedback to the provider regarding the issue. The AQIS audits will continue to do so and an annual review with any necessary corrective actions will be implemented.

Measure(s) of effectiveness

Annual summary of the results of the year's audits will show at least 90% compliance with these requirements.

Person Responsible

Kathleen Murray

DHCS Response

Finding Number 4C

Requirement
The MHP shall ensure that Client Plans:

1) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis
2) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
3) Have a proposed frequency of the intervention(s).
4) Have a proposed duration of intervention(s).
5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance (CCR, title. 9, § 1830.205(b).
6) Have interventions that are consistent with client plan goal(s)/treatment objective(s).
7) Have interventions consistent with the qualifying diagnosis.

Finding

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

- One or more goal/treatment objective was not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments. **Line numbers 3, 10 and 13.**
- One or more proposed intervention did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded. **Line numbers 3, 10 and 13.**
- One or more proposed intervention did not include an expected frequency or frequency range that was specific enough. **Line number 3.**
- One or more proposed intervention did not include a specific expected duration. **Line numbers 13, 15 and 20.**

Citation
MHP Contract, Ex. A, Att. 9

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; the goal is for Care Plan goals to meet documentation requirements. Care Plan goals shall be specific, measurable and quantifiable. Interventions shall be specific and not just service types. Interventions shall include an expected frequency or frequency range. Interventions shall include an expected duration. During the on-site review, a reformatted Interim Care Plan (ICP), containing all the elements required on any Care Plan, was presented to DHCS reviewers, however this reformatted ICP was not in use during the timeframe of the audit period.

Target audience: All MHP providers.

Steps to be implemented:

Step 1: During the Annual Provider Training during the first half of 2020-21, retrain all MHP staff on the Care Plan requirements including at a minimum 1) the difference between documenting goals and recommendations; 2) requirements that goals shall be specific, measurable and quantifiable; 3) the difference between specific interventions and service types; 4) the requirement for specific frequency or frequency range; 5) the expectation of and examples of a duration. Evidence for this item will be the relevant Annual Provider Training slides and "Attendance log" page which will be given during the first quarter of 2020-2021.

Step 2: Reformat the Interim Care Plan (ICP) to require all the same elements as any other Care Plan. Evidence for this will be the reformatted ICP. This will take some time as it needs to go through the electronic health record change process. It will be submitted by the end of 2020-21.

Plan for providers/contractors:

Providers/contractors receive the same training as county staff and will use an ICP that contains the same ICP elements.

Evidence of correction/improvement:

Evidence for Step 1 will be the relevant Annual Provider Training slides and a page from the "Attendance log".

Evidence for Step 2 will be the reformatted ICP.

Ongoing Monitoring Plan:

AQIS chart review audit protocol will be revised to ensure that ICPs have all the required items.

Measure(s) of effectiveness

Annual summary of the results of the year's audits will show at least 90% compliance with these requirements

Person Responsible

Kathleen Murray

DHCS Response

Finding Number 4E

Requirement

The MHP shall ensure that Client Plans include documentation of the beneficiary's participation in and agreement with the Client Plan.

The MHP shall ensure that Client Plans include the beneficiary's signature or the signature of the beneficiary's legal representative when:

a. The beneficiary is expected to be in long-term treatment, as determined by the MHP, and,
b. The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS.

When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan includes a written explanation of the refusal or unavailability of the signature.

Finding
There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the Client Plan, when a signature was required by the MHP Contract with the Department and by the MHP's written documentation standards:

- **Line number 3.** Plan documented on a progress note, with no explanation of the degree of the beneficiary's participation in and agreement with the Client Plan.
- **Line number 7**.
- **Line number 10.**
- **Line number 13.**
- **Line number 18.**

Citation
MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).
CCR, title 9, § 1810.440(c)(2)(A).
CCR, title 9, 1810.440 c 2 B

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; plan for providers/contractors:

Corrections to be made: The goal is for all Care Plans to clearly document the client or legal representative's degree of participation in and agreement with the Client Plan as required. Following receipt of the DHCS Chart Review Findings, all the cited Line numbers were reviewed and a variety of issues identified that caused the findings. The steps below address all these identified issues. While all relevant notes were provided relative to the audit period, this did not include those notes from prior plans that may have described client participation for the prior plans that were also looked at by DHCS.

Target audience: All MHP providers.

Steps to implement:
Step 1: Reformat the Interim Care Plan (ICP) to have all required items including degree of client/representative participation/agreement with the Care Plan. Evidence to be submitted will be the ICP and will be submitted by the end of 2020-21.

Step 2: Ensure that all contractors Care Plans include the verbiage regarding client/representative participation/agreement. Evidence for this step will be multiple examples of interim care plans and annual care plans. Evidence to be submitted by the end of 2020-21.

Step 3: The Annual Provider Training to be completed in the first half of 2020-21 will include retraining on the requirement to document degree of client/representative participation in and agreement with the Care Plan. Evidence for this step will be the relevant Annual Provider Training slide and a page from the "Attendance Log". The training will occur during the first quarter of 2020-21.

Plan for providers/contractors:
Providers/contractors will be addressed as in Step 2 and providers/contractors take the same Annual Provider Training as county staff.

Evidence of correction/improvement
Evidence for Step 1 will be the reformatted ICP as noted above to include all elements required of any Care Plan.

Evidence for Step 2 will be the examples of the contractor Care Plans.

Evidence for Step 3 will be the relevant slides and a page from the "Attendance log".

Ongoing Monitoring Plan
AQIS chart review audit protocol will be revised to ensure that ICPs have all the required items.
Measure(s) of effectiveness
Annual summary of the results of the year's audits will show at least 90% compliance with these requirements

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 4G

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

Finding
Line numbers 3, 4, 7, 10, and 13: There was no documentation on the current Client Plan that the beneficiary or legal guardian was offered a copy of the Plan.

- **Note - Line number 4** had no documentation that the beneficiary was offered a copy of the Plan, although this was not an Interim Care Plan. Therefore, a Corrective Action Plan is required.

Citation
MHP Contract, Ex. A, Att. 9

Corrections to be made: The goal is for all Care Plans to clearly document the offer of a copy of the Client Plan as required. Following receipt of the DHCS Chart Review Findings, all the cited Line numbers were reviewed and a variety of issues identified that caused the findings. The steps below address all these identified issues.

Target audience: All MHP providers.

Steps to implement:
Step 1: Reformat the Interim Care Plan (ICP) to have a spot to document the offer of a copy of the Care Plan. Evidence to be submitted will be the ICP and will be submitted by the end of 2020-21.

Step 2: Ensure that all contractors Care Plans have a spot to document the offer of a copy of the Care Plan. Evidence for this step will be multiple examples of initial care plans and annual care plans. Evidence to be submitted by the end of 2020-21.

Step 3: The Annual Provider Training to be completed in the first half of 2020-21 will include retraining on the requirement to document the offer of a copy of the care plan. Evidence for this step will be the relevant Annual Provider Training slide and a page from the "Attendance Log".

Plan for providers/contractors:
Providers/contractors will be addressed as in Step 2 and providers/contractors take the same Annual Provider Training as county staff.

Evidence of correction/improvement
Evidence for Step 1 will be the reformatted ICP as noted above.

Evidence for Step 2 will be the examples of the contractor Care Plans.

Evidence for Step 3 will be the relevant slides and a page from the "Attendance log".

Ongoing Monitoring Plan
AQIS chart review audit protocol will be revised to ensure that ICPs have all the required items.
Measure(s) of effectiveness
Annual summary of the results of the year's audits will show at least 90% compliance with these requirements

Person Responsible
Kathleen Murray

DHCS Response

Finding Number 5B

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

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

<u>Reasons for Recoupment (RR):</u> ***Refer to the enclosed Recoupment Summary for additional details about disallowances.***

RR8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:

a) No progress note submitted
b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:
   1) Specialty Mental Health Service claimed.
   2) Date of service, and/or
   3) Units of time.

Finding

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

- **line numbers 11, 18, 19 and 20.** Thirty nine progress notes were not completed within the MHP's written timeliness standard of 14 days after the provision of service.
- **line number 20.** Nine progress notes did not document the beneficiary's response to the interventions provided
- **line number 17.** One progress note did not match its corresponding claim in terms of service date. **RR8b2, refer to Recoupment Summary for details.**
- **line number 20.** Three progress notes did not match its corresponding claim in terms of amount of time to provide services: The service time documented on the Progress Note was less than the time claimed. **RR8b3, refer to Recoupment Summary for details.**
- **line numbers 4, 9 and 14.** Twenty five progress notes were missing the provider's professional degree, licensure or job title.

Citation

MHP Contract, Ex. A, Att. 9)
MHSUDS IN No. 18-054, Enclosure 4

Corrections to be made. Include Goal (optional); Target audience; Change to be made; Steps to implement; Plan for providers/contractors:

Corrections to be made: The goal is for progress notes to have all elements required by the MHP Contract and be in accordance with the MHP's written documentation standards. Following receipt of the DHCS Chart Review Findings County QI staff thoroughly reviewed all cited Line numbers. A variety of issues were identified as contributing to the findings. The action steps below address these issues. One of the issues related to differences between the documentation and the date a service is claimed and time claimed. This relates to the current situation in which contract providers are required to double data entry, first in their own system for the documentation and then into the County system for claiming. These errors in claiming are a result of double entry which makes human error more likely. This situation of double entry is expected to continue into the foreseeable future. The corrective action for that item is ongoing items and the training for contract providers noted below.

Target audience: All MHP providers.

Steps to be implemented:

Step 1: Review of the individual line numbers cited during the review suggests that there was confusion regarding the relevant signature date on progress notes to establish the date documented. County will clarify in its documentation manual that it is the date of the clinician's signature that is the relevant date. In addition, the documentation manual will clarify that when a progress note is modified in accordance with MHP guidelines after it was originally completed, it is the date of the original clinician signature that is used to determine compliance with the MHPs standards for timeliness of documentation. The date of the clinician signature which shows the date of the modification, will not be used to determine timeliness of documentation. Evidence of this step will be the modified documentation manual to be completed by December 31, 2020.

Step 2: The two providers that did not have the date documentation was entered into the medical record appear on the printed progress notes revised their electronic health record in January of 2019 to include that item. This action is complete. Evidence will be a copy of the current progress note from each of those two providers.

Step 3: The Annual Provider Training will retrain all MHP providers on the documentation of response to the intervention, including multiple examples. The Annual Provider Training will be completed during the

first quarter of 2020-21 and the evidence for this item will include the relevant training slides and a page from the “Attendance Log”.

Step 4: The Annual Provider Training will retrain all MHP contract providers on the need to take great care that documentation of service time match the time claimed. The Annual Provider Training will be completed during the first quarter of 2020-21 and the evidence for this item will include the relevant training slides and a page from the “Attendance Log”.

Step 5: The Annual Provider Training will retrain all MHP providers on the need to take great care that documentation of service date matches the date claimed. The Annual Provider Training will be completed in the first quarter of 2020-21 and the Evidence for this item will include the relevant training slides and a page from the “Attendance Log”.

Step 6: The Annual Provider Training will retrain all MHP providers on the requirement for signatures to include the license/degree/title? The Annual Provider Training will be completed in the first quarter of 2020-21 and the Evidence for this item will include the relevant training slides and a page from the “Attendance Log”.

Plan for providers/contractors:
The providers/contractors take the same Annual Provider Training as do the county staff.

Evidence of correction/improvement
Evidence for Step 1 will be the modified pages of the documentation manual.
Evidence for Step 2 will be the relevant APT slides and page from the “Attendance Log”.
Evidence for Step 3 will be the relevant APT slides and page from the “Attendance Log”.
Evidence for Step 4 will be the relevant APT slides and page from the “Attendance Log”.
Evidence for Step 5 will be the relevant APT slides and page from the “Attendance Log”.
Evidence for Step 6 will be the relevant APT slides and page from the “Attendance Log”.

Ongoing Monitoring Plan
Step 2-6 will be reviewed as part of the AQIS chart audit review protocol.
Measure(s) of effectiveness
End of the year report of audit results will be 90% compliance with each of these items.

Person Responsible
Kathleen Murray