

Santa Barbara County Department of Behavioral Wellness
FY 19/20 Specialty Mental Health Triennial Review
Corrective Action Plan

System Review

Requirement

The MHP shall offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county. (Fed. Code Regs., tit. 42, § 438, subd.207(b)(1).)

DHCS Finding: Protocol Section A. I. B

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulation, title 24, section 438, subdivision 207(b)(1). The MHP must offer an appropriate range of SMHS that is adequate for the number of beneficiaries in the county.

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

- Policy & Procedure 2.001 Network Adequacy Standards and Monitoring
- Map Overview
- Map all beneficiaries
- Map PSY child
- Map PSY adult
- Map SMHS child
- Map SMHS adult
- NACT
- Santa Barbara CAP Remediation Tool
- Network Certification Findings Report
- Timely Access Reporting

While the MHP submitted evidence to demonstrate compliance with this 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 Remediation Tool. The MHP received a conditional pass on the Network Adequacy Findings Report for Outpatient Specialty Mental Health Services (SMHS) Provider Capacity for Children/Youth, and is required to complete a Corrective Action Plan (CAP).

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 CAP requirements per the Network Adequacy Finding Report addressing this finding of non-compliance.

Corrective Action Description

MHP received a CAP on 9/13/2019 stating that we did not have enough providers in Children/Youth psychiatry provider capacity and children/youth outpatient SMHS provider capacity. CAP was submitted on 10/31/2019 and approved by DHCS on 12/27/2019. The CAP was completed on 01/15/2020 and was considered implemented and completed by DHCS on 04/02/2020.

Proposed Evidence/Documentation of Correction

- 1) Santa Barbara MHP Annual NA Cert CAP Approval Letter
- 2) Santa Barbara Network Certification CAP
- 3) Santa Barbara MHP Implementation Letter.

Measures of Effectiveness

- 1) Medical Director will continue to hire Psychiatrists based on the ratios provided. Medical Director will work with current and future psychiatrists to ensure that their time is allocated appropriately.
- 2) QCM will work with internal staff and CBO providers to ensure that they are coding their time correctly between the age groups (0-20 and 21+). In addition, QCM will track open positions (positions that need to be hired for) and account for this in our calculations so that we can meet the ratios with fully staffed positions.

Implementation Timeline: 1/15/2020

Requirement

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

DHCS Finding: Protocol Section A. III. F

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 provide TFC services to all children and youth who meet medical necessity criteria for TFC.

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

- P&P Katie A./Pathways to Mental Health Services
- P&P Intensive Mental Health Services for Youth
- Requests for Qualifications for Therapeutic Foster Care FY 2019-2023

Specifically, while the MHP is currently making efforts to identify providers for TFC services, the MHP currently does not have any TFC providers and therefore this services is not being provided.

DHCS deems the MHP out of compliance with the 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.

Corrective Action Description

The MHP has previously posted a Request For Proposal for TFC services, however has only had one inquiry to date. The MHP is currently working with County Counsel to determine the possibility of contracting with this provider. In addition, the MHP is partnering with Child Welfare Services (CWS) and Probation to further discuss options to be able to provide TFC services. The MHP is creating a work group with CWS and Probation representatives to problem solve and explore collaborative ideas to gain interest. The work group will explore options including reaching out to neighboring counties. The MHP will also identify out of county TFC providers and work to contract with those providers.

Proposed Evidence/Documentation of Correction

- 1) Request for Proposal for TFC services.
- 2) Minutes/agendas for work group meetings.
- 3) List of out of county TFC providers.
- 4) Contract for out of county TFC providers.

Measures of Effectiveness

- 1) Contract monitoring
- 2) QIC Work Plan (NACT Goal)

Implementation Timeline: By 12/31/20

Requirement

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

DHCS Finding: Protocol Section A. III. G

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.

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

- P&P Katie A./Pathways to Mental Health Services
- P&P Intensive Mental Health Services for Youth
- Requests for Qualifications for Therapeutic Foster Care FY 2019-2023
- Katie A –Pathways to Mental Health Services

While the MHP submitted evidence to demonstrate compliance with this requirement, and stated that they do determine the level of care needed for all children and youth, evidence was not provided that they determine if children and youth who meet medical necessity criteria need TFC.

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

Corrective Action Description

Any client who is 21 and under will be required to be provided a "Katie A" assessment. The Katie A assessment will be renamed and reformatted to assess all youth (not just the Katie A population). The form will have a section specific to TFC. When youth are determined to meet criteria for needing TFC, the Interagency Placement Committee (IPC) will discuss how to link client with appropriate services.

Proposed Evidence/Documentation of Correction

- 1) Copy of modified Katie A assessment.
- 2) IPC minutes.

Measures of Effectiveness

- 1) Chart review

2) IPC minutes

Implementation Timeline: By 11/30/20

Requirement

The MHP has a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved. (Cal. Code Regs., tit. 9, §1810, subd. 370(a)(5)).

DHCS Finding: Protocol Section B. IV. D

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, subdivision 370(a)(5). The MHP must have a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes are being resolved.

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

- MH Template Final
- CenCal health and County Mental Health Dispute Resolution
- SB County Mental Health MOU

Specifically, the MHP's dispute resolution process does not include a means for beneficiaries to receive prescription drugs, while disputes are being resolved.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, subdivision 370(a)(5). The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

The MHP and the MCP will update the MOU to include language that allows beneficiaries to continue to receive SMHS and prescription drugs while disputes between the MHP and MCP are being resolved. The MHP has requested this language be added.

Proposed Evidence/Documentation of Correction

- 1) Email from Celeste to MCP Counsel requesting additional language.
- 2) Copy of MOU once complete.

Measures of Effectiveness

Minutes from MCP/MHP coordination meetings.

Implementation Timeline: By 11/30/20

Requirement

The Quality Assessment and Performance Improvement Work Plan includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. (MHP contract, Ex. A, Att. 5)

DHCS Finding: Protocol Section C. II. B

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 Work Plan (QAPI) includes evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

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

- MHP QAPI Work Plan FY 19/20
- MHP QAPI Work Plan Evaluation FY 18/19

Specifically, the QAPI Work Plan submitted focuses on accurately logging Mental Health grievances but does not include the review of beneficiary grievances, appeals, expedited appeals, fair hearings, and provider appeals.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

Update QIC Work Plan to include expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review data.

Proposed Evidence/Documentation of Correction

QIC Work Plan

Measures of Effectiveness

- 1) QIC Work Plan Evaluation
- 2) QIC Agenda

Implementation Timeline: By 10/30/20

Requirement

The Quality Assessment and Performance Improvement Work Plan includes evidence that Quality Improvement activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service. (MHP contract, Ex. A, Att. 5)

DHCS Finding: Protocol Section C. II. C

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 Work Plan includes evidence that Quality Improvement activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.

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

- MHP QAPI Work Plan FY 19/20
- MHP QAPI Work Plan Evaluation FY 18/19

Specifically, the QAPI Work Plan submitted identified a goal that the MHP tracks the progress of the Performance Improvement Projects (PIPs) without any progress information or evidence of implementation. The MHP did not provide any additional information related to how their PIPs contributed to meaningful improvement in clinical care and beneficiary service.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

The MHP will ensure that both the clinical and non- clinical PIPs are added to the QIC agenda quarterly in order to share updates on data and interventions as well as to discuss how the PIPs have contributed to meaningful improvement in clinical care and beneficiary services. This will be reflected in the QIC minutes and the QIC Work Plan Evaluation.

Proposed Evidence/Documentation of Correction

- 1) QIC Minutes
- 2) QIC Work Plan/Evaluation

Measures of Effectiveness

- 1) QIC Work Plan Evaluation

2) QIC Agenda

Implementation Timeline: By 10/30/20

Requirement

The MHP shall establish a Quality Improvement Committee to review the quality of SMHS provided to beneficiaries. The Quality Improvement Committee shall: (MHP contract, Ex. A, Att. 5) Recommend policy decisions.

DHCS Finding: Protocol Section C. III. A

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must establish a Quality Improvement Committee to review the quality of SMHS provided to beneficiaries including above listed elements.

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

- Sample of Quality Improvement Committee (QIC) meeting minutes
- Behavioral Wellness Quality Improvement Committee Charter

Specifically, The Behavioral Wellness Quality Improvement Committee Charter identifies that the QIC committee is responsible for recommending policy decisions however; the MHP did not submit evidence of this practice. The MHP identified that they plan to add policy updates as part of the QIC minutes in the future.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

The MHP has added a section entitled "Policy Recommendation" to each goal and objective in the QIC Work Plan Evaluation. Every sub-group working on these specific goals will evaluate whether or not there is a need for any policy changes related to each goal/objective. Recommendations will be forwarded to the Policy & Procedure staff to bring to policy work groups for updates.

Proposed Evidence/Documentation of Correction

- 1) QIC minutes
- 2) QIC Work Plan/Evaluation

Measures of Effectiveness

- 1) QIC Work Plan Evaluation

2) QIC minutes

Implementation Timeline: By 10/30/20

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (Cal. Code Regs., tit. 9, chap. 11, § 1810, subd.405(d) and 410(e)(1).)

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

DHCS Finding: Protocol Section D. VI. B

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). Each MHP must provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes. The seven (7) test calls are summarized below.

TEST CALL #1

Test call #1 was placed on Monday, September 30, 2019, at 8:45 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. The DHCS test caller was instructed to call 911 in a life-threatening emergency. The caller requested information about accessing mental health services in the county. The operator advised the caller of the assessment process and requested information regarding the caller's residence. The operator provided the caller with the name of a clinic, phone number and hours of operation. The caller was advised to call for an assessment and an appointment and

that the clinic does allow walk-ins. The operator advised the caller the 24/7 Access line is available in the event of a crisis. The caller was provided information about how to access SMHS and the caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL #2

Test call #2 was placed on Monday, November 18, 2019, at 7:45 a.m. and 7:39 a.m. The call was answered via a phone tree and repeated the same information in Spanish. The recording also mentioned to dial 911 if this was a life-threatening emergency. The phone tree proceeded to provide options to select. The caller selected #2 for Mental Health Services and the call went directly to a voice message system to leave a voice message.

The DHCS caller ceased the call and proceeded to call the hotline again and pressed #4 this time for information only. The call was answered by a live operator who inquired why the caller was calling. The caller informed the operator that he/she would like to obtain some information about services for his/her son. The operator asked for the caller's name and telephone number. The caller provided his/her name, but not the telephone number. The operator said that he/she needs the number in order to provide information, a safety assessment, and to provide a counselor to follow up. The operator said the caller could call back after 8 a.m. to speak to staff and that they could help the caller with the process. The caller thanked the operator and ceased the call. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL #3

Test call #3 was placed on Tuesday, October 29, 2019, at 2:17 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. The caller then heard a recorded greeting and instructions to call 911 if this is a life-threatening emergency; for mental health services, press 2; for alcohol and drug, press 3; for information only, press 4; and, for all other calls, press 5. The caller pressed 2. The caller was placed on hold for 5 minutes and transferred to a live operator. The caller requested information

about filing a complaint against a therapist in the county. The operator asked the caller to provide his/her name and date of birth. The operator provided the caller with options to file a complaint, which included; 1) the caller can address it with the clinician and the clinician's supervisor first; 2) the operator can take the complaint over the phone; 3) the operator can mail the Grievance form to caller's residence; and, 4) the caller can pick up the Grievance form at the clinic and the caller can view/print the Grievance form on the website. No additional information about SMHS was provided to the caller. The toll-free telephone number provided information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

FINDING

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

TEST CALL #4

Test call #4 was placed on November 5, 2019 at 8:59 a.m. The call was answered by phone tree. After selecting the option for mental health services, the call was put on hold for one minute for the next available screener. The caller requested information on how to obtain a medication refill. The operator asked the caller for insurance information and advised the caller that a screening has to be completed first which will take about two weeks. The operator advised the caller that if it is urgent need, then the caller should go to the urgent care. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL #5

Test call #5 was placed on Tuesday, November 19, 2019, at 7:18 a.m. The call was immediately answered via a phone tree and information repeated in Spanish. The recording also mentioned to dial 911 if it was a life-threatening emergency. The phone tree proceeded to provide options to select. The caller selected #4 for Information only and the call went directly to a live operator who identified himself/herself as Michelle. The caller asked how he/she could file a complaint against a therapist. The operator stated that she was not 100% sure how to answer the question and asked for the caller's information to have someone to call back. The caller stated he/she did not want to give the information and asked again if the operator could assist with the information. The operator stated that the caller would have to call back after 8:00 a.m. The caller

was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

FINDING

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

TEST CALL #6

Test call #6 was placed on Tuesday, November 19, 2019, at 7:55 a.m. The call was answered after two (2) rings via a phone tree directing the caller to select a language option, which included the MHP's threshold language. 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 while the call was transferred to a live operator. The caller discussed issues he was having related to caring for his mother and requested information about accessing mental health services in the county. The operator asked the caller to provide his/her name. The caller spelled out his/her name to the operator. The operator informed the caller that the right solution would be to start with caller's information before his mother's. The caller replied that his mother was of more importance at the moment and needed to find a way to help her. The caller further stated that the mother was irritable and found it difficult to cope, which made him depressed. The operator asked the caller if the service request was for the mother or for himself. The caller explained that his mother's condition was the source of his depression and finding a way to help her will also help him get out of depression. The operator asked for the caller's phone number. The call dropped after five (5) minutes without getting the information requested. The caller was not provided with the information on how to access SMHS. The caller was provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL #7

Test call #7 was placed on Monday, November 25, 2019, at 11:03 a.m. The call was answered after one (1) ring via a phone tree directing the caller to select a service option and allowed callers to select Spanish (threshold language). After selecting the option for mental health services, the DHCS test caller heard a recorded greeting that included what to do in case of an emergency and was placed on hold for five (5) minutes. When the test caller reached a live operator, she requested information about accessing mental health services in the county. The operator provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

FINDING

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

Corrective Action Description

The MHP will retrain ProtoCall (contracted after-hours answering service) staff specifically on how to obtain services for routine, urgent, and crisis mental health needs as well as providing information on beneficiary problem resolution processes. In addition, internal staff from the MHP's crisis team have been trained on the Access Line requirements and will be assisting in after hours calls beginning on September 27th, 2020. The MHP will update the Access Line script to include the above information as well. Additionally, all Access Line staff were re-trained on June 2nd, 2020. On September 25th, 2020, the Access Line staff will be trained specifically on medication refill requests.

Proposed Evidence/Documentation of Correction

- 1) Access Line Script for Protocall
- 2) Access Flow for Linkage to BWell Programs
- 3) Training PowerPoint for Access Line
- 4) Access Line Team meeting agendas

Measures of Effectiveness

Monthly test calls that are reported out to QIC monthly.

Implementation Timeline: By 10/30/2020

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. (Cal. Code Regs., tit. 9, chap. 11, §1810, subd.405(f)). The written log(s) contain the following required elements:

- 1) Name of the beneficiary.
- 2) Date of the request.
- 3) Initial disposition of the request.

DHCS Finding: Protocol Section D. VI. C

The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). The MHP must

maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request.

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

- Language Line training flow chart
- Policy & Procedure 24/7 Toll free access line
- Policy & Procedure 24/7 Toll free access line monitoring

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

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. This is a repeated deficiency identified in the previous triennial review.

Corrective Action Description

The MHP will train clinic staff, as well as, Access Line staff to log all ProtoCall calls into Clinician's Gateway (EHR) and include name of beneficiary, date of request, and initial disposition of request. Access Line staff were retrained on September 4th, 2020. Clinic Staff will be trained on October 13th, 2020. A memo will also be sent to all staff reminding them of the procedure to log SMHS requests.

Proposed Evidence/Documentation of Correction

- 1) Access Team meeting agendas
- 2) Memo to clinics on logging ProtoCall calls

Measures of Effectiveness

Monthly test calls that are reported out to QIC monthly.

Implementation Timeline: By 10/30/2020

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

DHCS Finding: Protocol Section E. IV. A

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.

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

- Service Request Log
- 29 NOABDS

Specifically, the MHP provided twenty nine (29) Notices of Adverse Beneficiary Determinations (NOABD) related to the Service Request Log. However, five (5) NOABD's were not provided to all beneficiaries that were denied based on not meeting medical necessity criteria.

DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 400(b)(1). The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

Update Clinician's Gateway (CG) to auto populate NOABD template upon assessment with no medical necessity.

Proposed Evidence/Documentation of Correction

- 1) Providing an example of NOABD in CG.
- 2) Provide data report from CG illustrating number of NOABDs issued from assessments not meeting medical necessity.

Measures of Effectiveness

Quarterly CG reports with data supporting NOABDs issued for beneficiaries who were not meeting medical necessity.

Implementation Timeline: By 3/31/2020

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

DHCS Finding: Protocol Section F. II. A

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.

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

- Sample of 47 grievances
- Grievance Log

Specifically, the MHP process did not include stamping their grievances with a date upon receipt, as such DHCS was unable to verify if the grievances were logged within one (1) working day.

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.

Corrective Action Description

QCM staff implemented use of date stamp upon receipt of grievance. All grievances will be stamped prior to scanning into electronic folder.

Proposed Evidence/Documentation of Correction

Recent date stamped grievances.

Measures of Effectiveness

QCM Coordinator will verify that QCM Office Professional has date stamped the grievance prior to logging grievance into the Grievance Log.

Implementation Timeline: 2/1/2020

Requirement

Notify the beneficiary of the resolution of a grievance in a format and language that meets applicable notification standards. (Fed. Code Regs., tit. 42, § 438, subd.408(d)(1) and 10.)

DHCS Finding: Protocol Section F. III. D

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(d)(1) and 10. The MHP must notify the beneficiary of the resolution of a grievance in a format and language that meets applicable notification standards.

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

- Policy 4.020 Beneficiary Problem Resolution Process
- Sample of 47 grievance resolution notifications

Specifically, thirty (30) out the forty seven (47) grievance resolution letters reviewed were not in 12 point font, therefore did not meet the format requirements.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(d)(1) and 10. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

QCM staff updated auto font setting to 12 points and will complete a font check prior to printing resolution letter. QCM staff also updated the grievance template with 12 point font.

Proposed Evidence/Documentation of Correction

Recent grievance resolutions for review.

Measures of Effectiveness

QCM staff will review grievance template to ensure it is in 12 point font.

Implementation Timeline: 2/1/2020

Chart Review

Requirement

The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b).)

1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16-051, and 17-004E)

The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1):

1. A significant impairment in an important area of functioning.
2. A probability of significant deterioration in an important area of life functioning.
3. A probability that the child will not progress developmentally as individually appropriate
4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate.

(CCR, title 9, § 1830.205 (b)(2)(A-C).)

The proposed and actual intervention(s) meet the intervention criteria listed below:

b) The focus of the proposed and actual intervention(s) addresses the condition identified in No. 1b (1-3)above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that the SMHS can correct or ameliorate per No. 1 (b)(4).

(CCR, title 9, § 1830.205(b) (3)(A).)

c) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D):

- A. Significantly diminish the impairment.
- B. Prevent significant deterioration in an important area of life functioning.
- C. Allow the child to progress developmentally as individually appropriate.
- D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.

(CCR, title 9, § 1830.205 (b)(3)(B)(1-4).)

The condition would not be responsive to physical health care based treatment. (CCR, title 9, § 1830.205(b)(3)(C).)

DHCS Finding: 1A-3b

The actual interventions documented on the progress notes for the following Line numbers did not meet medical necessity criteria since the interventions were not reasonably likely to result in at least one of the following: a) significantly diminish the impairment; b) prevent deterioration in an important area of life functioning; c) allow the child to progress developmentally; d) correct or ameliorate the mental health condition of a beneficiary who is under age 21. Specifically:

- 1) **Line numbers 15 and 17.** The progress note indicated a “no-show” or cancelled appointment and the documentation failed to provide evidence of another valid service. **RR15a, refer to Recoupment Summary for details.**
- 2) **Line numbers 3, 6 and 11.** The intervention documented on the progress note did not meet the definition of a valid Specialty Mental Health Service. **RR15b, refer to Recoupment Summary for details.**

Corrective Action Description

The MHP will ensure that all SMHS interventions claimed will be reasonably likely to assist a client in meeting Treatment Plan/Client Plan objectives that are aimed at reducing a beneficiary's functional impairments, prevent deterioration, or help a beneficiary who is under the age of 21 to progress developmentally as individually appropriate by requiring that all staff take a documentation training on service codes and billable interventions. This has previously been the practice, however the training will be updated with recent descriptions and examples of services that would clearly assist a client in meeting Treatment Plan/Client Plan objectives and reducing functional impairments.

In addition, when documentation is found to be incorrectly coded and claimed (i.e. staff have chosen a claimable service code, rather than a non-billable service code for a service that is not directed at assisting clients in meeting Treatment Plan/Client Plan objectives), staff will be required to repeat the documentation training. Also, QCM will provide staff with additional resources: an intervention guide and rotating live documentation trainings to assist staff in understanding how to document a description of how services will assist client in meeting a Treatment Plan/Client Plan objective, services that are solely transportation, clerical, or payee related will not be claimed, and that services provided and claimed are appropriate, medically necessary, and only provided to clients with a qualifying diagnosis.

Proposed Evidence/Documentation of Correction

- 1) Treatment Plan/Client Plan Training
- 2) Intervention Guide

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20

DHCS Finding: 1A-3b1

The intervention(s) documented on the progress note(s) for the following Line number did not meet medical necessity since the service provided was solely clerical:

- **Line number 15. RR11f, refer to Recoupment Summary for details.**

Corrective Action Description

The MHP will ensure that all SMHS interventions claimed will be reasonably likely to assist a client in meeting Treatment Plan/Client Plan objectives that are aimed at reducing a beneficiary's functional impairments, prevent deterioration, or help a beneficiary who is under the age of 21 to progress developmentally as individually appropriate by requiring that all staff take a documentation training on service codes and billable interventions. This has previously been the practice, however the training will be updated with recent descriptions and examples of services that would clearly assist a client in meeting Treatment Plan/Client Plan objectives and reducing functional impairments.

In addition, when documentation is found to be incorrectly coded and claimed (i.e. staff have chosen a claimable service code, rather than a non-billable service code for a service that is not directed at assisting clients in meeting Treatment Plan/Client Plan objectives), staff will be required to repeat the documentation training. Also, QCM will provide staff with additional resources: an intervention guide and rotating live documentation trainings to assist staff in understanding how to document a description of how services will assist client in meeting a Treatment Plan/Client Plan objective, services that are solely transportation, clerical, or payee related will not be claimed, and that services provided and claimed are appropriate, medically necessary, and only provided to clients with a qualifying diagnosis.

Proposed Evidence/Documentation of Correction

- 1) Treatment Plan/Client Plan Training
- 2) Intervention Guide

Measures of Effectiveness

Chart Review

Implementation Timeline: Chart Review

Requirement

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

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

DHCS Finding: 2A

One assessment was not completed within the MHP's initial timeliness standard of no more than 60 days after the beneficiary's Episode Opening Date. Specifically:

- **Line number 5.** The beneficiary's Episode Opening Date was 9/20/2017, while the only Assessment the MHP submitted was not completed until 8/13/2018, with no documentation of why the completion date was late.

Corrective Action Description

The MHP will ensure that assessments are completed in accordance with the timeframes and frequency requirements specified in the MHP's standards/ policy by updating the current Assessment policy to have clear timeliness requirements for all assessment types. An attestation will be required to ensure all staff read and understand the updated timeliness requirements. The MHP will ensure that planned SMHS are not claimed in the absence of an assessment that substantiates services by creating a report which will be run, and reviewed monthly for compliance. This report will show any services billed without a finalized assessment that are not claimable (i.e. Therapy, Rehabilitation, Group Therapy, Targeted Case management, Intensive Care Coordination, Therapeutic Behavioral Service, Collateral, Medication Support, Medication Administration).

Proposed Evidence/Documentation of Correction

- 1) Updated Assessment Policy and Procedure
- 2) Report listing staff who have completed attestation
- 3) Assessment Report

Measures of Effectiveness

- 1) Chart Review
- 2) Reviewing Assessment Report

Implementation Timeline: By 12/30/20

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 with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis

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

DHCS Finding: 2B

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

- a) Relevant conditions and psychosocial factors. **Line number 6.**
- b) Medical History. **Line number 6.**
- c) Medications. **Line number 6.**
- d) Trauma History. **Line number 10.**

Corrective Action Description

The MHP will ensure that every assessment addresses all of the required elements by creating a memorandum and providing to all staff with a required attestation to ensure that all staff read and understand the requirement that all fields of an assessment must be completed. In addition, the documentation training will highlight and focus on the importance of including all of the required elements in an assessment.

Proposed Evidence/Documentation of Correction

- 1) Memo
- 2) List of staff who have completed attestation

Measures of Effectiveness

Chart Review

Implementation Timeline: 12/30/20

Requirement

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

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

DHCS Finding: 3A

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 a medication consent:

- 1) **Line number 7.** 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 number 10.** The medication consent form completed on 1/15/2019 was not signed by the beneficiary, with no further explanation.

Corrective Action Description

The MHP will retrain the prescribers on medication consent standards and requirements on October 21st, including the importance of having the beneficiary sign the medication consent or document the reason why the beneficiary did not sign. A QCM Psychiatrist

continues to monitor for the presence of medication consents during chart review for the MHP's clinical PIP.

Proposed Evidence/Documentation of Correction

Medical Staff Meeting Minutes

Measures of Effectiveness

Chart Review

Implementation Timeline: By 10/30/20

Requirement

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

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

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

DHCS Finding: 3B

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

- 1) Frequency or Frequency Range: **Line numbers 6, 13 and 18.**
- 2) Method of administration (oral or injection): **Line numbers 6, 13, 17 and 18.**
- 3) Duration of taking each medication: **Line numbers 6, 13, 17 and 18.**
- 4) Possible side effects if taken longer than 3 months: **Line number 2.**

Corrective Action Description

The MHP will retrain the prescribers on medication consent standards and requirements on October 21st. The training will go through all of the required elements of the medication consent process as described in the Policy and Procedure and listed on the medication consent form.

Proposed Evidence/Documentation of Correction

Medical Staff Meeting Minutes

Measures of Effectiveness

Chart Review

Implementation Timeline: By 10/30/20

Requirement

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

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

DHCS Finding: 4B-1

Client Plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards). Specifically:

- **Line numbers 2 and 6:** Although there was no Initial Client Plan found in the medical record, the beneficiary received one or more claimed treatment service. The MHP was given the opportunity to locate the documents in question but did not submit written evidence of them in the medical record. RR4a, refer to Recoupment Summary for details.
- **Line number 10:** The beneficiary resided in a Crisis Residential program. However, a valid Client Plan for this service was not found in the medical record. There was a progress note on the date of admission (1/17/2019) containing a section titled, "Treatment Plan/Follow-up", however, that note was signed by an LVN who cannot be the sole signatory of a client plan. The MHP was given the opportunity to locate the document in question but did not submit written evidence of it in the medical record. RR4a, refer to Recoupment Summary for further details.
- **Line number 18:** The Initial Client Plan was late However, this occurred outside of the audit review period. (i.e., Episode Opening Date = 3/14/2018; Initial Plan completed on 6/11/2018).

Corrective Action Description

With regard to the CRT Treatment Plan/Client Plan, beginning in November 2020, the MHP will be completing concurrent review of our contracted CRT providers. During this review process, QCM staff will ensure that all CRT clients have a current Treatment Plan/Client Plan while receiving services at the CRT. To ensure Treatment Plan/Client Plans are updated on an annual basis, the MHP currently has reports that show all expired Treatment Plan/Client Plans and the supervisors of programs review this report for compliance. The MHP will additionally create this report for contracted agencies as well as Behavioral Wellness programs. The MHP will require that each program provide a written reason why each expired plan has not been renewed and a plan to renew. This log will be reviewed in a monthly leadership meeting.

Proposed Evidence/Documentation of Correction

- 1) Treatment Plan/Client Plan Report
- 2) Treatment Plan/Client Plan Expiration log

Measures of Effectiveness

- 1) Treatment Plan/Client Plan Report
- 2) Treatment Plan/Client Plan Expiration log
- 3) Chart Review

Implementation Timeline: By 12/30/20

Requirement

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

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

DHCS Finding: 4B-2

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

- **Line numbers 8 and 12:** There was a **lapse** between the prior and current Client Plans. However, this occurred outside of the audit review period:
 - **Line number 8.** Episode Opening Date = 6/5/2012. The MHP did not submit a prior Client Plan; current Client Plan completed on 10/23/2018.
 - **Line number 12.** Prior Client Plan expired on 3/23/2018. Current Client Plan completed on 3/28/2018.

- **Line number 4:** There was a **lapse** between the prior and current Client Plans. However, there were no claims during this period:
 - Prior Client Plan expired on 3/1/2019. Current Client Plan completed on 3/6/2019.

Corrective Action Description

To ensure Treatment Plan/Client Plans are updated on an annual basis, the MHP currently has reports that show all expired Treatment Plan/Client Plans and the supervisors of programs review this report for compliance. The MHP will additionally create this report for contracted agencies as well as Behavioral Wellness programs. The MHP will require that each program provide a written reason why each expired plan has not been renewed and a plan to renew. This log will be reviewed in a monthly leadership meeting.

Proposed Evidence/Documentation of Correction

- 1) Treatment Plan/Client Plan Report
- 2) Treatment Plan/Client Plan Expiration log

Measures of Effectiveness

- 1) Treatment Plan/Client Plan Report
- 2) Treatment Plan/Client Plan Expiration log
- 3) Chart Review

Implementation Timeline: By 11/30/20

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.

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

DHCS Finding: 4C

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 number 10.** Provider #9196. Plan completed on 01/17/2019.
- One or more proposed intervention did not include an expected frequency or frequency range that was specific enough.
 - **Line number 16.** Provider #4213. Plan completed on 02/22/2019.
 - **Line number 18.** Provider #4213. Plan completed on 06/11/2018.
- One or more proposed intervention did not include an expected duration.
 - **Line number 7.** Provider #9190. Plan completed on 08/03/2018.
 - **Line number 10.** Provider #9100. Plan completed on 01/17/2019.

Corrective Action Description

To ensure that Treatment Plan/Client Plans meet all requirements stated, the MHP will develop a new Treatment Plan/Client Plan training that describes each requirement in detail. The MHP will edit the Treatment Plan/Client Plan template in our EHR to be more clear for providers and clients to ensure no sections are missed

Proposed Evidence/Documentation of Correction

- 1) Treatment Plan/Client Plan Training
- 2) Updated Treatment Plan/Client Plan template

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20

Requirement

The MHP shall ensure that Client Plans are signed (or electronic equivalent) by:

- a) The person providing the service(s) or,

- b) A person representing a team or program providing the service(s) or,
- c) A person representing the MHP providing service(s).

(CCR, title 9, § 1810.440(c).)

Services (i.e., Plan Development) shall be provided within the scope of practice of the person delivering the service, if professional licensure is required for the service.

Services shall be provided under the direction of one or more of the following:

- A. Physician
- B. Psychologist
- C. Licensed Clinical Social Worker
- D. Licensed Marriage and Family Therapist
- E. Licensed Professional Clinical Counselor
- F. Registered Nurse, including but not limited to nurse practitioners and clinical nurse specialists
- G. Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.

(CCR, title 9, § 1840.314(e); CCR, title 9, § 1810.440(c).); State Plan, Supplement 3, Attachment 3. 1-A, pp. 2m-p, MHSUDS IN No. 17-040

The Client Plan must be co-signed by the LMHP directing services, within their scope of practice under State law. If the individual providing services must be under the direction of an LMHP (from the categories above).

(CCR, title 9, § 1840.314(e); CCR, title 9, § 1810.440(c).); State Plan, Supplement 3, Attachment 3. 1-A, pp. 2m-p, MHSUDS IN No. 17-040

DHCS Finding: 4D

The Client Plan was not signed (or electronic equivalent) by the appropriate provider, as specified in the MHP Contract and CCR, title 9, chapter 11, section 1810.440(c)(1)(A-C):

- **Line number 10:** The Client Plan was not signed or co-signed (or electronic equivalent) by an approved category of provider: i.e., MD/DO, RN, licensed/registered/waivered LCSW, MFT, LPCC, or licensed / waivered psychologist). RR4a, refer to Recoupment Summary for details.

Corrective Action Description

To ensure that an appropriate provider signs or co-signs all Treatment Plan/Client Plans, the MHP will make a requirement in our EHR that all Treatment Plan/Client Plans must be signed by an LMHP before they can be finalized.

Proposed Evidence/Documentation of Correction

Treatment Plan/Client Plan template

Measures of Effectiveness

Chart Review

Implementation Timeline: By 11/30/20

Requirement

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

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

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.

(CCR, title 9, § 1810.440(c)(2)(A).)

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.

(CCR, title 9, § 1810.440(c)(2)(B).)

DHCS Finding: 4E

The MHP's written documentation standards require the beneficiary or legal representative to sign each Client Plan as evidence of participation in and agreement with the Plan. However, a signature was missing, and there was no written explanation of the beneficiary's refusal or unavailability to sign on the following Client Plans:

- **Line number 1.** Provider #9177. Plan completed 12/20/2018
- **Line number 3.** Provider #9177. Plan completed on 01/11/2019
- **Line number 7.** Provider #9190. Plan completed on 08/03/2018 *
- **Line number 10.** Provider #9100. Plan completed on 01/17/2019
- **Line number 17.** Provider #4213. Plan completed on 03/01/2019

**** The signature of, or other evidence for, the LPS Conservator's agreement with the beneficiary's Client Plan was missing.***

Corrective Action Description

To ensure that all Treatment Plan/Client Plan requirements are met, the MHP will revise the Treatment Plan/Client Plan policy to clarify that a plan can be finalized and valid with verbal consent from the client, Legal Guardian, or LPS Conservator. The Treatment Plan/Client Plan template will be modified to capture the documentation of this verbal agreement.

Proposed Evidence/Documentation of Correction

- 1) Treatment Plan/Client Plan policy
- 2) Treatment Plan/Client Plan template

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20

Requirement

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

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

DHCS Finding: 4G

There was no documentation on the current Client Plan that the beneficiary or legal guardian was offered a copy of the Client Plan. Specifically:

- **Line number 7.** Plan completed on 08/03/2018
- **Line number 10.** Plan completed on 01/17/2019

Corrective Action Description

To ensure that there is documentation that each beneficiary was offered a copy of the Treatment Plan/Client Plan, the MHP will edit the Treatment Plan/Client Plan template in our EHR to input a date in which each client will be offered a copy of the plan and require documentation that this was completed.

Proposed Evidence/Documentation of Correction

Treatment Plan/Client Plan template

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20

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.

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

DHCS Finding: 5B

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

Specifically:

- **Line numbers 1, 2, 3, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20.** Several progress notes were not completed within the MHP's written timeliness standard of one (1) business days after provision of service. 177 or 29.1 percent of all progress notes reviewed were completed late.
- **Line number 3.** One progress note 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.

Corrective Action Description

To ensure that progress notes are documented within the MHP's required timeliness standards, the progress note policy will be revised to have clear timeliness requirements. Quality Care Management will review for timeliness when reviewing progress notes. To ensure that MHS claimed are accurate and are actually provided to

the beneficiary, the MHP will add descriptions and examples of appropriate time claimed in the required documentation training.

Proposed Evidence/Documentation of Correction

- 1) Mental Health Progress Note Policy & Procedure
- 2) Documentation Training

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20

Requirement

When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include:

- 1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary.
- 2) The exact number of minutes used by persons providing the service.
- 3) Signature(s) of person(s) providing the services.

(CCR, title 9, § 1840.314(c).)

DHCS Finding: 5C

Documentation of services provided to, or on behalf of, a beneficiary by more than one person at one point in time did not include all required components. Specifically:

- **Line numbers 2 and 17.** Several progress notes did not document the specific involvement of each provider in the context of the mental health needs of the beneficiary. **RR13a, refer to Recoupment Summary for details.**

Corrective Action Description

To ensure that all staff document all requirements for a group service, group note documentation will be added to the progress note training. In addition, an attestation will be required to ensure all staff read and understand the "Required Elements of a Progress Note" and the "Group Note" note sections of the Documentation Manual.

Proposed Evidence/Documentation of Correction

Documentation Training

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20

Requirement

Progress notes shall be documented at the frequency by types of service indicated below:

- a) Every service contact for:
 - i. Mental health services;
 - ii. Medication support services;
 - iii. Crisis intervention;
 - iv. Targeted Case Management;
- b) Daily for:
 - i. Crisis residential;
 - ii. Crisis stabilization (one per 23/hour period);
 - iii. Day Treatment Intensive;
 - iv. Therapeutic Foster Care
- c) Weekly:
 - i. Day Treatment Intensive: (clinical summary);
 - ii. Day Rehabilitation;
 - iii. Adult Residential.

(MHP Contract, Ex.A, Att. 9); (CCR, title 9, §§ 1840.316(a-b);1840.318(a-b), 840.320(a-b),)

DHCS Finding: 5D

Progress notes were not documented according to the frequency requirements specified in the MHP Contract. Specifically:

- **Line numbers 7, 13 and 17:** There was no progress note in the medical record for the services claimed. **RR8a, refer to Recoupment Summary for details.** *The MHP was given the opportunity to locate the documents in question but did not provide them.*
- **Line number 15:** For Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehab) identified on the progress note was not consistent with the specific service activity actually documented in the body of the progress note. Specifically:
 - While the progress notes corresponding to services provided on 01/04/2019 and 01/15/2019 recorded and claimed as ICC services, the Client Plan included Targeted Case Management, but not ICC services.

Corrective Action Description

The MHP will review 5 claims per month from providers who do not utilize the MHPs EHR for documentation and ensure that the services claimed are documented in the medical record. When documentation is found to be incorrectly coded and claimed (i.e. staff have chosen a claimable service code, rather than a non-billable service code for a service that is not directed at assisting clients in meeting Treatment Plan/Client Plan objectives), staff will be required to repeat the documentation training. Also, QCM will provide staff with additional resources: an intervention guide and rotating live documentation trainings to assist staff in understanding how to document a description of how services will assist client in meeting a Treatment Plan/Client Plan objective, services that are solely transportation, clerical, or payee related will not be claimed, and that services provided and claimed are appropriate, medically necessary, and only provided to clients with a qualifying diagnosis. To ensure that progress notes are documented within the MHP's required timeliness standards, the progress note policy will be revised to have clear timeliness requirements. Quality Care Management will review for timeliness when reviewing progress notes. To ensure that MHS claimed are accurate and are actually provided to the beneficiary, the MHP will add descriptions and examples of appropriate time claimed in the required documentation training.

Proposed Evidence/Documentation of Correction

- 1) Mental Health Progress Note Policy & Procedure
- 2) Documentation Training

Measures of Effectiveness

- 1) Chart Review
- 2) Review of claims

Implementation Timeline: By 11/30/20

Requirement

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

DHCS Finding: 6A

The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility and need for

ICC services and IHBS, and that if appropriate, such services were included on their Client Plan:

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

Corrective Action Description

To ensure that all staff and providers are trained to determine eligibility and need for ICC and IHBS, a training will be created and required with all requirements for children and youth. To ensure each beneficiary under the age of 22 who is authorized to receive SPMHS also receives an individualized determination of eligibility and need for ICC Services and IHBS prior to the development of the initial Treatment Plan/Client Plan, the MHP will require that documentation is completed in the chart. The MHP has a form that is required for the Katie A population where the level of care (ICC and IHBS) assessment is documented. The MHP will require this form to be completed for all clients in the children's system.

Proposed Evidence/Documentation of Correction

- 1) ICC/IHBS Training
- 2) Katie A form

Measures of Effectiveness

Chart Review

Implementation Timeline: By 12/30/20