MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES ON-SITE REVIEW, May 16, 2016

SISKIYOU COUNTY PLAN OF CORRECTION TO DHCS

Section & Item No.

Summary of Deficiencies/Findings
DHCS POC-MHP POC (Action Taken)-Date Completed
Evidence of Correction

Section A
2c7 -Internal provider list missing components. Specifically MHP must inform beneficiaries of providers that are not accepting new beneficiaries- Demonstrate that its provider list contains all of the required components.-Added component to Provider List. -6/4/16-Provider list attached

Section A
5d-The P&P did not specify the reading grade level of its written materials. The MHP indicated staff is available to provide assistance to beneficiaries; however, the MHP did not have written P&Ps which specify its process for ensuring assistance is provided. -Provide evidence to DHCS to substantiate its POC and to demonstrate that its written materials take into consideration persons with limited vision and/or persons with limited reading proficiency (e.g., 6th grade reading level).
-We are using Microsoft Word readability statistics to assure that our written beneficiary materials are at an appropriate reading level.
-10/11/16-Link and policy attached

Section A A8a-The MHP did not furnish evidence of assertive outreach to persons who are homeless with mental disabilities and/or hard-to-reach individuals with mental disabilities.-Provide evidence to substantiate its POC and to demonstrate that it conducts assertive outreach to persons who are homeless with mental disabilities.
-The MHP's top management continues to participate on the Quality of Life (now referred to as Team Shasta) Committee to address homelessness in southern Siskiyou County. In addition, the MHP has contracted with the local seasonal shelter to provide outreach to the homeless population in Yreka, and is working with Team Shasta to develop a similar program in Mt. Shasta.-On-Going-2016/2017 MHSA Plan Update

Team Shasta workshop meeting notes

MHP contract with Beacon of Hope

Section A 9a2 & 9a3**-**Protocol questions A9a2 and A9a3 are deemed in partial compliance-The MHP will submit a POC addressing the OOC findings for these requirements.-The MHP works closely with after-hours contract provider to ensure issues are addressed immediately.

Training conducted by Alameda NightWatch to address issues identified by the DHCS audit team.

Training conducted with MHP Health Assistants (HA's). (see attached)-9/30/16-Training materials provided by Alameda NightWatch.

Email communication between MHP Compliance Officer and Alameda NightWatch.

POC submitted by Alameda NightWatch.

Section A 10b1, 10b2 and 10b3-Protocol questions A10b1, A10b2 and A10b3 are deemed in partial compliance.

-The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with all regulatory requirements.
-The MHP is in the process of converting to an electronic log for all access calls. It is anticipated that this log will facilitate accurate tracking/logging of access calls.

All MHP HA staff received targeted training based upon DHCS audit findings.-Communication completed for HA's 7/21/16 Electronic log 4/10/16 -Attached Meeting Agenda Health Assts. (HA)

Section A 12c**-**The MHP did not demonstrate that it completes an annual report of CCC activities.-The MHP is required to provide evidence to DHCS demonstrating that it completes an annual report of CCC activities.

-12/21/16 Co-Chair of CCC met with QA Manager to format a CCC Work Plan that will comply with QI standards and regulations. -
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Section A 13a3**-**The MHP did not furnish evidence it has a plan for cultural competence training for persons providing SMHS employed by or contracting with the MHP.-Develop a plan for, and provide evidence of implementation of cultural competency training for persons contracting with the MHP.
-MHP added language regarding Cultural Competency training requirements to Organizational Provider Manual (included with all Organizational Provider contracts).

MHP implemented tracking procedures for training activities conducted with MHP and contracted staff.-11/7/16
Organizational Provider Manual Updated

12/13/16
Remi Vista contract amendment executed

Copy of Tracking Log for training-Organizational Provider Manual Updated

Remi Vista contract amendment executed

Copy of Tracking Log for training

Section A 13b-MHPs contracts do not contain contract language requiring contractors to provide cultural competency training to their staff.-Provide evidence and demonstrate that it has a plan for the implementation of training programs to improve cultural competence skills of both their staff and their contracted providers. -See above (Section A13a3)-See above for evidence of compliance**.**

-See Above

Section B
1c-Eight (8) TARS were not approved within the 14 calendar days of the receipt of the TAR.-Provide evidence regarding TARS approval or denial within 14 days calendars of receipt for hospital services -DHCS staff provided clarification during their triennial visit about how to count the 14 days which was different from how the MHP was counting them. After our staff psychiatrist died in September 2015, there was a gap in having available MDs for reviews of TARs and appeals. The tele-psychiatry contracts were amended to review TARs as part of their scope of service (see attached contract addendum). Timeliness of TARs since the triennial review in May 2016 shows a 92% compliance rate (see attached TAR data). The deficiency is the result of a personnel change at the front reception desk where the TARs are received and processed prior to delivery to the QA manager. The receptionist was trained in November 2016 on processing TARs. In addition, the receptionist is entering data on the TAR receipt log (see attached). The QI committee will receive quarterly reports of the compliance of TARs with the 14-day requirement as part of the plan of correction which will be documented in the QIC minutes for the remainder of the fiscal year. -On-going-Tele Psych addendum

QI Meeting

Tar Log
Section B
4b-MHP did not provide evidence of annual Utilization Management review activities. There is no inter-rater reliability or intra-rater reliability-Demonstrate that it has a mechanism to ensure consistent application of review criteria for authorization decisions and/or that it is reviewing (UM) activities annually.
-The MHP utilizes a standardized tools provided by DMH to ensure consistent application of review criteria for TAR's.

The MHP has contracted with Praxis Associates, LLC for technical assistance developing program and system-level process and outcome measures, measurement methods, and analytic strategies.

The MHP's QI Work Plan includes goal (5.2) to review UM activities annually, including monitoring activities to ensure that the MHP meets established standards for authorization decision making.-4/3/17-

CA DMH Form, Revised 2/23/2012

CA DMH Medi-Cal Oversight
Form
Revised 1/23/2012

Contract with Praxis executed 11/17/16

Notes from 12/19/16 meeting with Praxis

QI Work Plan 2016

Section B
5a1-Seven (7) out of the 20 assessments that were reviewed should have been issued a NOA-A.-Demonstrate it provides for a second opinion from a qualified health care professional within the MHP network or arrange for the beneficiary to obtain a second opinion outside the MHP network, at no cost to the beneficiary.
-With the implementation of the ACA, the MHP was initially unclear on whether NOA-A's were required following the screening process. The MHP sought clarification from DHCS and has been issuing NOA-A's to beneficiaries who do not meet medical necessity criteria for services at the time of screening.

The MHP provides for a second opinion at no cost to beneficiaries upon request.-On- Going-NOA Policy

Second Opinion Policy

Copies of Requests for Second Opinions and response letters

Section B
5b**-**Did not furnish evidence it provides a written NOA-B to the beneficiary when the MHP denies, modifies, or defers (beyond timeframes) a payment authorization request from a provider for SMHS.-MHP must provide written NOA-B to the beneficiary when the MHP denies, modifies, or defers (beyond timeframes) a payment authorization request from a provider for SMHS.
-Upon review of this item, it appears that the BHD staff did not possess the knowledge during the triennial review about our process of providing NOA-Bs for SARs that are denied, modified or deferred. No SAR in the sample given to the audit team required a NOA-B since there were no SARs in the sample that were modified, denied or deferred. BHD's process is outlined in the SAR and Notice of Action policies attached. Since we have new staff in the Children's System of Care unit, training in issuing NOA-Bs and tracking them was completed with the CSOC supervisor and two health assistants on 12/21/16 (see sign-in sheet attached). -12/21/16-NOA Policy

Training sign in sheet for NOA training
Section B
5d**-** One (1) grievance that was not resolved within the required timeframes and a NOA-D was not issued-Demonstrate that it provides a written NOA-D to the beneficiary when the MHP fails to act within the timeframes.-MHP provides NOA training for all staff upon hire and annually.

All NOA's issued by the MHP are logged for the purpose of monitoring for accuracy and timeliness. The MHP QI committee reviews the NOA log quarterly to verify requirements are met. If issues are identified by the QI team, a plan of correction is implemented.-On-Going -NOA Policy

Orientation Checklist for new employees reviewing NOA process

Agenda for upcoming QI meeting
Section C 3b**-**One (1) out of the 12 grievances that were reviewed was not resolved within the required timeframes and the required notice of an extension was not provided to the beneficiary.-Demonstrates that it provides evidence to DHCS to

substantiate its POC and to demonstrate that it ensures grievances, appeals, and expedited appeals are resolved within established timeframes.
See above-On-Going-See above
Section E 1-The MHP's Implementation Plan has not been updated and does not reflect its current policies and procedures.-The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a current Implementation Plan which meets title 9 requirements.
The MHP has worked with DHCS liaison, Dawn De Sousa, to develop an Implementation Plan that meets Title 9 requirements.
The MHP will complete Implementation Plan by 3/31/17.-Target date for completion: 3/31/17-NA
Section H 2e-MHP did not furnish evidence of effective training and education for staff of its contracted providers-The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides for effective training and education for its contracted providers.
The MHP has updated provider contracts to include training/education requirements.

The MHP had developed a Training Log to track participation in training activities by County employees and contract providers.

Participation in required training activities ensures compliance with regulatory and/or contractual requirements.
-AttachmentsA13a3, A13b -Remi Vista contract Addendum executed 12/13/16

Organizational Provider Manual Revised 11/7/16

Contracted Provider Training Log
Section H
2f-MHP did not provide evidence off effective lines of communication between the Compliance Officer and its contracted providers.-The MHP is required to provide evidence to DHCS to demonstrate that it ensures effective lines of communication between the compliance officer and its contract providers.
MHP's Compliance Officer will provide annual Compliance training for organizational providers, and will ensure that information regarding the Compliance Hotline is distributed to organizational provider employees and posted prominently in provider facilities.
Targeted completion dates for Compliance training 3/13/16.

Compliance Hotline information verified during recent site certification 9/15/16. -Email to provider regarding training.
Letter of completed site certification.

CHART REVIEW

NOTE: See corrective action that pertains to items 1c-1; 2a; 2b; 4a-2; 4b; 5a; 5c at the end of this section. In addition, full versions of the 2016 Medi-Cal documentation training presentation and the QA documentation manual are provided for this section in the source documents folder.

Section K 1c-1-Did not meet medical necessity criteria since the focus of the proposed interventions did not address MH condition as specified in CCR , title 9 section 1830.205 (b)(3)(A) -Indicate how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to MH. -The new QA documentation manual was distributed in the fall of 2016 and the clinical staff were trained in this area (see excerpted pages 6 and 19).

See end of document for additional corrective action. -On-going-See end of document for additional corrective action.

QA documentation manual
Section K 2a-Assessments were not completed in accordance w/regulatory & contractual requirements: -Indicate how the MHP will ensure assessments are completed.- [1] was transferred back to BHD from an organizational provider at the time the assessment was due for an update, leading to a lapse. The QA manager reviewed the case and determined that no inappropriate billing took place prior to the completion of the client's assessment and client plan update.

In 2016, the Health Information Department began monitoring and reviewing new cases at 60 days from the date of face-to-face assessment to assure that all assessments and treatment plans are completed timely (see attached spreadsheet).

For assessment updates, notifications were instituted (after the audit chart review period) in the Anasazi electronic health system to notify clinicians, nurse practitioners and psychiatrists 30 days before updates are due.

Timeliness standards are published in the clinical assessment policy and procedure (see clinical policy 16-07). Also, assessments are reviewed weekly in supervisor-clinician meetings to assure they are completed within 30 days of intake, verified by fiscal services prior to billing, and reviewed through the UR process.

A policy and procedure will be developed outlining transfers of cases between providers and required documentation.

See end of document for additional corrective action. -On-going

[1] Line number(s) removed for confidentiality

On-going

On-going

Will be submitted by 6/1/17-

HID review form and tracking sheet

Clinical Policy 16-07

Section K 2b-One or more assessments did not include all elements.-Indicate how the MHP will ensure all elements are met-Since the chart audit review period, changes were made to improve the Anasazi electronic assessment form to include all required elements through our contractor Kings View (see attached forms).

Deficiencies were particularly high in the psychiatric assessments so training was given to a contracted tele-psychiatrist and tele-nurse practitioner during the Medi-Cal yearly training. Intern clinicians' assessments are reviewed and signed off by their clinical supervisor to be sure that they are comprehensive (clinical policy 16-07).
The QA documentation manual assessment section outlines all regulatory requirements (see excerpt).

See end of document for additional corrective action. -On-going-
Assessment forms, diagnosis review form, medical necessity form

Training forms

QA documentation manual
Section K 3a-The provider did not obtain and retain a current written medication consent form, agreeing to the administration of each prescribed psychiatric medication.
[2]: Consent was not signed by beneficiary and/or parent, as required
Note: Three consent forms contained a note from parents agreeing to the medication prescribed , but no documentation of why no consents were not signed.-Indicate how the MHP will ensure :

1) A written consent is obtained & retained for each medication that includes the beneficiary's signature, or clear documentation of why beneficiary refused to sign the consent.

[2] Line number(s) removed for confidentiality

Written medication consents forms are signed as required. -The MHP is anticipating the DHCS documentation training information notice and will respond with a draft medical consent form and revised policy at that time to adequately reflect the changes. -Will be submitted by 6/1/17 or later depending on the date the DHCS information notice is released. -To be completed
Section K 3b-Written consents forms did not contain all the required elements. -Indicate how the MHP will ensure all the elements are listed on consent forms. -The MHP is anticipating the DHCS documentation training information notice and will respond with a draft medical consent form and revised policy at that time to adequately reflect the changes.
-Will be submitted by 6/1/17 or later depending on the date the DHCS information notice is released.-To be completed
Section K 4a-2-Client plan was not updated at least annually, as required in the MHP plan with the department, and as specified in the MHP's documentation standards):
[3]: Lapse between the prior and current client plans.
[4]: Client plan was late per the MHP's written documentation standards. This occurred outside the audit review period. -The MHP will indicate how the MHP will ensure:

- plans are completed annually.
- all types of inventions/service modalities provided and claimed are recorded correctly, specific, clear and address the functional impairments as a result of the mental disorder.
- Non-emergency services are not claimed when a client plan has not been completed.
- Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

-[5] the QA manager reviewed and determined that the lapse was due to a transfer of the case from an organizational provider to BHD. The organizational provider did not complete the update and the client had to wait for a scheduled assessment update appointment. The only service claimed prior to the new treatment plan being completed was for plan development, so no disallowances are required.

[6], the first plan was created on 12/10/14. The QA manager reviewed the case and found that the client received his initial assessment service on 10/1/14 and two plan development services on 11/12/14 and 12/9/14. The client did not keep his appointment on 11/26/14 so the client plan was completed outside of the 60-day requirement. The treatment plan that covered the chart audit period went from 12/10/14-12/9/15. No disallowances are required.

[3] Line number(s) removed for confidentiality
[4] Line number(s) removed for confidentiality
[5] Line number(s) removed for confidentiality
[6] Line number(s) removed for confidentiality

Line 10 the QA manager reviewed the case and found that the previous treatment plan went from 8/22/13-6/30/14. The plan that covered the audit period went from 7/1/14-6/30/15. No services were provided that were not covered by a treatment plan during the plan periods.

The new QA documentation manual was distributed in the fall of 2016 and the clinical staff were trained in November 2016 in these areas (see excerpts).

Yearly Medi-Cal documentation client plan training is provided to clinical staff, nurses and psychiatrists (see attached sign-in sheets and training PowerPoint excerpts).
Other monitoring mechanisms to assure that client plans are completed timely are as follows:

- IT began generating EHR reports of "unplanned" services monthly as a management tool. These reports show services that have been billed without a current treatment plan. The reports are distributed to supervisors and clinicians for correction. See attached copy of the unplanned services report.
- During the chart audit review period, BHD was still implementing Anasazi EHR features. The notification feature was instituted in the EHR to notify clinicians, nurse practitioners and psychiatrists within 30 days of the client's episode of care date to update the treatment plan.
- A policy and procedure will be developed outlining transfers of cases between providers and required documentation.

See end of document for additional corrective action. -On-going

Will be submitted by 6/1/17

-Clinical policy 16-03

QA documentation
manual

Training slide & sign in sheets

Sample unplanned services report

To be completed

Section K 4b-Client plan did not include all items as required. 4b-3, one or more of the proposed interventions did not indicate expected frequency.[7]**.** -Indicate how the MHP will ensure that all MH interventions proposed on client plans indicate both expected frequency and duration for each intervention. -The QA manager reviewed line 10 and found that the treatment plan created after the review period did include frequency measures (see attached client plan) which coincided with training about the use of frequency measures (in other words not using "ad hoc" or as needed) which took place on 8-6-14 (see training sign-in sheets and treatment plan protocol).

Yearly Medi-Cal documentation client plan training is provided to clinical staff, nurses and psychiatrists (see attached sign-in sheets and training PowerPoint excerpts).

Clinical supervisors review and sign-off on all new and registered/waivered staff's client plans to assure that they are in compliance and reflect quality standards.

See end of document for additional corrective action. -On-going
Clinical policy 16-03

Client Plan [8]

Training slide and sign-in sheets

Section K 5a-The MHP was not following its own documentation standards for timeliness of staff signatures on progress notes.(ie: 15 progress notes were completed late based on the MHP's written documentation standards in effect during the audit period. -Indicate how the MHP will ensure: (See protocol 5a for requirements).

1) Progress notes meet MHP's own written standards, as well as regulatory and contractual requirements.

The documentation is individualized for each service provided. -1) Since the chart audit review period, training, tools and reprimands have been utilized to improve timely progress note documentation.

- See attached reprimand letter
- See timeliness of service entry EHR report

[7] Line number(s) removed for confidentiality
[8] Line number(s) removed for confidentiality

- Throughout the QA documentation manual, "late documentation" guidelines are described.
- The progress notes and late entry documentation policy and procedure outlines the timelines (see clinical policy 16-06).
- This remains an on-going issue for compliance. As such, the QA manager will review the progress note timeliness reports with clinical supervisors monthly in the supervisor's meeting. The QA manager will begin logging and create corrective action plans for staff who are over 10 days late in their documentation and monitor the results.

2) Considerable effort has been made by the deputy director to train clinical staff regarding individualized documentation in 2016 (see team meeting notes). In addition, the QA manager provided training to clinical staff who appear to be using "canned" language including the clinician with repetitive notes for client [9].

See end of document for additional corrective action.
-On-going
-Clinical policy 16-06

Reprimand letter

Timeliness of service EHR report

QA documentation manual

Sample late note log format

Children's System of Care team meeting agenda

Section K 5c-The type of specialty mental health service documented (SMHS) on the progress note was not the type of SMHS claimed. -Indicate how the MHP will ensure :

1) That each SMHS is claimed for the correct service modality and billing code

Progress notes are accurate and meet documentation requirements. -The definitions of services and correct billing are parts of clinical staff training throughout BHD's continuum and are addressed in a variety of ways:

- The QA manager will provide training to individual staff members to improve compliance and log those training events.
- The QA documentation manual was distributed in the fall of 2016 which outlines the regulatory definition of all services, as well as, tips for distinguishing between different codes (see excerpts). Clinical staff were trained in the manual in November 2016.

[9] Line number(s) removed for confidentiality

- Clinical supervisors review progress notes and fiscal department runs reports to catch service coding errors prior to billing.
- Disallowance letters are issued by the QA manager for incorrect service coding (see a sample of the letters).

See next item for additional corrective action. -On-going-QA documentation
Manual

Disallowance letters

Additional corrective action pertaining to items 1c-1; 2a; 2b; 4a-2; 4b; 5a; 5c---1) All clinical staff receive yearly training in Medi-Cal documentation including contract providers. See sign-in sheets and excerpts of the trainer's PowerPoint presentations.

2) Documentation training is provided by the quality assurance (QA) manager for new hires within the first 30 days of hire; to all clinical staff on a regular basis; and 1:1 with employees who require additional training to improve the quality of their documentation for Medi-Cal billing. See attached support documentation of training.

3) Beginning in 2017, the QA manager will keep a log of all documentation training. See attached log.

4) Clinical utilization review of charts occurs on-going by our Medi-Cal consultant and the QA manager. UR activities are published in the QI annual work plan evaluation and discussed in the QI Committee and other management/supervisor meetings. See attached work plan evaluation.

5) Deficiencies, including the need for billed in error forms to delete billing, are communicated to individual staff members and their supervisors in writing. See attached UR procedure.

6) The QA documentation manual was distributed in the fall of 2016 which offers guidance in proper Medi-Cal documentation and billing. Staff training occurred in November 2016 for the manual will be provided when new revisions of the manual are published (see attached training sign-in sheet). Contract providers were sent the manual with their new contracts and provider manuals. The manual is updated as needed and staff are trained on all new updates. Trainings are recorded in the documentation training log.

7) Clinical supervisors co-sign all documentation of new staff until staff members demonstrate full competence. After which, they co-sign documentation that of clinician interns; and if any clinical staff become identified as needing training and improvement.

8) For those clients who are full service partners (FSPs), since the audit period BHD instituted billing MHSA as a means to provide FSPs with "whatever it takes" (see QA documentation manual page 29) and reduce Medi-Cal billing errors.
-Yearly

On-going

On-going

On-going

On-going

On-going

On-going

On-going-See sign-in sheets and excerpts of the trainer's PowerPoint presentations

See attached support documentation of training.

See attached log.

See attached work plan evaluation.

See attached UR procedure.

See attached training sign-in sheet

See QA documentation manual page 29