Amador County Behavioral Health

Fiscal Year (FY) 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement for Question 1.2.7

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES:

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 [Question 1.2.7]

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

- TFC RFP Distribution
- TFC RFP
- Policy 1-113 Pathways to Wellbeing

While the MHP submitted evidence to demonstrate with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria. Per the discussion during the review, the MHP stated that they were not successful securing a TFC provider to provide these services. DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care Services (TFC) for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Corrective Action Description

The MHP will schedule a meeting with Amador County Department of Social Services to continue discussions regarding Therapeutic Foster Care (TFC) and to address TFC criteria, TFC screening tool and a strategy to collaborate with the two Foster Family Agencies in our County to implement this service. The MHP will request additional Technical Assistance (TA) from the Department of Health Care Services (DHCS) as needed.

Proposed Evidence/Documentation of Correction

- Emails and meeting minutes
- TFC criteria
- TFC screening tool
- Agreement with a TFC provider

Ongoing Monitoring (if included)

- If an agreement with a TFC provider is obtained, the MHP will monitor the agreement and services as deemed by the agreement.
- Ongoing tracking and monitoring of clients meeting TFC criteria and those youth receiving TFC services.
- If an agreement is not obtained, the MHP will continue to seek TA from DHCS.

Person Responsible (job title)

UR/QI Coordinator

BH Director

Fiscal Officer (For Contract)

Implementation Timeline:

- Schedule meeting with MHP and Amador DSS by September 30, 2021
- Schedule meetings with 2 local Foster Family agency by November 30, 2021

Requirement for Question 1.2.8

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

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 [Question 1.2.8]

The MHP did not furnish evidence to demonstrate 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 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:

- Sierra Child & Family Services Proposal
- Level of Care Review
- Level of Care Example

While the MHP submitted evidence to demonstrate with this requirement, it is not evident that the MHP determines if children and youth who meet medical necessity criteria need TFC. Per the discussion during the review, the MHP stated that it does not have a mechanism in place to determine if children and youth meet TFC criteria. 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.

Corrective Action Description

The MHP will schedule a meeting with Amador County Department of Social Services to continue discussions regarding Therapeutic Foster Care (TFC) and to address TFC criteria, TFC screening tool and a strategy to collaborate with the two Foster Family Agencies in our County to implement this service. The MHP will request additional Technical Assistance (TA) from the Department of Health Care Services (DHCS) as needed.

Proposed Evidence/Documentation of Correction

- Emails and meeting minutes
- TFC criteria
- TFC screening tool

Ongoing Monitoring (if included)

- Monitor process for determining if youth that meet medical necessity criteria need TFC
- Ongoing meetings and collaboration with Amador DSS to ensure youth are identified and receiving the appropriate level of service

Person Responsible (job title)

UR/QI Coordinator

BH Director

Implementation Timeline:

- Schedule meeting with MHP and Amador DSS by September 30, 2021
- Develop TFC criteria and screening tool by November 30, 2021

Requirement for Question 1.4.6

NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

If the MHP identifies deficiencies or areas of improvement, the MHP and the subcontractor shall take corrective action. (MHP Contract, Ex. A, Att. 8)

DHCS Finding [Question 1.4.6]

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP and the subcontractor shall take corrective action if the MHP identifies deficiencies or areas of improvement. The MHP submitted the following documentation as evidence of compliance with this requirement:

- Sierra Child and Family provider monitoring tool samples
- Amador documentation training
- Documentation training sign in list
- Sierra Child and Family provider monitoring follow up example

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a mechanism to take corrective action when it identifies deficiencies or areas of improvement. Per the discussion during the review, the MHP stated that it currently does not a corrective action plan mechanism. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

Corrective Action Description

The MHP will expand on the provider monitoring tool process and implement a Corrective Action process, which will include a Corrective Action Tracking Log.

Proposed Evidence/Documentation of Correction

- Corrective Action tracking mechanism/log
- Samples of Corrective Actions taken with outcomes

Ongoing Monitoring (if included)

- Continue to review provider monitoring tools, including monitoring of the Corrective Action Tracking Log during Quarterly QI meeting or as needed.
- Provide training as needed

Person Responsible (job title)

UR/QI Coordinator

BH Director

Implementation Timeline:

- Implement Corrective Action Tracking by September 30, 2021
- Provide sample corrective action taken with outcomes to DHCS by December 31, 2021

Requirement for Question 4.3.2

ACCESS AND INFORMATION REQUIREMENTS

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

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. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

DHCS Finding [Question 4.3.2]

FINDING

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). The toll-free telephone number provides information to beneficiaries about 1) how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met; 2) services needed to treat a beneficiary's urgent condition; and 3) provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes. The seven (7) test calls are summarized below.

TEST CALL #1

Test call was placed on Friday, October 16, 2020, at 5:10 p.m. The call was answered after four (4) rings 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 press one (1) for crisis worker. The caller requested information about accessing mental health services in the county for anxiety medication refill. The operator explained that the office closed at 5:00 p.m. and that the call was transferred to the After-Hour Crisis Line. The caller asked if there was a doctor that could refill the medication and the operator replied in the negative. The operator instructed the caller to call back on Monday at 8:00 a.m. No additional information about

SMHS was provided to the caller. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition.

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 #2

Test call was placed on Friday, October 23, 2020, at 3:51 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator assessed the caller's current condition by asking if he/she required immediate services. The caller replied in the negative. The operator shared the assessment screening process and advised the caller that the screening process could be completed within 15 minutes. The caller declined to participate in a screening and advised the operator that they would call back. The operator advised the caller of business hours and that the clinic was closed for walk-ins due COVID-19. The operator reminded the caller that the 24/7 access line was available for crisis and urgent services. The caller was provided information about how to access SMHS and 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 #3

Test call was placed on Friday, October 23, 2020, at 9:47 a.m. The call was answered after one (1) ring via a live operator. The caller requested information about how to access mental health services for his/her son. The operator assessed the caller's child's current condition by asking if the child required immediate services or was at risk of harm. The caller replied in the negative. The operator described the assessment and screening process and advised the caller of the various levels of care for which his/her child may be eligible. The operator also stated that the process could be conducted via phone or Zoom, but the walk-in process was not available as the site was closed to the public due to COVID. The operator advised the caller that the 24/7 access line was available if the condition escalated and for crisis/urgent services. The caller was provided information about how to access SMHS and 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 #4

Test call was placed on Monday, October 26, 2020, at 7:42 a.m. The call was answered after one (1) ring via a live operator. The caller requested information about how to access mental health services for sleeplessness, uncontrollable crying, and sadness. The operator requested personal identifying information to schedule assessment. The caller provided their first name, address, and date of birth, but declined to provide a social security number or Medi-Cal number. The operator assessed the caller for crisis by asking if the caller was at risk of harming himself/herself or others, to which the caller replied in the negative. The operator proceeded to provide information regarding the assessment process. The operator provided the address and hours of operation. The operator advised the caller that the 24/7 access line was available for crisis and urgent services. The caller was provided information about how to access SMHS as well as 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 #5

Test call was placed on Friday, November 20, 2020, at 2:29 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county. The operator asked if the caller had Medi-Cal and the caller replied in the affirmative. The operator stated that she could transfer the caller to a crisis counselor or begin the intake process with the caller. The caller stated that he/she just wanted general information about the process and did not wish to speak to a crisis counselor. The operator informed the caller that the intake process would be conducted via phone or zoom due the pandemic. The operator explained that the process begins with a phone screening and proceeded to explain the entire process. The operator advised the caller that the process can take up to two weeks. The operator asked if the caller again if he/she wanted to start the process but the caller declined. The operator advised the caller of the county's 24/7 access line for crisis and urgent services. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was provided with 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 #6

Test call was placed on Tuesday, October 27, 2020, at 1:06 pm. The call was answered after one (1) ring via a live operator. The operator asked for the caller's first and last name. The caller provided their first name and informed the operator that he/she did not want to provide the last name. The caller requested information about how to file a complaint. The operator provided two (2) methods for filing a complaint. The operator informed the caller that he/she could come to the office to pick up a grievance form or one could be mailed to the caller. The operator provided the caller with the hours of operation and telephone number. The caller was provided information about how to use the 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 #7

Test call was placed on Thursday, November 12, 2020, at 1:42 pm. The call was answered after one (1) ring via a live operator. The operator introduced him/herself and asked for the caller's first name. The caller provided his/her name. The caller requested information about how to file a complaint. The operator informed the caller there are two options to file a complaint. The operator could mail the grievance form or the caller could pick up the information in person. The operator provided the address, hours of operation, and telephone number. The caller was provided information about how to use the 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).

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1)

Corrective Action Description

After review of the test call findings, it was determined that Call #1 which was out of compliance, was an after hours call that was answered by our 24/7 Access line. The MHP will follow up with the contract provider regarding the deficiency and request a Corrective Action Plan to address the findings, including additional training for staff.

Proposed Evidence/Documentation of Correction

- Email sent to 24/7 Access Contract Provider, Alameda Crisis Support, regarding test call requesting Corrective Action Plan
- Corrective Action Plan from 24/7 Access Contract Provider
- Proof of training from 24/7 Access Contract Provider
- Biweekly and Quarterly QI meeting minutes
- MHP test call results

Ongoing Monitoring (if included)

- The MHP will continue to conduct test calls during the business day and afterhours and review in Quarterly QI meetings or as needed
- The MHP will continue to monitor daily call logs from the 24/7 Access Contract Provider and follow up as needed
- The MHP will ensure that the 24/7 Access Contract Provider completes Corrective Action Plan and training

Person Responsible (job title)

Compliance Officer

UR/QI Coordinator

BH Director

Implementation Timeline:

- Email to 24/7 Access Contract Provider, Alameda Crisis Support, regarding test call requesting Corrective Action Plan sent on June 18, 2021
- Corrective Action Plan to be received from 24/7 Access Contract Provider by August 18, 2021
- Proof of training from 24/7 Access Contract Provider to be received by September 30, 2021
- QI Meeting minutes submitted by December 31, 2021
- MHP Test Call results submitted by December 31, 2021

Requirement for Question 4.3.4

ACCESS AND INFORMATION REQUIREMENTS

The written log(s) contain the following required elements:

a) Name of the beneficiary.

b) Date of the request.

c) Initial disposition of the request. (CCR, title 9, chapter 11, section 1810.405(f).)

DHCS Finding [Question 4.3.4]

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:

- MHP Access Log

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

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Corrective Action Description

After review of the test call findings, it was determined that one call that was out of compliance was answered by our 24/7 Access line and the other was during business hours. The MHP will follow up with contract provider regarding the deficiency and request a Corrective Action Plan to address the findings, including additional training for staff. The MHP will also follow up internally with staff to provide additional training regarding the Access Log. The MHP will continue to provide test calls and monitor the access log on a Quarterly basis or more often as needed.

Proposed Evidence/Documentation of Correction

- Email sent to 24/7 Access Contract Provider, Alameda Crisis Support, regarding test call requesting Corrective Action Plan
- Corrective Action Plan from 24/7 Access Contract Provider
- Proof of training from 24/7 Access Contract Provider
- Proof of training to MHP staff on Access Log requirements
- Biweekly and Quarterly QI meeting minutes

- MHP test call results

Ongoing Monitoring (if included)

- The MHP will continue to conduct test calls during the business day and afterhours and review in Biweekly and Quarterly QI meetings or as needed
- The MHP will continue to monitor daily call logs from the 24/7 Access Contract Provider and follow up as needed
- The MHP will ensure that the 24/7 Access Contract Provider completes Corrective Action Plan and training
- The MHP will monitor Access Log in Quarterly QI meetings

Person Responsible (job title)

Compliance Officer

UR/QI Coordinator

BH Director

Implementation Timeline:

- Email to 24/7 Access Contract Provider, Alameda Crisis Support, regarding test call requesting Corrective Action Plan sent on June 18, 2021
- Corrective Action Plan to be received from 24/7 Access Contract Provider by August 18, 2021
- Proof of training from 24/7 Access Contract Provider to be received by September 30, 2021
- Proof of training for MHP staff on Access Log requirements by September 30, 2021
- QI Meeting minutes submitted by December 31, 2021
- MHP Test Call results submitted by December 31, 2021

Requirement for Question 4.4.5

ACCESS AND INFORMATION REQUIREMENTS

Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services:

1) There is a plan for cultural competency training for the administrative and management staff of the MHP.

2) There is a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP.

3) There is a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing). (CCR, title 9, § 1810.410 (c)(4).)

DHCS Finding [Question 4.4.5]

The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4). The MHP must plan for annual cultural competence training necessary to ensure the provision of culturally competent services.

1) There is a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing).

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

   - Cultural Competence Policy
   - Cultural Competence Committee minutes
   - Policy #1-300

   While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the evidence submitted that the MHP has a process to ensure interpreters are trained and monitored for language competence. Specifically, while the MHP has no threshold languages and uses the language line, the MHP also stated that it uses staff for the purposes of providing interpretation, but per discussion during the review, the MHP stated that it does not have a training or monitoring process for language competence of these staff.

   DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4).

Corrective Action Description

The MHP will continue to search to locate a training program for interpreters or formal testing to ensure language competence.

Proposed Evidence/Documentation of Correction

- Proof of training or testing for Spanish Speaking staff

Ongoing Monitoring (if included)

- Ongoing training or testing to ensure language competence as needed.

Person Responsible (job title)

Ethnic Services Manager

Implementation Timeline:

- Train or test Spanish Speaking Staff by December 31, 2021

Requirement for Question 6.1.5

BENEFICIARY RIGHTS AND PROTECTIONS

1) The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1).)

2) The acknowledgment letter shall include the following (MHSUDS IN18-010E):

   a) Date of receipt

   b) Name of representative to contact

   c) Telephone number of contact representative

   d) Address of Contractor

3) The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E)

DHCS Finding [Question 6.1.5]

The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting above listed standards.

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

- FY 18/19 Grievance Log
- FY 19/20 Grievance Log
- Grievance forms samples
- Acknowledgement letter samples

While the MHP submitted evidence to demonstrate compliance with this requirement, one (1) of the acknowledgment letters exceeded the five-calendar day timeline requirement. In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement.

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E.

Corrective Action Description

The MHP will update the current policy to incorporate a back-up procedure to ensure that timelines are met when the Compliance Officer is out of the office. Training will be provided to the UR/QI Coordinator and Medical Records staff. The MHP will continue to review grievances, appeals and expedited appeals in the biweekly QI meetings and Leadership meeting.

Proposed Evidence/Documentation of Correction

- Updated P&P with back-up procedure
- Proof of training provided to UR/QI Coordinator and Medical Records staff
- Bi Weekly QI meeting minutes
- Leadership meeting minutes, if applicable

Ongoing Monitoring (if included)

- Continue to review grievances, appeals and expedited appeals in biweekly QI meetings
- Review grievances, appeals and expedited appeals in Leadership meetings if needed

Person Responsible (job title)

Compliance Officer

Implementation Timeline:

- Submit P&P with back-up procedure by September 30, 2021
- Submit proof of training provided to UR/QI Coordinator and Medical Records staff by September 30, 2021
- Submit any applicable QI Meeting minutes and/or Leadership meeting minutes by December 31, 2021

Chart Review

Requirement for Question 8.1.1.3b

MEDICAL NECESSITY

The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b) (outpatient) and 1830.210 (EPSDT), Welf. & Inst. Code § 14132(v) and 14059.5).

The proposed and actual intervention(s) meet the intervention criteria listed below: (CCR, title 9, § 1830.205(b)(3)(A), (B), and (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.

DHCS Finding [Question 8.1.1.3b]

The actual interventions documented in the progress note(s) for the following Line number(s) did not meet medical necessity criteria since the intervention(s) 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:

Line number 8. 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. Group Therapy service claimed on 10/24/19 indicates that client failed to show for appointment. MHP staff confirmed that this service was claimed in error on the noted date.

Corrective Action Description

The MHP will provide training to staff to ensure that all SMHS interventions are reasonably likely to correct or reduce the beneficiary’s documented mental health condition, prevent the condition’s deterioration, or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency.

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on Medical Necessity provided to staff by September 30, 2021

Requirement for Question 8.1.1.3b1

MEDICAL NECESSITY

The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b) (outpatient) and 1830.210 (EPSDT), Welf. & Inst. Code § 14132(v) and 14059.5).

The proposed and actual intervention(s) meet the intervention criteria listed below: (CCR, title 9, § 1830.205(b)(3)(A), (B), and (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.

DHCS Finding [Question 8.1.1.3b1]

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

Clerical: Line number 1. RR11f, refer to Recoupment Summary for details. Progress note on 10/15/19 describes solely clerical activity of client informing MHP by telephone that client would no longer be seeking services from MHP. During the review the MHP confirmed this note does not meet their criteria for a billable service

Corrective Action Description

The MHP will provide training that will ensure that services provided and claimed are not solely clerical

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency.

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on Medical Necessity provided to staff by September 30, 2021

Requirement for Question 8.2.1

ASSESSMENT

The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att. 9)

DHCS Finding [Question 8.2.1]

Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

One or more assessments were not completed within the update frequency requirements specified in the MHP's written documentation standards. The MHP's Practice Guidelines pertaining to Assessments indicate that, "the Assessment must be completed at least every 2 years…"

The following are specific findings from the chart sample:

- Line number 2. Current Assessment completed as signed on 1/25/19, and would have been due on 1/13/19, based on prior Assessment's completion date of 1/13/17.
- Line number 6. Current Assessment completed as signed on 9/5/18, and would have been due on 5/4/18, based on prior Assessment's completion date of 5/4/16.
- Line number 8. Current Assessment completed as signed on 1/14/19, and would have been due on 11/19/17, based on prior Assessment's completion date of 11/19/15.
- Line number 9. Current Assessment completed as signed on 8/16/19, and would have been due on 4/18/19, based on prior Assessment's completion date of 4/18/17.

Corrective Action Description

The MHP will provide training to staff and monitor assessment due dates to ensure that assessments are completed in accordance with the update frequency requirements specified in the documentation standards

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Proof that staff will receive monthly assessment reports of those that are due in the upcoming month
- QI meeting minutes

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

- Ongoing monitoring in QI meetings

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on Medical Necessity provided to staff by September 30, 2021
- Sample assessment reports that are provided to staff to be submitted by September 30, 2021

Requirement for Question 8.2.2

ASSESSMENT

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

1) 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.

2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.

3) History of trauma or exposure to trauma

4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.

5) Medical History, including:

   a) Relevant physical health conditions reported by the beneficiary or a significant support person.

   b) Name and address of current source of medical treatment.

   c) For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.

6) Medications, including:

   a) Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.

   b) Documentation of the absence or presence of allergies or adverse reactions to medications.

   c) Documentation of informed consent for medications.

7) 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.

8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).

9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.

10) Mental Status Examination

11) 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, tit. 9, §§ 1810.204 and 1840.112):

DHCS Finding [Question 8.2.2]

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

A mental status examination: Line number 4. Mental Status Examination (MSE) was incomplete as majority of Mental Status Examination elements were left blank.

The MHP was given the opportunity to provide additional MSE elements or another MSE, however, they were unable to provide any further information

Corrective Action Description

The MHP will provide training to ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department. The Utilization Review team will review all new and annual assessments to ensure all required elements are completed in the assessment.

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Emails with Kingsview to support that all fields of the assessment are now required and the document cannot be final approved until all areas are completed.

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing review in Utilization Review meetings to ensure all elements are completed

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on required elements of the assessment provided to staff by September 30, 2021
- Emails with Kingsview to support that all fields of the assessment are now required and the document cannot be final approved until all areas are completed provided by July 31, 2021

Requirement for Question 8.3.1

MEDICATION CONSENT

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 [Question 8.3.1]

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

- Line number 5: There was a written medication consent form in the medical record. However, additional medication(s) was/were added later to the already signed consent form and there was no documentation of the beneficiary's consent to the new medication(s).

As noted in Progress Note on 11/1/19, prescriber provided a one-time prescription of Klonopin but did not add this medication to the established medication consent form.

It should be noted that MHP has made concerted effort since the last Triennial Review to ensure that medication consent forms are being completed and that the MHP has a very thorough and detailed medication consent form meeting compliance requirements

Corrective Action Description

The MHP will provide training and continue peer chart reviews to ensure the following:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.

2) Written medication consent forms are completed in accordance with the documentation standards.

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to the psychiatrists and medical staff to address the above deficiency
- Sample peer chart reviews to ensure that all medication consents are completed

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on Medication Consents provided to medical staff by September 30, 2021
- Sample peer chart reviews to support monitoring for medication consents will be submitted by December 31, 2021

Requirement for Question 8.4.3a

CLIENT PLANS

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 [Question 8.4.3a]

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

- Line number 7: There was a lapse between the prior and current Client Plans and, therefore, no client plan was in effect during a portion or all of the audit review period. RR4b, refer to Recoupment Summary for details. Prior Client Plan expired on 9/23/2019 based on Prior Client Plan being completed as signed on 9/24/18; current Client Plan completed as signed on 11/7/2019. During this lapse between Client Plans, an Individual Therapy session (10/4/19) and a Group Therapy session (10/17/19) were provided. Both of these services require a Client Plan to be in place prior to provision.
- Line numbers 3 and 8: There was a lapse between the prior and current Client Plans. However, this occurred outside of the audit review period.
- Line number 3. Prior Client Plan expired on 8/12/2019 based on Prior Client Plan being completed as signed on 8/13/18; current Client Plan completed as signed on 9/18/2019.
- Line number 8. Prior Client Plan expired on 12/4/2018 based on Prior Client Plan being completed as signed on 12/5/17; current Client Plan completed as signed on 12/10/2018.

Corrective Action Description

The MHP will provide training and monthly reports to staff to ensure that: 1) Client plans are completed prior to the provision of planned services. 2) Client plans are updated at least on an annual basis, as required by the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards. 3) Planned services are not claimed when the service provided is not included on a current Client Plan

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Proof that staff will receive monthly Client Plan reports of those that are due in the upcoming month
- QI meeting minutes

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

- Ongoing monitoring in QI meetings

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on Client Plans provided to staff by September 30, 2021
- Sample Client Plan reports that are provided to staff to be submitted by September 30, 2021

Requirement for Question 8.4.4

CLIENT PLAN

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 impairment as a result of the mental health diagnosis.

2) Identify the proposed type(s) of interventions or 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.

6) Have interventions are consistent with client plan goal(s)/treatment objective(s).

7) Have interventions are consistent with the qualifying diagnoses.

DHCS Finding [Question 8.4.4]

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

- One or more proposed intervention did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded. Line numbers 2, 3, 4, 5, 6, 7, 8, 9, and 10. For the noted line numbers, the Client Plans had one or more intervention descriptions which referred more to the general definition of the intervention category, and were not a detailed or client-specific description.
- One or more proposed intervention did not include an expected frequency or frequency range that was specific enough. Line number 5, 6, 7, 8, and 9. For the noted line numbers, the Client Plans had one or more interventions with "Ad Hoc" as the listed frequency, which is not a specific intervention frequency.
- One or more proposed intervention did not include an expected duration. Line numbers 2, 3, 4, 5, 6, 7, 8, 9, and 10. For the noted line numbers, the Client Plans were either missing an expected duration or the duration included referred to session length (e.g. 1 hour of therapy) and not the duration of the intervention (e.g. 12 months).

Corrective Action Description

The MHP will provide training and peer chart reviews to ensure that:

1) Mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or

modality of service (e.g. “therapy”, “medication”, “case management”, etc.). 2) Mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Proof of peer chart reviews to monitor and ensure that all required elements of the client plan are included

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring
- Ongoing monitoring in QI meetings

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on required elements of the Client Plans (including intervention description, frequency and duration) provided to staff by September 30, 2021
- Sample peer chart reviews to support monitoring for required elements in the client plan will be submitted by December 31, 2021

Requirement for Question 8.5.2

PROGRESS NOTES

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:

1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions.
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.
4) The date the services were provided.
5) Documentation of referrals to community resources and other agencies, when appropriate.
6) Documentation of follow-up care or, as appropriate, a discharge summary
7) The amount of time taken to provide services.
8) The following:
   a) The signature of the person providing the service (or electronic equivalent);
   b) The person's type of professional degree, and,
   c) Licensure or job title. (MHP Contract, Ex. A, Att. 2)

DHCS Finding [Question 8.5.2]

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, 4, 7, 8, 9, and 10. One or more progress note was not completed within the MHP's written timeliness standard of 3 days after provision of service. Forty-eight (48) or 39 percent of all progress notes reviewed were completed late.

Corrective Action Description

The MHP will provide training and weekly reports to staff to ensure that progress notes are documented timely as specified in the MHP Contract with the Department and the MHP documentation standards

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Proof of weekly reports provided to staff regarding unresolved documentation and timeliness

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Weekly unresolved scheduled services reports provided to staff
- Ongoing Peer Chart Review Monitoring
- Ongoing monitoring in QI meetings

Person Responsible (job title)

UR/QI Coordinator

BH Director

Implementation Timeline:

- Proof of documentation training focusing on timely completion of documentation provided to staff by September 30, 2021
- Sample weekly reports provided to staff regarding unresolved documentation and timeliness submitted by September 30, 2021

Requirement for Question 8.5.3

PROGRESS NOTES

When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, the progress notes shall 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 [Question 8.5.3]

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

- Line number 4, 7, 8, and 9. While progress note(s) themselves did not accurately document the number of group participants on one or more group progress notes, the MHP was able to provide separate documentation listing the number of participants in each group.

Corrective Action Description

The MHP will provide training and work with Kingsview to ensure that progress notes contain the actual number of clients participating in a group activity, the number and identification of all group provider/facilitators, the correct type of service (e.g., Group Rehabilitation or Group Psychotherapy), and date of service

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Correspondence with Kingsview regarding request to add the number of participants to each progress note in the Electronic Health Record (EHR)

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

Person Responsible (job title)

UR/QI Coordinator

Implementation Timeline:

- Proof of documentation training focusing on group notes provided to staff by September 30, 2021

- Correspondence with Kingsview regarding request to add the number of participants to each progress note in the Electronic Health Record (EHR) submitted by September 30, 2021

Requirement for Question 8.5.4

PROGRESS NOTES

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

1) Every service contact for:

   A. Mental health services

   B. Medication support services

   C. Crisis intervention

   D. Targeted Case Management

   E. Intensive Care Coordination

   F. Intensive Home Based Services

   G. Therapeutic Behavioral Services

2) Daily for:

   A. Crisis residential

   B. Crisis stabilization (one per 23/hour period)

   C. Day treatment intensive

   D. Therapeutic Foster Care

3) Weekly for:

   A. Day treatment intensive (clinical summary)

   B. Day rehabilitation

   C. Adult residential (MHP Contract, Ex. A, Att. 9; CCR, title 9, §§ 1840.316(a)-(b); 1840.318 (a-b), 1840.320(a-b).)

DHCS Finding [Question 8.5.4]

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

- Line numbers 2 and 6: 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.
- Line number 2: Progress note for Assessment service claimed on 12/10/19 describes Plan Development service of updating the treatment plan.

- Line number 6: Progress note for Assessment service claimed on 10/7/19 describes Plan Development service of updating the treatment plan.

Corrective Action Description

The MHP will provide training to ensure that all Specialty Mental Health Services claimed accurately describe the type of service or service activity, the date of service and the amount of time to provide the service, as specified in the MHP Contract with the Department.

Proposed Evidence/Documentation of Correction

- Proof of documentation training provided to staff to address the above deficiency
- Proof of training to support staff to ensure that they are scheduling client plan appointments as plan development, rather than assessment.

Ongoing Monitoring (if included)

- Ongoing documentation training to staff
- Ongoing Peer Chart Review Monitoring

Person Responsible (job title)

UR/QI Coordinator

Compliance Officer

Implementation Timeline:

- Proof of documentation training focusing on progress notes type of service provided to staff by September 30, 2021
- Proof of training to support staff to ensure that they are scheduling client plan appointments as plan development, rather than assessment, by September 30, 2021