NAPA Mental Health Services

FY 18/19 Specialty Mental Health Triennial Review

System Review

Requirement and Citation(s)

The MHP shall meet, and require its providers to meet, DHCS standards for timely access to care and services, taking into account the urgency of need for services (42 CFR 6 438.206(c)(1)(i)).

DHCS was not able to verify the MHP has adopted the statewide standards for timely access to care pursuant to Welf. & Inst.
Code,§ 141197(d)(1) and California Code Regulations, title 28, § 1300.67.2.2(c)(5)(D).

DHCS Finding

No finding number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.206(c) (1) (i). The MHP must meet, and require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of SMHS. The MHP did not submit to DHCS its policies and procedures (P&Ps) addressing the timely access standards and requirements.

The MHP submitted the following documentation at the time of the Triennial Review as evidence of compliance with this requirement at time of review:

- Service request log; Performance dashboards - timely access;
- Timely access corrective action plans;
- Aldea Contract; and,
- Provider Contract Boilerplate.

While the services request log demonstrates compliance with the standards, it is not evident the MHP is requiring its contracted providers to meet the requirements. The MHP's Aldea Contract, and timely access corrective action plans, indicates the provider must meet the MHP's timely access standards. However, those standards are not defined in the contract.

In addition, the MHPs dashboard report (FY 2017/18) indicates the MHP's standard for post-assessment follow-up service is 21-days. This exceeds the statewide standard (i.e.,
within 10-business days of the request for the service), which became effective July 1, 2018.

Corrective Action Description

(1) Description of corrective actions, including milestones:

- The MHP will update its Access Policy to include current timely access standards and requirements.
- Provider contracts will be updated to include specific timeliness definitions and standards.

(2) Timeline for implementation and/or completion of corrective actions:

- Both the Policy updates and Contract updates will be completed no later than 11/15/19

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

- The MHP will submit the updated policy and contract(s)

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

- In addition to the tracking process intrinsic to the new CSI timeliness reporting, the MHP will update its MH Data Dashboard to include these metrics.

(5) Description of corrective actions required of the MHP's contracted providers to address findings:

Contracted providers will report all timeliness indicators that are applicable to their programs. The data will be reviewed and, as needed, corrective action plans will be developed to address problematic findings.

Proposed Evidence/Documentation of Correction

Please refer to the Corrective Action Description above.

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

_____

Requirement and Citation(s)

If the MHP's provider network is unable to provide necessary services to a particular beneficiary, the MHP shall adequately and timely cover the services out of network, for as long as the MHP's provider network is unable to provide them (MHP Contract, Ex. A, Alt. 7; 42 CFR § 438.206/b)/4)).

The MHP shall require that out-of-network providers coordinate authorization and payment with the MHP IMHP Contract, Ex. A, Att. 7; 42 CFR § 438.206(b)(5)).

DHCS Finding

No finding number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.206(b)(4). If the MHP's provider network is unable to provide necessary services, covered under the MHP Contract, to a particular beneficiary, the MHP must adequately and timely cover the services out of network, for as long as the MHP's provider network is unable to provide them.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.206(b)(4) and 42 CFR § 438.206(b)(5), as well as the terms of the MHP's contract with DHCS. The MHP must complete a POC addressing these findings of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:
• The MHP will update the language in its P&P, Mental Health Plan Requirements Regarding Availability and Accessibility of Service, to accurately reflect its practice of allowing, authorizing and covering both inpatient and outpatient out of network services.
(2) Timeline for implementation and/or completion of corrective actions:
• The Mental Health Plan Requirements Regarding Availability and Accessibility of Service Policy language will be updated no later than 11/15/19.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
• The MHP will submit the updated Mental Health Plan Requirements Regarding Availability and Accessibility of Service Policy.
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

(5) Description of corrective actions required of the MHP's contracted providers to address findings: N/A

The MHP team meets routinely with the HHSA Fiscal Division to review submitted bills and invoices. Any out of network invoices will be reviewed.

Proposed Evidence/Documentation of Correction

The MHP submitted at the time of Triennial Review the following documentation as evidence of compliance with this requirement:

- P&P (#2000200-0009-18) Mental Health Plan Requirements Regarding Availability and Accessibility of Service;
- Mental Health County Access Line Script for Exodus; and,
- Paid Invoices for Inpatient Services Provided Out-of-Network.

The MHP's P&P specifies that the MHP will adequately and timely cover inpatient services out-of-network for as long as the MHP's network is unable to provide them. However, the requirement to adequately and cover services out-of-network is not limited to inpatient services.

Measures of Effectiveness

None provided.

Implementation Timeline:

Not provided.

Requirement and Citation(s)

The MHP shall permit an American Indian beneficiary who is eligible to receive services from an Indian health care provider (IHCP) participating as a network provider, to choose that IHCP as his or her provider, as long as that provider has capacitv to provide the services. (42 C.F.R. § 438.14(b)(3).)

DHCS Finding

No finding number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.14(b)(3). The MHP shall permit an American Indian beneficiary who is eligible to receive services from an IHCP participating as a network provider, to choose that IHCP as his or her provider, as long as that provider has capacity to provide the services. (42 C.F.R. § 438.14(b)(3).)

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

- Napa County Agreement NO. 170344B, Suscol Intertribal Council, Inc.; and,
- Napa County Agreement NO. 180299B, Suscol Intertribal Council, Inc.

The MHP contracts with Suscol Intertribal Council Inc. to provide cultural services, outreach, and referrals to Native Americans, as a part of the MHP's Native American Prevention and Early Intervention (PEI) project and other Mental Health Services Act (MHSA) programs. However, while the contracts indicate the MHP has provider agreements in place, the MHP did not submit evidence that, as a matter of policy, American Indian beneficiaries are permitted to choose this IHCP, or another, as their provider.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.14(b)(3). The MHP must complete a POC addressing this finding of non-compliance.

Please Note: This finding was appealed, submitted May 8, 2019, inasmuch as the existing Mental Health Plan Requirements Regarding Availability and Accessibility of Service Policy, which was submitted during the original audit submission, contains the necessary language.

Corrective Action Description

None provided.

Proposed Evidence/Documentation of Correction

The MHP submitted the following documentation at the time of the Triennial Review as evidence of compliance with this requirement:

- Napa County Agreement NO. 170344B, Suscol Intertribal Council, Inc.; and,
- Napa County Agreement NO. 180299B, Suscol Intertribal Council, Inc.

The MHP contracts with Suscol Intertribal Council Inc. to provide cultural services,

outreach, and referrals to Native Americans, as a part of the MHP's Native American Prevention and Early Intervention (PEI) project and other Mental Health Services Act (MHSA) programs. However, while the contracts indicate the MHP has provider agreements in place, the MHP did not submit evidence that, as a matter of policy, American Indian beneficiaries are permitted to choose this IHCP, or another, as their provider.

Measures of Effectiveness

None provided.

Implementation Timeline:

Not provided

_____

Requirement and Citation(s)

The MHP's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR § 438.214(c).).

DHCS Finding

No finding number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.214(c). The MHP's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR § 438.214(c).).

The MHP's P&P and RFP template do not include the language specified in federal regulations. DHCS deems the MHP out-of- compliance with 42 CFR § 438.214(c). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:

• Napa County Mental Health will create a policy, Selection and Retention of Contract Providers, addressing procedures and protocols for the selecting of and retention of contract providers into the mental health plan. The policy will

underscore that the department does “not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment”.

(2) Timeline for implementation and/or completion of corrective actions:

- No later than 11/15/19

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

- The Selection and Retention of Contract Providers policy

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

- The policy will be re-evaluated every 2 years.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: N/A

Proposed Evidence/Documentation of Correction

The MHP submitted the following documentation as evidence of compliance at the time of the Triennial Review with this requirement:

- P&P (#2001201-1203-18) Requestfor Proposals (RFPs); and,
- Request for Proposal Template.

Measures of Effectiveness

None provide.

Implementation Timeline:

Not provided.

Requirement and Citation(s)

All contracts or written agreements between the MHP and any network provider specify the following (MHP Contract, Ex. A, At!. 1; 42 CFR § 438.230(b)(2) anq (c).):

A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees,
Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable available at any time for

inspection, examination or copying by the Department, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (42 C.F.R.

§438.3(h).) This audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (42 C.F.R. § 438.230(c)(3)(iii).) The Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk, then. (42 C.F.R. § 438.230/c)/3\(iv).)

DHCS Finding

No finding number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.230(b)(2). All contracts or written agreements between the MHP and any subcontractor must meet the requirements of 42 CFR § 438.230(c).

A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable available at any time for inspection, examination or copying by the Department, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (42 C.F.R. §438.3(h).)

- This audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (42 C.F.R. §· 438.230(C)(3)(iii).)
- DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk, then. (42 C.F.R. § 438.230(c)(3)(iv).)

DHCS deems the MHP out-of-compliance with the contractual requirements in the MHP Contract and 42 CFR § 438.230(b)(2). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

1) Description of corrective actions, including milestones:
- The needed language will be inserted as an amendment to the contract

terms and conditions for all subcontractors.

(2) Timeline for implementation and/or completion of corrective actions:

- The language will be inserted into contracts no later than 11/15/19.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

- Examples of the revised contract terms including this language.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

Contract terms will continue to be reviewed at each contract renewal. If at any time, the contractor fails to honor the terms upon request of DHCS, CMS, the HHS IG, the US Comptroller General, their designees and other authorized federal or state agencies, a POC will be required in addition to any other fines, sanctions or penalties the failure may incur.

(5) Description of corrective actions required of the MHP's contracted providers to address findings:

Corrective actions will be required upon evidence of non-compliance .

Proposed Evidence/Documentation of Correction

The MHP submitted the following documentation as evidence of compliance with this requirement at the time of the Triennial Review:

- Provider Subcontract Boilerplate

Measures of Effectiveness

None provided.

Implementation Timeline:

Not provided.

Requirement and Citation(s)

The MHP shall comply with the provisions of the MHP's Implementation Plan as approved by DHCS (MHP Contract, Exhibit A, Attachment 1; Cal. Code Regs., tit. 9, § 1810.310). The Implementation Plan shall include:

A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

DHCS Finding

No finding number was provided.

The MHP did not furnish evidence to demonstrate it complies with the California Code of Regulations, title 9, § 1810.310. The MHP's Implementation Plan must include:

- A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP; and

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

Implementation Plan for Consolidation of Specialty Mental Health Services (August 2018).

The MHP's Implementation Plan did not include the required element described above. DHCS deems the MHP out-of- compliance with California Code of Regulations, title 9, § 1810.310. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:

- The required language describing a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP will be added to the MHP Implementation Plan.

(2) Timeline for implementation and/or completion of corrective actions:

- No later than 11/15/19.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

- Updated Implementation Plan

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

- Hospitalizations at non-contract hospitals when necessary have been a normal business procedure for many years and are tracked along with all hospital admissions as part of ongoing UM procedures. This will continue.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: N/A

Proposed Evidence/Documentation of Correction

Please see Corrective Action Description.

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

_____

Requirement and Citation(s)

The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be:

1. Under the supervision of a person licensed to prescribe or dispense medication.

2. Performed at least annually.

3. Inclusive of medications prescribed to adults and youth.

(MHP Contract, Ex. A, Alt. 5

DHCS Finding

No finding number was provided.

The MHP did not furnish evidence to demonstrate it complies with the MHP Contract, Exhibit A, Attachment 5, Section 1', Paragraph H. H. The MHP shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

During the onsite interview, the MHP indicated it did not have mechanisms to monitor the safety and effectiveness of medication practices related to children/youth.

DHCS deems the MHP out-of-compliance with the terms of the MHP Contract. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:

- The MHP will update the language in the Med Clinic Peer Review Policy to include specific language regarding review of children's as well as adult's medications under the direction of the MHP Psychiatric Medical Director or designee psychiatrist.

- Additional language, reflecting practices being implemented, will reflect routine, at least annual, periodic review of the documentation and medication regimes practiced by the child psychiatrist at the contracted organizational provider.

(2) Timeline for implementation and/or completion of corrective actions:
- Both the practices and policy will be updated no later than 11/15/19.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- Updated Med Clinic Peer Review Policy

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS: Medication practices will be checked by annual audits. The results will be cross calibrated with the results of the peer reviews.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: The organizational provider with a staff psychiatrist will be expected to actively participate in medication reviews and audits.

Proposed Evidence/Documentation of Correction

Not provided.

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

Requirement and Citation(s)

Beneficiary information required in 42 CFR§ 438.10 (e.g.,information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if of the following condition is met: The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days (42 CFR § 438.10(c)(6)).

DHCS Finding

No Finding Number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.10(c) (6). Beneficiary information required in 42 CFR § 438.10 (e.g., information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if of the specified conditions are met.

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

- Policy and Procedure: 2000201-1003- 15 Medi-Cal Beneficiary Rights; and, Medi-Cal Mental Health Beneficiary Brochure, Forms and Booklets.

The documentation did not indicate the MHP informs beneficiaries that the information specified is available in paper form without charge upon request and provides it upon request within 5 business days.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.10(c)(6). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

1) Description of corrective actions, including milestones:
- Required language will be added to the Medi-Cal Beneficiary Rights P&P, the Provider Directory and the Beneficiary brochure.

(2) Timeline for implementation and/or completion of corrective actions: no later than 11/15/19

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- Updated Medi-Cal Beneficiary Rights policy, Provider Directory and Beneficiary Brochure

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
- In addition to updating the language in the brochure, reception staff will be trained to be certain to let beneficiaries know of the option to receive a printed version upon request.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: N/A

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

Requirement and Citation(s)

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number (Cal. Code Regs., tit. 9, chapter 11,
§§ 1810.405(d) and 1810.410(e)(1).

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

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

DHCS' review team made six (6) calls to test the MHP's statewide 24/7 toll-free number.

The six (6) test calls must demonstrate it complies with California Code of Regulations, title 9, chapter 11, §§ 1810.405(d) and 1810.410(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.

OOC Calls:
TESTCALL#2

The call was placed on Thursday, September 27, 2018, at 7:38 a.m. The call was answered after three (3) rings via a phone tree that the caller reached the Napa County Mental Health Access Team. The phone tree prompted the caller to select a language option in Spanish or English. The caller was asked if he/she was

experiencing a Mental Health Crisis and if there was an urgent need to press one (1). The phone tree stated that if he/she was seeking services or needed help in another language to press three (3). The phone tree continued to say, "if this was a non-emergency seeking Mental Health Services to leave their name and number and they will call back promptly during business hours and that the call is very important to them.' The caller selected three (3) and was transferred to the crisis center. The caller requested information about how to access mental health services. The operator responded with, you need to reach out to adult services and to call back around 9:00 a.m. The caller asked who he/she reached. The operator replied, "This is the crisis center." The caller then replied that he/she would call back. 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.

DHCS deems the MHP out-of-compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d).

TEST CALL#6

The call was placed on Thursday, September 27, 2018, at 10:40 a.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold language. The phone tree continued with direction to press one (1) if caller is experiencing a mental health crisis or is in urgent need and select three (3) if seeking mental health services or need help in another language or if not urgent, to leave your name and number if in need of mental health services or help in a different language. The caller selected option three (3) and requested information about filing a complaint against a therapist in Napa County. The operator provided the telephone number and name of the director at Patient's Rights. The operator informed the caller that he/she is with a crisis facility and informed the caller to call back the Napa County Mental Health Access Team line for additional information or to contact Patient's Rights. The caller dialed the number to Patient's Rights and was connected to a voicemail. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes.

DHCS deems the MHP out-of-compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d).
Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, § 1810.405(d). The MHP must complete a POC addressing this finding of non- compliance.

DHCS Finding

No Finding Number provided

DHCS deems the MHP out-of-compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d).

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, § 1810.405(d). The MHP must complete a POC addressing this finding of non- compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:

• The MHP has implemented a Corrective Action Plan with Exodus Recovery, who is responsible for after hours and back-up response to the 24/7 Access Line. The CAP includes:

- Enhanced training of staff in all aspects of Access line response and recording of calls, including a plan for routine refreshers and including the training in new employee compliance training.
- In addition to the MHP's test call regime, which will continue, Exodus QA will conduct a robust test call regime, reporting results to the Program Director and MH Quality Coordinator bi-weekly. The access call log will be checked for entry of all calls.
- Test calls will test access to services information as well as problem resolution. (urgent calls are handled immediately by the CSSU.)
- The CAP will continue until 3 months of error-free test calls occur.

(2) Timeline for implementation and/or completion of corrective actions:

• The CAP will commence on 7/1/19 and be completed when 3 months of error free test calls occurs at a date to be determined.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

• The Corrective Action Plan document will be submitted. County MHP test call results are submitted quarterly to DHCS and will continue to be. They can also be submitted to the compliance unit as evidence of maintenance of effort on the CAP.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

- Exodus' CAP will be monitored bi-weekly by the Quality Coordinator and results reviewed during weekly meetings between program managers and

MHP management.
Ultimately, if the CAP fails to improve the performance significantly, the MHP may seek to contract after hours call answering to a new vendor tbd.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: The CAP described above is required of a contracted provider, Exodus Recovery Services.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness

None provided.

Implementation Timeline:

Not provided.

Requirement and Citation(s)

The written log(s) contain the following required elements (Cal. Code Regs., tit. 9, chapter 11, § 1810.405(f).):

a) Name of the beneficiary.

b) Date of the request.

c) Initial disposition of the request.

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

- Access Log; and, CAAT Log (version 4.0) Form.

DHCS Finding

No Finding Number Provided

The MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, chapter 11, § 1810.405(f). The MHP must maintain a written log of the initial requests for SMHS from beneficiaries of the MHP. The requests must be

recorded whether they are made via telephone, in writing, or in person. The log must contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

Two of five required DHCS test calls were not logged on the MHP's access log.

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, § 1810.405(f). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:
- One of the elements of the Exodus CAP is checking the access log for accurate recording of all required elements, including Name, date and disposition.

(2) Timeline for implementation and/or completion of corrective actions:
- Current.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- We need some feedback on this from DHCS: the finding is specifically related to test calls that were not entered on the log. The vast majority of the 100’s of logged calls contain all required elements, if available. Our suggestion for evidence is to include this specific element of the CAP in our call report, which is one of the reported elements on the quarterly test call report. We can also extract from the log the specific lines pertaining to the test calls and provide that. Please advise.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
- As described above, the CAP will be monitored bi-weekly by the Quality Coordinator for log compliance.
- (5) Description of corrective actions required of the MHP's contracted providers to address findings: All test calls must be reported on an Access call form that is faxed to the Access secretaries and logged in the call log.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness

None provided.

Implementation Timeline:

Not provided.

_____

Requirement and Citation(s)

The MHP shall have a comprehensive policy and procedure describing its process for timely provision of services to children and youth subject to Presumptive Transfer. (MHSUDS IN No., 17-032 and 18-027)

DHCS Finding

No Finding Number provided.

The MHP did not furnish evidence to demonstrate it complies with the requirements in MHSUDS Information Notice 18-027. The Information Notice provides clarification and guidance to county MHPs, county probation agencies, and child welfare agencies regarding implementation of presumptive transfer of SMHS for children, youth, and non- minor dependents (NMD) in foster care.

While the MHP did submit a P&P addressing requirements for presumptive transfer; the P&P does not comprehensively address all the requirements for presumptive transfer.
For instance, the P&P does not specify the following:
The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services for children/youth presumptively transferred to the MHP's responsibility. (42 C.F.R. § 438.206(c)(1)(i).)

- In situations when a foster child or .youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, MHPs must provide SMHS immediately, and without prior authorization. (MHSUDS IN No., 18-027)

- Pursuant to (W&I) Code§ 14717.1(b)(2)(F), the MHP has a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction. (MHSUDS IN No., 18-027; W&I Code § 14717.1(b).)

DHCS deems the MHP out-of-compliance with the requirements described in MHSUDS Information Notice 18-027 and W&I Code§ 14717.1. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:

•The MHP has begun updating its Children's Out-of-County Authorization and Delivery of SMHS policy to include the missing elements identified in the DHCS findings. This policy will include an explicit description of MHP's policies and procedure as it relates to the manner in which the MHP meets, and requires its providers to meet, Department standards for timely access to care and services for children/youth presumptively transferred to the MHP's responsibility; a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction; make more explicit the that the MHP will provide SMHS immediately, and without prior authorization access to crisis stabilization services in situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition,; and that foster child (ren), youth or Non Minor Dependent residing in Napa County are notified of access to 24 hours Crisis Stabilization Services Program and Mental Health 24 hour crisis line by MHP staff.

(2) Timeline for implementation and/or completion of corrective actions:

- The Policy updates will be completed no later than 11/15/2019.
- Ongoing: Napa County MHP will continue to operate under the DHCS standards for timely access to care and services in its routine practices, which includes SMHS for children, youth, and non- minor dependents (NMD) in foster care. Napa County MHP explicitly understood that once presumptively transferred under requirements in MHSUDS Information Notice 18-027, the MHP was responsible for providing SMHS for children, youth, and non- minor dependents (NMD) in foster care. Napa County MHP has continued to provide Presumptively Transferred Medi-Cal beneficiaries access to services under the same timeliness standards and access to Crisis Stabilization services as all Napa County Medi-Cal beneficiaries.
- Ongoing: Napa County MHP will continue to provide immediate Crisis Stabilization Services to foster child(ren)/youth in imminent danger to themselves or others or experiencing an emergency psychiatric condition without prior authorization.

Ongoing: Napa County MHP as a practice has and will continue to provide expedited services for clients who present with immediate need through Centralized Access. Centralized Access assesses Napa County residents for Specialty Mental Health Services and program referral. Centralized Access coordinates with the sending county to obtain any necessary documentation to facilitate assessment or program referral.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- The MHP will submit the updated Children's Out-of-County thorization and Delivery of SMHS policy.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
- Ongoing: Napa County MHP tracks children and youth subject to Presumptive Transfer utilizing reports and tracking spreadsheet. These tracking mechanisms are monitored ongoing. At the time of Presumptive Transfer, Napa County assumes responsibility for provision of specialty mental health services for the foster child (ren) or youth, and those foster child (ren)/ youth/NMD are subject to Napa County MHP mechanisms for monitoring treatment effectiveness and compliance. All SMHS are reviewed as part of the monthly Chart Review process, which monitors several service provision standards including, but not limited to timely access to services. This chart review process is coordinated by the UR Coordinator, who also monitors the MHP Plan of Corrections (POC) in conjunction with Quality Coordinator and Mental Health Management Team. The HHSA Quality Management Team, also monitors POC compliance and standards. This MHP has created mechanisms in the electronic health record to identify this client population to more easily track service provision utilizing reports. The MHP is in the process of adopting a CERNER product Electronic Health Record, a plan is being developed for implementation to include reporting options to assist with monitoring service provision for Foster Children/Youth.

- Ongoing: Timely access to services is currently monitored utilizing several mechanisms: the aforementioned Central Access Authorization Team (CAAT) Log; and in the aforementioned monthly Utilization Review Steering Committee meeting by reviewing MH Dashboard findings.
- Napa County MHP tracks hospitalizations in a bi-weekly Inpatient Hospitalization Admission Review and Authorization meeting facilitated by the UR Coordinator in conjunction with the MHP Hospital Liaison and the MHP's contracted Crisis Stabilization Services. Acute Psychiatric Hospitalization Admissions for Presumptively Transferred Foster Youth will be monitored in this

meeting; this will be included in the updated Concurrent Review Authorization policy. Further, the MHP will continue to track theses hospitalizations in the MH Data Dashboard.

(5) Description of corrective actions required of the MHP's contracted providers to address findings:

• There is no corrective action currently required of the MHP's contracted provider to address this finding. The contracted Crisis Stabilization Services Program (CSSP) will continue to immediately provide SMHS for foster child (ren) or youth in imminent danger to themselves or others due to experiencing an emergency psychiatric condition; including but not limited to crisis stabilization services and medically necessary Acute Psychiatric Hospitalization without prior authorization; this standard will also be monitored daily through communication between the CSSP, MHP Management, and UR Coordinator; and weekly in a review meeting held between the CSSP and MHP, which includes possible corrective action plans when indicated by breach of policy/practice. Further, the CSSP's admissions/census will be monitored monthly in Utilization Review Steering Committee meeting, where trends are identified for possible practice/policy changes and/or Project Improvement Plans. The data of the contracted CSSP provider will be reviewed in the above monitoring interventions/meetings, and, as needed, corrective action plans will be developed to address problematic finding(s).

- The CSSP currently serves all Napa County residents who are experiencing an emergency psychiatric condition. The CSSP is responsible for Acute Psychiatric Hospitalizations and 24 hour access. Any foster child (ren), youth or NMD has access to the CSSP and the 24 hour crisis hotline as a Napa County resident 24 hours a day.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

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

- P&P (2000200-0017-18) Children's Out-of-County Authorization and Delivery of SMHS

Measures of Effectiveness

Not provided.

Implementation Timeline:

Not provided.

Requirement and Citation(s)

If the MHP denies a request for an expedited appeal resolution, the MHP shall:

a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.410(c)(1).)

b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal. Provide written notice of the decision and reason for the decision within two calendar days of the
date of the denial, and inform the beneficiary of the right to file a grievance if he or she disagrees with the decision. (42 C.F.R. § 438.410 c 2; 42 C.F.R. 438A08 c 2. FINDING
The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.410(c)(1). If the MHP denies a request for expedited resolution of an appeal, it must transfer the appeal within the timeframe for standard resolution in accordance with 42 CFR § 438.408(b)(2).

The MHP submitted the following documentation as evidence of compliance with this requirement:
- P&P (2000200-0002-18) MHP
Second Opinions, Appeals, and State Fair Hearings as evidence of compliance with this requirement.

The MHP's P&P does not address these requirements.

DHCS Finding

No Finding Number provided.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.410(c)(1) and (2). The MHP must complete a POC addressing this
finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:
- P&P (2000200-0002-18) MHP Second Opinions, Appeals, and State Fair Hearings will be updated to include the required language. Additionally, the Beneficiary Rights posters posted in all lobbies and the NOABD Appeals

process sheets provided to beneficiaries have been updated to include required language.

(2) Timeline for implementation and/or completion of corrective actions:
- Current and no later than 11/15/19.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- Updated MHP Second Opinions, Appeals, and State Fair Hearings Policy, Beneficiary Poster and Appeals Process Information sheet.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
- If and when requests for expedited appeals are filed, the timeliness of communications will be monitored.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: Post updated posters and Appeals information sheets.

Proposed Evidence/Documentation of Correction

Please see Corrective Action Description

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

Requirement and Citation(s)

If the MHP or the State Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MHP must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72- hours from the date it receives notice reversing the determination. 42 CFR §_438.424 a

DHCS Finding

No Finding Number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.424(a). If the MHP, or the state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MHP must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72-hours from the date it receives notice reversing the determination.

DHCS deems the MHP out-of-compliance with 42 CFR § 438.424(a). The MHP must complete a POC addressing this finding of non-compliance.

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

- P&P (2000200-0002-18) MHP Second Opinions, Appeals, and State Fair Hearings

The MHP's P&P does not address these requirements. None provided with in the CAP document.

Corrective Action Description

(1) Description of corrective actions, including milestones:
• P&P (2000200-0002-18) MHP Second Opinions, Appeals, and State Fair Hearings will be updated to include required language.

(2) Timeline for implementation and/or completion of corrective actions:
•No later than 11/15/19.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
•Updated MHP Second Opinions, Appeals, and State Fair Hearings Policy.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
•If and when a State Hearing Officer reverses a decision to deny, limit or delay services, and services are required to be authorized or provided within 72 hours, the timeframe of this occurring will be monitored by the Quality Coordinator.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: N/A

Proposed Evidence/Documentation of Correction

Please see Corrective Action Description.

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

Requirement and Citation(s)

The MHP implements and maintains procedures designed to detect fraud, waste and abuse that include provisions to verify services reimbursed by Medicaid were received by the beneficiary 42 CFR 438.608 a)(5)).

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.608(a)(5). The MHP must have established administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. DHCS, through its contract with the MHP, must
require that the MHP or subcontractor to the

DHCS Finding

No Finding Number was provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.608(a)(5). The MHP must have established administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. DHCS, through its contract with the MHP, must extent that the subcontractor is delegated responsibility by the MHP for coverage of services and payment of claims under the contract between DHCS and the MHP, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.

The MHP's audit tool (highlighted by the MHP) does include the following audit requirement, "When claiming for a group service, is there verification of attendance?" However, the audit tool does not include any details how the verification of attendance is conducted. The MHP did not include any policies and/or procedures to

address this requirement. It is not clear from the evidence submitted that the MHP has a systematic process for conducting service verification in· compliance with the federal and state requirements.
DHCS deems the MHP out-of-compliance with 42 CFR § 438.608(a)(5). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:
- A new MHP Service Verification policy describing the policies and procedures of the existing service verification process and audit is being written.

(2) Timeline for implementation and/or completion of corrective actions:
- No later then 11/15/19.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- Service Verification Policy and Procedure.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
The existing service verification procedure includes annual auditing as an additional monitoring check.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: N/A

Proposed Evidence/Documentation of Correction

None was provided within the CAP document.

Measures of Effectiveness

None provided.

Implementation Timeline:

11/15/19

Requirement and Citation(s)

The MHP ensures collection of disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the MHP, if applicable, and ensures its subcontractors and network providers submit disclosures

to the MHP regarding the network provider's (disclosing entities) ownership and control (42 CFR && 455.101 and 104).

The MHP did not furnish evidence to demonstrate it complies with 42 CFR §§ 455.101 and 455.104. The MHP must
provide evidence of verification of disclosure

DHCS Finding

No Finding Number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR §§ 455.101 and 455.104. The MHP must provide evidence of verification of disclosure of ownership, control and relationship information from individual providers, agents, and managing employees. The MHP is responsible to monitor and obtain the required information from their contracted providers, regardless of for-profit or non- profit status.

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

- P&P (2001404-0002-15)

Credentialing Program & Excluded Individuals Screening; and,

- P&P (2001303-1109-18) Compliance

- "Covered" Contractor Compliance Requirements.

The MHP's P&P addresses requires contracts to complete a "Self-disclosure form that is signed by an individual provider declaring whether he/she is or is not an excluded individual." This form was not submitted to DHCS for review. In addition, such declarations do not address the specific requirements in 42 CFR §§ 455.101 and 455.104.

DHCS deems the MHP out-of-compliance with 42 CFR §§ 455.101 and 455.104. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:

The MHP, in coordination with the County contracts division and County Counsel, will be inserting the needed language by amendment into the Terms and Conditions section of sub-contractor contracts.

- The MHP will design a Disclosure of Ownership form.
- Contractors will be notified by letter of these changes, as well as

receiving county issued ownership disclosure forms with instructions.

- Annually, the forms will be distributed and instructions reiterated in July.
- Forms will be collected by the MHP and reviewed for any prohibited disclosures. If found, appropriate follow up action will occur.
- Napa County HHSA Quality Management Division will add this process to the Compliance Covered Contractor Policy.

(2) Timeline for implementation and/or completion of corrective actions:

•Forms, contract language and policy updates will be completed no later than 11/15/19. Initial notification and distribution to providers will occur per pre-existing compliance calendar by 1/31/20.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

- Amended contract Terms and Conditions.
  - Napa County Providers Disclosure form
  - Updated QM Compliance Covered Contractor Policy
  - MHP Notification letter to providers.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:

•Disclosure forms will be reviewed by the MHP upon submission for prohibited disclosures.

Annually, disclosure forms will be audited by the QM Division.

(5) Description of corrective actions required of the MHP's contracted providers to address findings: Corrective actions, if necessary, will be designed to respond to problematic disclosures.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Corrective Action Description.

Implementation Timeline:

1/31/20

_____

Requirement and Citation(s)

1) The MHP, and subcontractors, shall allow DHCS, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the contractor and its subcontractors pertaining to such services at any time (MHP Contract, Ex. E; 42 CFR §§ 438.3/h) and 438.230(c)(3)(i-iiil).
2) The MHP shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 1O years from the term
end date of this contract or in the event the contractor has been notified that an audit or investigation of this contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (MHP Contract, Ex. E; 42 CFR §§ 438.3/h) and 438.230/c)/3)(i-iiil).

DHCS Finding

No Finding Number provided.

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.3(h). DHCS, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the MHP, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for 1O years from the final date of the contract period or from the date of completion of any audit, whichever is later.

In addition, the MHP did not furnish evidence to demonstrate ii complies with 42 CFR § 438.230(c)(3)(i-iii). The MHPs must include in the contract with subcontractor that it must agree that DHCS, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MHP's contract with DHCS. The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this requirement, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries. The right to audit under paragraph (c)(3)(i) of this requirement will exist through 1O years from the final dale of the contract period

or from the date of completion of any audit, whichever is later.
DHCS deems the MHP out-of-compliance with 42 CFR §§ 438.3(h) and 438.230(c)(3)(i-iii). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(1) Description of corrective actions, including milestones:
• The required language will be added by amendment to the general terms and conditions of all contracts. All providers have previously been verbally advised of this requirement.
(2) Timeline for implementation and/or completion of corrective actions:
• No later than 11/15/19.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
• Amended Contract example.
(4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:
• During annual contractor compliance review by Provider Services Coordinator, record retention requirement compliance will be reviewed.
(5) Description of corrective actions required of the MHP's contracted providers to address findings: to be determine if contractor found out of compliance.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness

Please see Corrective Action Description.

Implementation Timeline:

11/15/19

Chart Review

Requirement and Citation(s)

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

Assessment documentation.

(MHP Contract, Ex. A, Att. 9) RR2: Service, except for Crisis Intervention and/or services needed to establish medical necessity criteria, shall be provided, in accordance with the State Plan, to beneficiaries who meet medical necessity criteria, based on the beneficiary's need for services established by an Assessment. The MHP did not submit documentation substantiating the beneficiary's need for services was established by an Assessment.

(MHSUDS IN No. 17-050, Enclosure 4)

1. Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. (MHP Contract, Ex. A, Att 2)

   The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. (MHP Contract, Ex. A, Att 2)

DHCS Finding

No Finding Number was provided.

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

1. One or more assessments were not completed within the timeliness and/or frequency requirements specified in the MHP's written documentation standards. According to the MHP standards, "re-assessments are due annually {every 3 years for Med Clinic only clients)." The following are specific findings from the chart sample:
2. **Line number 3**: The updated assessment was completed late. The updated assessment was completed on 10-25-17. The prior assessment was completed on 2- 24-16, and consisted of just a diagnosis page. According to the MHP, the beneficiary was a "med clinic" only client prior to 10-25- 17 and required an assessment every 3 years. At the onsite review, the chart lead requested the previous assessment but the MHP could not locate that assessment.
3. **Line number 1:** For tracking timeliness of updated assessments, there is no clear definition of "medication only"
   clients and no clear documentation in the record when a beneficiary's

"medication only" services begin and end.

4. Assessments for "meds only" clients are updated every three years based on MHP Policy. Many have chronic conditions and receive medication only services. Based on the current assessment frequency, determination of services provided in sufficient amount, duration, and scope cannot be made.

The MHP shall submit a POC that:

1. Provides evidence that the MHP has written documentation standards for assessments, including required elements or timeliness and frequency as required in the MHP Contract with the Department.

2. Describes how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

3. Provide a clear definition of “Med Clinic only” and document when the beneficiary’s “Medication Only” services begin and end.

Describe how the MHP will ensure that services are provided in sufficient amount, duration and scope.

Corrective Action Description

In order to ensure that Napa County Mental Health clinical staff Assessments expectations are aligned with required DHCS guidelines and best practice standards Napa County will and has done the following:

1. Ongoing: The Napa County MHP has written documentation standards for assessments, including required elements of timeliness and frequency as required in the MHP Contract with the Department included in the Clinical Documentation Manual Documentation Manual page 14-19. Further, Napa County MHP trains staff throughout their tenure at Napa County Mental Health on this standard including during New Employee Compliance Training (see New Employee Compliance Training PowerPoint), Monthly Clinical Documentation Meetings, and Annual Compliance Trainings (See Annual Compliance Training PowerPoint). Napa County also plans to integrate the new DHCS Documentation Training (when it is completed) into the required New Employee Compliance Training. A four-hour Annual Compliance Training took place on August 2018 and this years’ Annual Compliance Training will occur by October 31, 2019. DHCS and MHP standards for documentation and audit findings & recommendations are reviewed in depth during the Annual

Compliance Training. Program-specific documentation trainings will continue to be provided by the UR Coordinator throughout the year on an as-needed basis to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include, but are not limited to: Reviewing recent causes of documentation disallowance and ensuring that Assessments, Client Plans, progress notes are completed properly and in a timely manner. In addition to the above practices to assure timeliness in documentation, the UR Coordinator meets with supervisors on a monthly basis in the Monthly Clinical Documentation Meeting to discuss clinical documentation, audit findings, and staff documentation trends. In fact, the Monthly Clinical Documentation Meeting was created as a result of past audit findings so as to have a venue to discuss clinical documentation with supervisors on an ongoing basis.

2. Ongoing: The MHP ensures that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards utilizing several quality assurance mechanisms. Napa County MHP's quality assurance mechanisms include multiple levels including monthly Chart Review, Supervisor 100% review of new staff, and Quality Management review/audits. The Chart Review team selects one chart from every Mental Health program and reviews all progress notes and supporting clinical documentation for the two months preceding the month of review. The chart review team provides direct feedback to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements. If staff are identified as having difficulties with writing notes that meet medical necessity, they are placed on "100% review" which requires their supervisor to review 100% of progress notes (and other clinical documentation if applicable) until it is determined by the supervisor that the staff no longer requires 100% review. Additionally, Supervisors conduct 100% review of all progress notes of all new hire staff, until staff meet the clinical documentation standards for the DHCS and the MHP. Further, the Napa County Quality Management Team--a separate division from Mental Health-- conducts regular (typically yearly) audits of Mental Health Program charts which closely mirror the audits conducted by the DHCS. The Quality Management team provides findings and recommendations for correction of any findings and requires Plans of Correction. Napa County has embarked on an integration of the Quality Management Medi-Cal subject matter experts into the Mental Health Division monthly chart review process so as to expand the current monthly Chart Review process. Napa County finds value in increasing the number of subject matter experts and calibration of chart reviewers between Mental Health and

Quality Management, while also expanding our bandwidth in our monthly chart review process, thereby reviewing more charts, including external providers, on a monthly basis.

3. By October 31, 2019: Napa County MHP will implement a “Peer Chart Review” process which will allow clinical line staff to participate in the monthly chart review process. This process is being created in order to support quality review of charts as well as to engage staff in a learning process through reviewing charts for documentation standards. Staff will review charts monthly including Assessment documents, Treatment Plans, and Progress notes utilizing the Chart Review Tool developed by the UR Coordinator in conjunction with Quality Management.

4. By August 31, 2019: The Documentation Manual will be revised and will remove all mention of “Medication Clinic Only” clients as the MHP has decided to discontinue the use of the determination of Med Clinic Only so as to alleviate any confusion around the meaning. Medication Clinic documentation (Psychiatric Evaluations and Diagnosis Review Forms) is due every 3 years in the Medication Clinic whether the client is open to multiple programs or not. On February 28, 2019, the Chart Review team was instructed that Napa County MHP will be discontinuing any mention of “Med Clinic Only” in our documentation manuals and trainings.
5. June 27, 2019: Clinical Supervisors will be reminded in the Monthly Clinical Documentation meeting that we are no longer referring to clients as “Medication Clinic Only” in terms of documentation expectations. The Medication Clinic should complete a Psychiatric Evaluation and Diagnosis Review form every 3 years regardless of what other programs to which the client may or may not be open.

6. July 1, 2019: The Medication Clinic staff will be reminded in their upcoming biweekly staff meeting that all clients should receive a Psychiatric Evaluation and Diagnosis Review Form every 3 years regardless of what other programs to which the client is or is not opened. They will get additional clarification that “Medication Clinic Only” is not applicable moving forward in terms of what clinical documentation is due.

7. By August 31, 2019: The Clinical Documentation FAQ document will be revised to include all topics related to the 2018 Triennial findings & plans of correction.

   By July 2019: The Quality Management team will be integrated in the

monthly chart review process to further ensure and expand the MHP's ability to ensure services are provided in sufficient amount, duration, and scope. The expanded Chart Review Team will continue to review charts monthly to assure that services are provided in sufficient amount, duration, and scope and direct feedback will be provided to staff/programs as necessary.

9. Ongoing: Quality Management Team yearly audits (separate from their participation in the monthly chart review process) of Mental Health Plan program charts annually to ensure that services are provided in sufficient amount, duration, and scope.

10. Ongoing: Supervisors provide weekly supervision and review/discuss progress notes and individual cases to ensure that services are provided in sufficient amount, duration, and scope.

By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Corrective Action Description.

Measures of Effectiveness

Please see Corrective Action Description.

Implementation Timeline:

Please see Corrective Action Description.

Requirement and Citation(s)

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 Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

   Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include 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. If possible, include other medical information from medical records or relevant consultation reports;

c. Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications; Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

d. Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

e. Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;

f. A mental status examination;

g. A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,

h. Additional clarifying formulation information, as needed.

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

DHCS Finding

No Finding Number provided.

One or more of the assessments reviewed did not address all of the elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

a) Medications: **Line numbers 4 & 9.**

b) A mental status examination:

Line number 1.

A full diagnosis from the current ICD code: **Line number 5.**

NCMH APPEAL OF FINDINGS: On May 9, 2019, Napa County Mental Health Plan submitted an appeal to this finding stating the following:

Medications: With regard to the required element related to medications, the Napa County Assessments for line number 4 both indicate that the client takes medications and refers the reviewer to another area of the chart for an up-to-date, accurate notation of the client's current medications. Because this information exists in the client record, the Napa MHP disagrees with the finding that line 4 is missing a required assessment element and asks that this finding be reconsidered. With regard to line number 9, the client was not taking medications at the time that the Comprehensive Assessment was completed and therefore the assessing clinician selected "no" to the questions related to whether or not the client has taken any medications in the last two weeks and if the client reports taking any medications. Given such, the Napa MHP disagrees with this finding for line number 9 and asks that it be reconsidered. c) A full diagnosis form the current ICD code: With regard to line number 5, the Napa MHP respectfully disagrees with the finding that a full diagnosis from the current ICD was missing. Line #5 has a diagnosis review form completed by the Napa MHP (this diagnosis is also utilized by the contract provider Buckelew). Given that an ICD10 diagnosis is present, the Napa MHP asks that this finding be reconsidered.

Corrective Action Description

NCMH PLAN OF CORRECTION:

NOTE: The MHP is still awaiting the DHCS' response to the appeals submitted on May 9, 2019. Plans of Correction may adjust based upon feedback provided with regard to those appeals.

In order to ensure that every Napa County MHP assessment contains all of the

required elements specified in the MHP Contract with the Department, Napa County takes/will take the following steps:

1. Ongoing: Napa County MHP has written documentation standards for assessments, including all required elements of an assessment as required in the MHP Contract with DHCS included in the Clinical Documentation Manual Documentation Manual page 14-17. Further, Staff are trained on assessment requirements throughout their tenure at Napa County Mental Health including: New Employee Compliance Training (See New Employee Compliance Training PowerPoint), Monthly Clinical Documentation Meetings, and Annual Compliance Trainings (See Annual Compliance Training PowerPoint). Napa County plans to also incorporate the new DHCS Documentation Training when it is completed into staff required New Employee Compliance training. A four hour Annual Compliance Training took place on August 30, 2018 which outlines documentation requirements (See Annual Compliance Training PowerPoint).

2. By August 31, 2019: The Clinical Documentation Manual will be updated to further underscore the required elements of an assessment and will clarify that these required elements also apply to re-assessments (all assessment and re-assessment documents already include all of the required elements).

4. By August 31, 2019: The Clinical Documentation FAQ document will be revised to include mention of all of the required elements of an assessment and re-assessment. By October 31, 2019: Annual Compliance Training will occur which will include an in-depth review of the DHCS standards for documentation as well as all findings & recommendations from the 2018 DHCS Triennial Audit.

6. Ongoing: Program-specific trainings will continue to be provided by the UR Coordinator throughout the year on an as needed basis to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include, but are not limited to: Reviewing recent causes of documentation disallowance and quality findings; documentation requirements and documentation timeliness requirements. In addition to the above practices to assure timeliness in documentation, the UR Coordinator meets with supervisors on a monthly basis in the Monthly Clinical Documentation Meeting to discuss clinical documentation, audit findings, and staff documentation trends in tracked in monthly timeliness reports. By June 27, 2019: UR

Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

7. Ongoing: The MHP utilizes several quality assurance mechanisms to ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards. Napa County MHP's quality assurance processes includes multiple levels including monthly Chart Review, Supervisor 100% review of new staff, and Quality Management review/audits. The Chart Review team selects one chart from every program and reviews each month. The chart review team provides direct feedback to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements. If staff are identified as having difficulties with writing notes that meet medical necessity, they are placed on "100% review" which requires their supervisor to review 100% of progress notes (and other clinical documentation if applicable) until it is determined by the supervisor that the staff no longer requires
100% review. Additionally, Supervisors conduct 100% review of all progress notes of all new hire staff, until staff meet the clinical documentation standards for the DHCS and the MHP.

8. By July 2019: The Quality Management team will be included in the Chart Review team's monthly reviews of program charts. Napa County Quality Management Team, a separate division from Mental Health, also conducts yearly quality reviews of Mental Health Program charts. The Quality Management team provides findings and recommendations for correction of any findings. Napa County has embarked on an integration of the Quality Management Medi-Cal subject matter experts into the Mental Health Division monthly chart review process. Napa County finds value increasing number of subject matter experts and calibration of chart reviewers between Mental Health and Quality Management, while also expanding our bandwidth in our monthly chart review process, thereby reviewing more charts, including external providers on a monthly basis .

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

_____

Requirement and Citation(s)

All entries in the beneficiary record shall include:

1. The date of service.
2. The signature of the person providing the service (or electronic equivalent).
3. The type of professional degree, licensure, or job title of the person providing the service.
4. The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding

No finding number provided.

Assessment(s) in the chart sample did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, or the date the documentation was entered into the medical record. Below are the specific findings pertaining to the charts in the review sample:

- The type of professional degree, licensure, or job title of person providing the service: **Line number 5.**

The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes:

1) The signature of the person (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

Corrective Action Description

In order to ensure that Napa County MHP documentation includes the signature of the person (or electronic equivalent) with the professional degree, licensure or title of

the person providing the service by updating the credentialing mechanism in the current Electronic Health Record (Cerner), Napa County will implement and/or continue the following:

1. Ongoing: It is the requirement of the Napa County Health and Human Services Agency (HHSA) Mental Health Plan (MHP) that each user of the Cerner Electronic Medical Record and Billing (Cerner) system have a designation of a specific credential or privileging designation that directly relates to their scope of practice and licensure. This requirement pertains to all internal Mental Health Division staff and contracted Managed Care and Organizational Providers providing and billing for mental health services within the MHP. Subsequently, billing controls are set for each credential, to support with decreasing the likelihood that staff select service codes that are out of their scope of practice.
2. Completed June 10, 2019: Napa County MHP met with its Electronic Health Record Application Support Team to discuss this finding. Subsequently, the Application Support Team and a Staff Services Analyst has enabled functionality in the Electronic Health Record that ensures the staff's credentials are printed for all external provider staff. (Internal providers have always been set up to ensure that credentials are printed).

3. Ongoing: To reinforce compliance to this standard, Napa County MHP has written documentation standards for scope of practice are included in the Clinical Documentation Manual as it relates to services provided including but not limited to Assessment, Diagnosis Review, Mental Status Exam, and Treatment Plans. A scope of practice grid is also included in the documentation manual that specifically outlines which staff can complete certain billing codes/services on pages 115-116.

   Ongoing: Napa County MHP's quality assurance mechanisms include multiple levels including monthly Chart Review, Supervisor 100% review of new staff, and Quality Management review/audits. These processes also allow for the MHP to determine whether staff are operating within their scope of practice.

4. By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

RR16: The service provided was not within the scope of practice of the person delivering the service.
(MHSUDS IN No, 17-050, Enclosure 4)

DHCS Finding

No finding number provided.

Documentation in the medical record did not meet the following requirements:

- The assessment was not signed by a provider whose scope of practice includes provision of the service documented on the assessment; i.e. the provider's scope of practice did not include conducting a mental status exam: **Line number 5.**

Corrective Action Description

1. Ongoing: It is the requirement of the Napa County Health and Human Services Agency (HHSA) Mental Health Plan (MHP) that each user of the

1. Ongoing: It is the requirement of the Napa County Health and Human Services Agency (HHSA) Mental Health Plan (MHP) that each user of the Cerner Electronic Medical Record and Billing (Cerner) system have a designation of a specific credential or privileging designation that directly relates to their scope of practice and licensure. This requirement pertains to all internal Mental Health Division staff and contracted Managed Care and Organizational Providers providing and billing for mental health services within

the MHP. Subsequently, billing controls are set for each credential, to support with decreasing the likelihood that staff select service codes that are out of their scope of practice.

2. Completed June 10, 2019: Napa County MHP met with its Electronic Health Record Application Support Team to discuss this finding. Subsequently, the Application Support Team and a Staff Services Analyst has enabled functionality in the Electronic Health Record that ensures the signers credentials are printed for all external providers. (Internal providers have always been set up to ensure that credentials are printed).

   May 2019 and ongoing: The MHP will have ongoing quarterly calibration meetings with external providers to ensure clarity across the board with regard to documentation expectations/requirements. Although most external providers were made aware of the scope of practice requirements related to assessments, effective May 2019, all external providers were made aware of the specific signature requirements of Assessments per the DHCS Info Notice 17-
   040. Specifically, providers were provided a hard copy of DHCS Info Notice 17-040 which outlines Assessment and scope of practice requirements and were also shown how to access DHCS Info Notices via the DHCS website.

4. Ongoing: To reinforce compliance to this standard, Napa County MHP has written documentation standards for scope of practice are included in the Clinical Documentation Manual as it relates to services provided including but not limited to Assessment, Diagnosis Review, Mental Status Exam, and Treatment Plans throughout the manual. A scope of practice grid is included in the manual that specifically outlines scope of practice for staff to provide each services on pages 115-116.

5. Ongoing: Napa County MHP's quality assurance mechanisms include multiple levels including monthly Chart Review, Supervisor 100% review of new staff, and Quality Management review/audits and this allows us to review charts to ensure that scope of practice requirements are met.

6. By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

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

No finding number provided.

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 9: 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.*
Line number 4: The written medication consent form was not signed by the beneficiary.

Corrective Action Description

In order to ensure that Napa County MHP has a Medication Consent form obtained and retained for each medication prescribed/administered under the direction of the MHP; and that the written medication consent forms are completed in accordance with the MHP's written documentation standards, Napa County has and will do the

following:

1. In February and March 2017, all Medication Clinic staff received training specifically related how to properly complete the newly created Electronic Medication Consent. Before this time, the Medication Consents were a paper form. Ongoing training is also provided to Medication Clinic Staff with regard to the importance of obtaining Medication Consents and ensuring that they are completed in compliance with State and program standards, to ensure that they are signed appropriately and that it is clearly documented when a client is unavailable or refuses to sign the form.

2. In September 2018, the Medication Clinic Documentation Manual was further revised to include clear guidelines regarding Medication Consents and the process for obtaining them and accurately completing them (Medication Clinic Documentation Manual pages 33-34 & 67-70).

3. By August 31, 2019: The Medication Clinic Documentation Manual will be updated again to add additional explanation regarding the importance of Medication Consents and to address as necessary any questions that often arise from prescribers.

4. Ongoing: A Physician Peer Review process occurs in the Medication and checking for presences of required consents is already part of the review checklist. The Physician Peer Review process occurs every 6 months (see attached Medication Management Peer Review Process P&P)

5. By August 31, 2019: Napa County MHP will create a Policy and Procedure specific to Medication Consents in an effort to further ensure that medication consent forms ar e obtained and retained for each medication prescribed and administered under the direction of the MHP; and that written medication consent forms are completed in accordance with the DHCS and MHP's written documentation standards.

6. March 2019: The MHP implemented a new process for tracking the completion of Medication Consents and ensure that each time a client presents for an appointment the Medical Secretary is checking to ensure whether or not a Medication Consent Form needs to be completed. This allows the MHP to more closely track the completion of Medication Consents and to problem solve the most common reasons for a Medication Consent not being obtained so that appropriate steps can be taken to address the concern.

Since January 2019, the reason for and importance of obtaining medication consents has been reviewed as part of every biweekly Medication Clinic staff meeting.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

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

(MHP Contract, Ex. A, Attachment 2)

The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition.

(MHP Contract, Ex. A, Attachment 9)

RR4. Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Services were claimed:

a. Prior to the initial Client Plan being in place; or
b. During the period where there was a gap or lapse between client plans; or
c. When the planned service intervention was not on the current client plan.

(MHSUDS IN No. 17-050, Enclosure 4)

DHCS Finding

No finding number provided.

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).

Below are the specific findings pertaining to the charts in the review sample:

Line number 1: The medical record indicated an acute change in the beneficiary's mental health status (e.g. multiple crisis interventions, recent medication changes, "excessive anxiety and panic for the last two months" in January 2018). However, no evidence was found in the medical record that the client plan was reviewed to determine if the plan continued to be appropriate and/or updated in response to the recent decline.

Corrective Action Description

In order to ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition, Napa County has and will do the following:

1. Ongoing: Napa County MHP's quality assurance mechanisms include monthly Chart Review, Supervisor 100% review of new staff, and Quality Management review/audits. The ongoing monthly Chart Review process also allows direct feedback to staff and their supervisors when the WRP reviewed does not meet county/state standards. (Please see attached Chart Review Tool item 3.1 through 3.8).

2. Ongoing: The Napa County MHP current Documentation Manual includes a section on the development of Wellness and Recovery Plans (WRPs) that meet state/county regulatory requirements and explicitly states **"a WRP can be updated at ANY time and MUST be updated if there is a significant change in the individual's treatment and/or clinical presentation. Additionally, it is necessary to revise the WRP if changes need to be made to problems, goals, objectives or interventions."** The clinical documentation component of the Annual Compliance Training held in August 30, 2018 specifically reviewed the importance of updating the WRP if there are "Significant changes in individual's condition." (See Annual Compliance Training PowerPoint).

3. By August 31, 2019: The Clinical Documentation Manual will be updated and the language referred to above with regard to updating if there is a significant change in the individual's treatment and/or clinical presentation will be bolded and highlighted.

4. By August 31, 2019: The Clinical Documentation FAQ document will be revised to include all topics related to the 2018 Triennial findings & plans of correction.

5. Ongoing: Napa County MHP Staff are trained throughout their tenure at Napa County Mental Health including: New Employee Compliance Training (See New Employee Compliance Training PowerPoint), Monthly Clinical Documentation Meetings, and Annual Compliance Trainings (See Annual Compliance Training PowerPoint). Napa County also plans to integrate the new DHCS Documentation Training (when it is completed) into staff required New Employee Compliance training. A four hour Annual Compliance Training took place on August 30, 2018. DHCS standards for documentation and audit findings & recommendations were/and are covered in the Annual Compliance Training. All of these training include a section that directs staff to make certain client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition/clinical presentation.

6. By October 31, 2019: Staff will participate in the MHP's 2019 Annual Compliance Training and this standard will continue to be reviewed in the training with special notation of the fact that this was a finding in the 2018 DHCS Triennial Audit.

7. By June 2019 & Ongoing: The UR Coordinator meets with supervisors on a monthly basis in the Monthly Clinical Documentation Meeting to discuss clinical documentation; this feedback is then discussed by supervisors in their monthly staff meetings on an as needed basis; and feedback is also provided monthly in the monthly chart review findings, which is reviewed regularly by supervisors/staff. The UR Coordinator routinely discusses client plan tracking with supervisors and staff, and that ensuring compliant plans is the responsibility of each staff. Feedback specific to this plan of correction will be reviewed in the June 2019 Monthly Clinical Documentation Meeting.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

The MHP shall ensure that Client Plans:

a. 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.
b. Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
c. Have a proposed frequency of intervention(s).
d. Have a proposed duration of intervention(s).
e. Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b).
f. Have interventions that are consistent with the client plan goals.
g. g. Be consistent with the qualifying diagnoses.

(MHP Contract, Ex. A, Attachment 9

DHCS Finding

No finding number provided.

Client Plans did not include all of the required elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis. **Line numbers 5 and 6.**
- One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan. **Line numbers 2, 4, 5, 6.**
- One or more of the proposed interventions did not indicate an expected duration. **Line numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.**
- One or more client plans did not address the mental health needs and functional impairments identified as a result of the mental disorder. **Line numbers 1, 5, 7, 9.**

On May 9, 2019, Napa County Mental Health Plan submitted an appeal to this finding stating the following:

1. **(No appeal of first bullet)**

2. **One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan. Line numbers 2, 4, 5, 6:**
   Per pages 23 and 24 of the current Napa County Mental Health Documentation Manual, it is clarified that client plans should list narrative interventions directly underneath the client plan objectives versus writing more generic interventions for every service code. Pages 25 and 26 of the current Napa County Documentation Manual provides an example of how this should look on the actual client plan in the Anasazi EHR. Line numbers 2, 4 and 6 all list specific interventions per the guidelines provided in the current Napa County Mental Health Documentation Manual. Given such, we request that line numbers 2, 4 and 6 be removed from the findings summary or, if the current process outlined in the Napa County Mental Health Documentation Manual is not acceptable, the Napa MHP asks that the DHCS please provide confirmation that the current process must be changed before the Napa MHP significantly changes the guidance and trainings currently being provided to Napa County Mental Health staff and contract providers with regard to the development of client plans.

3. **One or more of the proposed interventions did not indicate an expected duration. Line numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, 10:**

   Per page 24 of the Napa County Mental Health Documentation Manual, the expected duration of all interventions and objectives is one year (the length of the client plan) unless otherwise noted. Given such, the Napa MHP requests that this finding be reconsidered.

4. **One or more of the client plans did not address the mental health needs and functional impairments identified as a result of the mental disorder. Line numbers 1, 5, 7, 9:** The Napa MHP disagrees with this finding as line numbers 1, 5, 7 and 9 all have a client plan that directly addresses the mental health needs and functional impairments identified in the associated Assessment documentation. Given such, the Napa MHP requests that this finding be reconsidered.

Corrective Action Description

NOTE: The MHP is still awaiting the DHCS' response to the appeals submitted on May 9, 2019. Plans of Correction may adjust based upon feedback provided with regard to those appeals.

In order to ensure that all client plan goals/treatment objectives are specific,

observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis, Napa County MHP has and will do the following:

1. Ongoing: The Napa County MHP current Documentation Manual includes a section on the development of Wellness and Recovery Plans (WRPs) that meet state/county regulatory requirements regarding creating a WRP with goals/treatment objectives that are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis. The clinical documentation component of the Annual Compliance Training (See Annual Compliance Training PowerPoint) held on August 30, 2018 specifically reviewed these important standards that are the basis of a well written and co-created WRP for our clients.

2. By August 31, 2019: The Clinical Documentation Manual will be updated to provide additional guidance related to the completion of compliant and effective client plans.

3. By August 31, 2019: The Clinical Documentation FAQ document will be revised to include all topics related to the 2018 Triennial findings & plans of correction related to client plans.

4. Ongoing: Napa County MHP Staff are trained throughout their tenure at Napa County Mental Health including, New Employee Compliance Training (See New Employee Compliance Training PowerPoint), Monthly Clinical Documentation Meetings, and Annual Compliance Trainings (See Annual Compliance Training PowerPoint). Napa County also plans to integrate the new DHCS Documentation Training (when it is completed) into staff required New Employee Compliance training. A four hour Annual Compliance Training took place on August 30, 2018. DHCS standards for documentation and recommendations were/and are covered in this Annual Compliance Training. All of these training include a section that directs staff to make certain client plans are goals/treatment objectives that are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.

   By October 31, 2019: Staff will participate in Annual Compliance Training; client plan requirements will continue to be reviewed, with particular attention placed on the areas noted as findings/plans of correction in the 2018 DHCS Triennial audit.

6. Ongoing: The UR Coordinator meets with supervisors on a monthly basis in the Monthly Clinical Documentation Meeting to discuss clinical documentation; this feedback is discussed by supervisors in their monthly staff meetings on an as needed basis; and feedback is provided monthly in the chart review findings, which is provided to supervisor/staff. The UR Coordinator routinely discusses WRP quality standards with supervisors and staff, and that ensuring compliant plans is the responsibility of each staff.

By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

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, § 181O(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, the client plan provides that the beneficiary will be receiving more than one (1) type of SMHS.
b. (CCR, title 9, § 1810.440(c) (2) (A).)

c. 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).)

The MHP shall have a written definition of what constitutes a long-term care beneficiary.

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

DHCS Finding

No finding number provided.

There is no documentation that the beneficiary is participating in and agreeing with the client plan.
Line 2: The beneficiary is signing a printed copy of the treatment plan that is not clear. The plan contains multiple interventions that were used historically without a clear distinction between the current and historical interventions. In addition, there is no description of the interventions in order to make an informed decision.

Line 5: The beneficiary is signing two client plans from different providers and one provider's plan still contains interventions that it no longer provides directly. From a beneficiary's perspective this would be confusing.

NCMH FINDINGS APPEAL:

On May 9, 2019 Napa County Mental Health Plan submitted an appeal to this finding stating the following:

- **Line 2: The beneficiary is signing a printed copy of the treatment plan that is not clear. The plan contains multiple interventions that were used historically without a clear distinction between the current and historical interventions. In addition, there is no description of the interventions in order to make an informed decision:**

The Napa County MHP respectfully disagrees with the finding for Line number 2. Before obtaining a client signature on a client plan, the plan is developed in conjunction with the client and the client plan is reviewed in detail before obtaining a signature and offering the client a copy of the plan. Specifically, for line number 2 the clinician met with the client for a Plan Development session on 11/1/17 to review progress on the previous client plan and create the updated client plan together. They reviewed the new plan together during the session and the client signed in

agreement. Given such, the Napa MHP asks that this finding be reconsidered as there does not appear to be any concrete evidence that the client was unable to make an informed decision regarding their client plan or that the client felt their client plan was unclear.

- **Line 5: The beneficiary is signing two client plans from different providers and one provider's plan still contains interventions that it no longer provides directly. From a beneficiary's perspective this would be confusing:**

Similar to the item noted above, line number 5 participated in the development of their client plan with the contract provider and the most recent client plan was reviewed with the client in a Plan Development session held on 3/22/18. Specifically, it was noted in that progress note that the client expressed "enthusiasm and willingness to participate in the review and signing of the client plan". At no time was it documented or otherwise suggested that the client felt confused by their client plan and therefore the Napa MHP is requesting that this finding be reconsidered.

Corrective Action Description

NOTE: The MHP is still awaiting the DHCS' response to the appeals submitted on May 9, 2019. Plans of Correction may adjust based upon feedback provided with regard to those appeals.

In order to ensure each beneficiary's participation in and agreement with all client plans are obtained and documented, as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2), Napa County has and will do the following:

1. Ongoing : Napa County MHP has written documentation standards for Client Plans that are included in the Clinical Documentation Manual to e nsure that staff are trained that each beneficiary's participation in and agreement with all client plans is obtained and clearly documented, pursuant to the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2). Napa County Annual Compliance Training (Slide 31) held on August 30, 2018 addressed this standard.
2. Ongoing : Napa County MHP's quality assurance mechanisms include monthly Chart Review, Supervisor 100% review of new staff, and Quality Management yearly audits. The Chart Review team selects a chart from every program and reviews each month. The chart review team provides direct feedback to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements. If staff are identified as having difficulties with writing notes that meet medical necessity, they are placed on "100% review" which requires their

supervisor to review 100% of progress notes (and other clinical documentation if applicable) until it is determined by the supervisor that the staff no longer requires 100% review. Additionally, Supervisors conduct 100% review of all progress notes of all new hire staff, until staff meet the clinical documentation standards for the DHCS and the MHP.

3. By July 2019: The Quality Management team will be included in the Chart Review team's monthly reviews. Napa County Quality Management Team--a separate division from Mental Health--conducts yearly quality reviews/audits of Mental Health Program charts. The Quality Management team provides findings and recommendations for correction of any findings. Napa County has embarked on an integration of the Quality Management Medi-Cal subject matter experts into the Mental Health Division monthly chart review process. Napa County finds value increasing number of subject matter experts and calibration of chart reviewers between Mental Health and Quality Management, while also expanding our bandwidth in our chart review process, thereby reviewing more charts, including external providers monthly. All chart review processes include reviewing for the standard that beneficiary's participation in and agreement with all client plans is clearly documented.

4. By October 31, 2019: Napa County MHP will implement a Peer Chart Review process. Napa County MHP is in the process of designing a Peer Review process-- which will be a part of the current ongoing monthly chart review process--to increase quality review of charts, and engage staff in a learning process through having them engage in the chart review/auditing process.

5. By October 31, 2019: Staff will participate in Annual Compliance Training, this specific finding will be reviewed in the training. 6. By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

_____

Requirement and Citation(s)

The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client
plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:

a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
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;
g) The amount of time taken to provide services; and
The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.

(MHP Contract, Ex. A, Attachment 9)

Progress notes did not include timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity, as required in the MHP Contract. One or more progress notes was not completed within the timeliness and/or frequency standards in accordance with the MHP Contract and the MHP's written documentation standards. Below are the specific findings pertaining to the charts in the review sample:

- Progress notes associated with the following line number(s) did not include timely documentation of relevant aspects of beneficiary care, as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period). **Line numbers 1, 2, 3, 6, 7, 8, 9, 10.**

- Progress notes did not document beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions. The exact same verbiage was recorded on multiple

progress notes, and therefore those progress notes were not individualized. **Line numbers 1 and 3.**

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

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

RR14. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

RR15. The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

a. No show/appointment cancelled, and no other eligible service documented (e.g. chart review to prepare for an appointment that turns out to be a "no show"), or
b. Service provided did not meet the applicable definition of a SMHS (MHSUDS IN No. 17-050, Enclosure 4)

DHCS Finding

No finding number provided.

- The amount of time taken to provide services. There were progress notes in the medical record for the dates of service claimed. However, the amount of time documented on the progress note to provide the service was less than the time claimed. **Line numbers 4 and 5. RR8b3, refer to Recoupment Summary for details.**

Appointment was missed or cancelled. **Line number 8. RR1Sa, refer to Recoupment Summary for details.**

Corrective Action Description

In order to ensure that MHP has addressed the findings and plans of correction related to Progress Notes, Napa County has and will do the following:

1. Ongoing: Napa County MHP has written documentation standards for

Progress Notes that are included in the Clinical Documentation Manual and Clinical Documentation Frequently Asked Questions. To facilitate staff meeting the required documentation standards, the MHP utilizes the PBRIP format for the progress note template to ensure that all necessary components are present in the note and to ensure that medical necessity is illustrated. PBIRP includes the following: 'Purpose' of the encounter (service/meeting); 'Behavior' of the client to be addressed which connects to the functional impairments, diagnosis and current Client Plan; 'Intervention' the provider used in serving the client and how it relates to the Client Plan; 'Response' of the client to the intervention; and the 'Plan' for further/future clinical interventions.

Ongoing: In addition to the Documentation Manual, Napa County MHP Staff are trained throughout their tenure at Napa County Mental Health including: New Employee Compliance Training (See New Employee Compliance Training PowerPoint), Monthly Clinical Documentation Meetings, and Annual Compliance Trainings (See Annual Compliance Training PowerPoint). When the DHCS Documentation Training is completed, Napa County also plans to integrate the DHCS training into the staff required New Employee Compliance training. A four hour Annual Compliance Training took place on August 2018 and this year's Annual Compliance Training will occur by October 31, 2019. DHCS and MHP standards for documentation and recommendations are covered in the Annual Compliance Training. All of these training include a section that reviews the standards for clinical documentation of progress notes.

3. Ongoing: An additional layer of control in place to address quality assurance and compliance with documentation standards is the monthly Chart Review Process. Napa County MHP's quality assurance mechanisms include monthly Chart Review, Supervisor 100% review of new staff, and Quality Management yearly audits/review. The ongoing monthly Chart Review process also allows direct feedback to staff and their supervisors when the progress notes reviewed do not meet county/state standards. In addition to this, the UR Coordinator meets with supervisors on a monthly basis in the Monthly Clinical Documentation Meeting to discuss clinical documentation; this feedback is also discussed by supervisors in their monthly staff meetings on an as needed basis; and feedback is provided monthly in the monthly chart review findings. The UR Coordinator routinely discusses findings with supervisors and staff when progress notes are not found to meet medical necessity or have other quality related concerns. Recently, the MHP has begun to explore the possibility of creating codes specific to no-shows and cancellations so that staff decrease the likelihood of accidentally billing for an appointment that did not occur.

4. On May 23, 2019: The Clinical Supervisors were reminded in the Monthly Clinical Documentation Meeting to ensure that their staff are following the current 'No Show' practice to ensure we are not inadvertently billing for a no show or cancellation. In addition, discussion was had with regard to creating

codes specifically to document no-shows and cancellations so that when these codes are utilized there is no chance of the service being billed. If it is decided that this is the most appropriate way to address this finding, the MHP will create new non billable codes to document no-shows and cancellations by August 31, 2019.

5. By October 31, 2019: Staff will participate in Annual Compliance Training, these specific progress note related findings & plans of correction will be included in the training.

6. Ongoing: On a monthly basis, the Mental Health Staff Services Analyst runs a timeliness of progress notes report and it is submitted to all program supervisors and managers. The purpose of this report is to assist supervisors with identifying specific staff who need additional assistance with ensuring timely clinical documentation.

7. By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

Claims for ICC must use the following:

1) Procedure code T1017
2) Procedure modifier "HK"
3) Mode of service 15
4) Service function code 07

(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

No finding number provided.

One claim was submitted for Targeted Case Management (Service Function "01") but the progress note associated with the date and time claimed indicated that the service provided was actually for participation in a CFT meeting, or for providing another ICC-specific service activity, and should have been claimed as an ICC case management service (Service Function code 07). **Line 10**

Corrective Action Description

In order to ensure the service activity described in the body of all progress notes ·is consistent with the· specific service activity claimed - i.e., all claims submitted must be accurate and consistent with the actual service provided in terms of type of service, date of service and time of service, Napa County has and will do the following:

1. Ongoing: Napa County MHP has written documentation standards in the Documentation Manual which details that service activity described in the body of all progress notes should be consistent with the specific service activity claimed. The detailed expectation in the MHP Documentation Manual and all trainings are that all claims submitted must be accurate and consistent with the actual service provided in terms of type of service, date of service and time of service.

   Ongoing: In addition to the Documentation Manual, Napa County MHP Staff are trained throughout their tenure at Napa County Mental Health including: New Employee Compliance Training (See New Employee Compliance PowerPoint), Monthly Clinical Documentation Meetings, and Annual Compliance Trainings (See Annual Compliance Training PowerPoint). When the new DHCS Documentation Training is completed, Napa County also plans to integrate the DHCS training into the staff required New Employee Compliance training. A four hour Annual Compliance Training took place on August 2018 and this year's Annual Compliance Training will occur by October 31, 2019. DHCS standards for documentation and recommendations are covered in the Annual Compliance Training. All of these trainings include a section that directs staff to make certain progress note service activity information is accurate to service provided, time, etc.

3. By October 31, 2019: Staff will participate in Annual Compliance Training, this finding and plan of correction will be specifically included in the training.

   Ongoing: An additional layer of control in place to address quality assurance and compliance with documentation standards is the monthly Chart Review Process. Napa County MHP's quality assurance mechanisms include monthly Chart Review, Supervisor 100% review of new staff, and Quality Management yearly audits/review. The ongoing monthly Chart Review process also allows direct feedback to staff and their supervisors when the progress notes reviewed do not meet county/state standards. In addition to this, the UR Coordinator meets with supervisors on a monthly basis in the Monthly Clinical Documentation Meeting to discuss clinical documentation; this feedback is also discussed by supervisors in their monthly staff meetings on an as needed basis; and feedback is provided monthly in the monthly chart review findings.

5. By October 31, 2019: Napa County MHP will implement a Peer Chart Review process. Napa County MHP is in the process of designing a Peer Review process--which will be a part of the current ongoing monthly chart review process--to increase quality review of charts, and engage staff in a learning process through having them engage in the chart review/auditing process.

   By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.

Requirement and Citation(s)

The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child/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

No finding number provided.

The MHP did not furnish evidence that it has a standard procedure for providing individualized determinations of eligibility for ICC and IHBS services for beneficiaries 0-20 years of age that is based on their strengths and needs. The medical record associated with the following Line number(s) did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS:

- **Line 7:** Beneficiary is in special education and recently hospitalized but no documentation that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS
- **Line 9**: Beneficiary is involved with two child-serving systems (Mental Health and Child Welfare) but no documentation that the beneficiary received an individualized determination of eligibility and need for ICC and IHBS.

Corrective Action Description

In order to ensure that written documentation is in place describing the process for determining and documenting the eligibility and need for ICC and IHBS; training is provided to all staff and contracted providers who have the responsibility for determining the eligibility and need for the provision of ICC and IHBS; and each beneficiary under the age of 22 who is authorized to receive Specialty Mental Health Services (SMHS) also receives an individualized determination of eligibility and need for ICC and IHBS prior to or during the development of the beneficiary's Initial Client Plan, Napa County has and will do the following:

1. By December 31, 2019: Napa County MHP will develop written documentation to meet this standard. Napa County Quality Coordinator and Program staff are currently developing a Project Improvement Plan (PIP) to create written documentation describing the process for determining and documenting the eligibility and need for ICC and IHBS for clients.

2. Ongoing: Currently, Napa County Children's/Transitional Aged Youth (TAY) Programs determine need for these services on a case by case basis during the plan development process (for new clients) and/or as needed based on severity of impairment such as, high risk aggression, self-harm, school/vocational failure. Treating therapists consult with their supervisor regarding referrals to IHBS, which are generally made when a client displays need for services more than 2x/week from the current clinician, to address significant behavior problems and/or risk issues. Currently, Napa County MHP contracts the IHBS service to an external provider. Napa County internal MHP staff only perform the ICC/CFT duties, and an annual refresher training for current staff will take place by October 31, 2019. This practice will be revised when the aforementioned PIP is completed.

3. By October 31, 2019: Children/TAY program staff will receive refresher training on ICC, IHBS, & CFT services, which will include determining and documenting the eligibility and need for ICC and IHBS for clients.

4. By October 31, 2019: New Hires will receive an orientation training through the Learning Management System (LMS). The UR Coordinator in conjunction with the LMS liaison are in the process of uploading a IHBS, ICC, and CFT training that will be assigned to all new hire staff entering Children's/TAY Mental Health Programs. Newly hired staff also learn from one-on-one training with their supervisor and shadowing current clinicians to observe how to effectively lead a CFT meeting.

5. By June 27, 2019: UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2018 DHCS Triennial Audit.

4. By August 31, 2019: The documentation manual will be updated to provide additional information and clarification related to this requirement.

Proposed Evidence/Documentation of Correction

Please see Correction Action Description.

Measures of Effectiveness

Please see Correction Action Description.

Implementation Timeline:

Please see Correction Action Description.