Riverside University Health System Behavioral Health

FY 18/19 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

Provider Selection and Monitoring (A.VI.C6)

The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

DHCS Finding -1 (A.VI.C6)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.12(a)(1). The MHP's shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).).

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

- P&P Contracted Provider Selection and Retention (no policy number); and
- P&P Providers Credentialing and Re-Credentialing (no policy number).

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall give practitioners or group of practitioners who apply to be a MHP contract providers and whom the MHP decides not to contract with them provide a written notice of the reason for a decision not to contract. DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.12(a)(1). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

A process will be developed with the department's Program Support to develop a notification system of the reason not to contract

A non-award letter will be used to notify bidders who were not awarded a contract. Letters will be sent when the notice of award is issued by Purchasing. It is effective immediately for the RFPs currently in process. For Managed Care and Children's providers who submit proposals through the application process, in the event a

provider is not selected, the letter will be modified by the analyst and sent to the provider.

Implementation Timeline: August 30, 2020

Requirement

C.I.E3- The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5).

DHCS Finding -2 (C1.E3)

The MHP did not furnish evidence to demonstrate it complies with the MHP Contract, Ex. A, Att. 5. The MHP shall inform providers of the beneficiary/family satisfaction activities. (MHP Contract, Ex. A, Att. 5).

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

- Client Phone Satisfaction Survey Results;
- Consumer Perceptions Survey (CPS); and
- Survey results.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall inform providers of the beneficiary/family satisfaction activities.

DHCS deems the MHP out-of-compliance with the terms of the MHP Contract, Ex. A, Att. 5. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

Results of the satisfaction surveys will be shared at the Children's Provider meetings and also e-mailed to the adult contractors.

Results of the satisfaction surveys will be shared at the QIC meeting upon completion of the Satisfaction Summary Report 2x/annually by the Research program. The report will then be e-mailed to all Adult and Children's contractors, as well as being shared in the next scheduled Quarterly Children's Provider meeting.

Implementation Timeline: December 31, 2020

Requirement

D.I.B5- Beneficiary information required in Title 42 of the Code of Federal Regulations part 438.10 (e.g., information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if all of the following conditions are met:

1. The format is readily accessible;

2. The information is placed in a location on the MHP's website that is prominent and readily accessible;

3. The information is provided in an electronic form which can be electronically retained and printed;

4. The information is consistent with the content and language requirements of the MHP Contract; and

5. 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 C.F.R. 438.10(c)(6).)

DHCS Finding-3 (D1.B5)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. 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 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 C.F.R. 438.10(c)(6).).

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

- Policy and Procedure: 290 Mental Health Consumer Brochures and Posters;
- Beneficiary Handbook; and
- MHP website.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the beneficiaries is informed that the information 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

“Without charge” and “Within 5 business days” has been added to the statement advising the consumer about the handbook.

Implementation Timeline: March 31, 2020

Requirement

D. II. GCc-The MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973:

a) Prohibiting the expectation that family members provide interpreter services

b) A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services

c) Minor children should not be used as interpreters. (Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973).

DHCS Finding-4 (D2.GCc)

The MHP did not furnish evidence to demonstrate it complies with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The MHP complies with the following requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 that Minor children should not be used as interpreters.

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

- Poster of Interpreter Services are available free of charge;
- Interpreter Invoices; and
- Beneficiary Handbook.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP complies with requirement that minor children should not be used as interpreters.

DHCS deems the MHP out-of-compliance with the terms of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The MHP must complete a POC addressing this finding of non-compliance

Corrective Action Description

This is included in Policy 162 (pg. 3), but was not specifically highlighted in response to that question on the Document Submission Key

Implementation Timeline: January 17, 2020

Requirement

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

> 1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
>
> 2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
>
> 3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
>
> 4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

DHCS Finding-5 (D.VI.B4)

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate it complies with California Code of Regulations, title 9, sections 1810.405(d) and 1810.410(e)(1). Each MHP must provide:

- The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
- The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.

The seven (7) test calls are summarized below:

Test call #1 was placed on Thursday, January 17, 2019, at 7:35 a.m. The call was answered after one (1) ring via a phone tree. The caller was directed to select option for

English or Spanish. After selecting one of the options, it instructed the caller to dial 911 or go to the nearest emergency room if the caller was in a crisis or experiencing a psychiatric emergency. An operator then answered the call. The caller requested information on how to access services. The operator asked for the caller's information. Upon providing some information to the operator, the operator provided the phone number, address, and hours of operation to the mental health clinic in Blythe. The caller thanked the operator and ended the call. The caller was provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met, the caller provided was information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #2 was placed on Thursday, January 17, 2019, at 1:17 p.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The caller selected one of the options and an automated message stated "if this an emergency, please hang up and dial 911" and if this for a non-emergency mental health services, select option to speak with a staff. The caller selected the option to speak to staff and after three (3) rings, a live operator answered the call. The caller requested information about filling a medication. The operator asked for the caller's information. The caller stated that he/she does not have that information. The operator informed the caller that the county has 3 urgent walk-in locations where he/she could fill their medication. The operator provided the hours of operation, phone number, and address to the urgent care clinic. The operator conducted a brief status of the caller's current mental health condition. The operator added that the caller is able to refill his/her medication at any emergency room. The caller thanked the operator and ended the call. The operator provided information about SMHS to the caller. The caller was provided information about how to access SMHS, including SMHS required assessing whether medical necessity criteria are met, the caller provided was information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #3 was placed on Tuesday, January 22, 2019, at 11:09 a.m. The call was answered via a phone tree. The caller was prompted to select the correct language option and was provided instructions for emergencies. The call was then answered via a live operator. The caller requested information about accessing mental health services in the county. The operator walked the caller through the process. The operator asked if the caller would like to begin the process. The caller responded in the negative and that he/she was seeking information only. The operator provided information on accessing SMHS, including SMHS required to assess whether medical necessity criteria are met, including information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #4 was placed on Tuesday, February 12, 2019, at 5:12 p.m. The call was answered via a phone tree. The caller was prompted to select a language option for English or Spanish. After selecting an option, a recording stated that if the caller was in crisis or experiencing an emergency to call 9-1-1 or go to the nearest emergency room. After the recording, there was another prompt asking the caller to select to talk to someone or for Mental Health Services to call back during business hours. After selecting the option to talk to someone, the call was answered by a live operator. The caller requesting information about how to access mental health services. The operator asked the caller a few questions, informed the caller to go to the mental health facility in Riverside, and informed the caller that they have therapists on staff that can provide urgent care mental crisis. The operator asked the caller for his/her insurance information, to which the caller stated Medi-Cal. The operator provided the clinic information, address, and phone number. The operator provided information on accessing SMHS, including SMHS required to assess whether medical necessity criteria are met, including information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #5 was placed on Friday, March 1, 2019, at 12:54 p.m. The call was answered after one (1) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the DHCS caller then heard a recorded greeting and instructions to call 911 in an emergency. The caller then was transferred to a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller to provide their name and Medi-Cal or Insurance number. The caller informed the operator that their information was packed. The operator informed the caller that for medication refills that Riverside Mental Health has a 24/7 walk-in clinic located at Mental Health Urgent Care, which the operator provided the address and telephone number. The caller was also informed that once they received services at the clinic they could set-up an appointment at the Department of Behavioral Health Department. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and provided information about services needed to treat a beneficiary's urgent condition. The call is deemed in compliance with the regulatory requirements for protocol questions D.VI.B1, D.VI.B2 and D.VI.B3.

Test call #6 was placed on Wednesday, December 26, 2018, at 9:24am. The call was answered immediately via a phone tree directing the caller to select a language option between English and Spanish. After selecting the option for English, the DHCS test caller received a recorded greeting and provided the caller several options to choose. The caller pressed three (3). After four rings, the line was answered by the voice message stating Riverside County Behavioral Health, Quality Improvement Department and to leave message and phone number and the staff will call back at later time. The same voice message was repeated in Spanish. The caller did not leave voice message

and ended the call. The caller was not provided information about how to use the beneficiary problem resolution and fair hearing processes. The call is deemed out of compliance with the regulatory requirements for protocol questions D.VI.B4.

Test call #7 was placed on Thursday, December 20, 2018, at 7:34 a.m. The call was answered after three (3) ring via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The phone tree also instructed the caller to dial 911 or go to the emergency room if the call was a life threatening emergency or if the caller was in crisis. Another recording directed the caller that if he/she is requesting authorization for mental health services that they are open during business hours. The caller selected the option to talk to someone. A live operator answered the caller immediately. The caller requested information about how to file a complaint with the county. The operator asked where the caller had services, Indio or Palm Springs. The caller replied Indio. The operator instructed the caller to call another telephone number. The caller paused for a bit to see if the operator would provide any additional information, however the operator did not. The caller thanked the operator and ceased the call. The caller was not provided information about how to use the problem resolution and fair hearing process. The call is deemed out of compliance with the regulatory requirements for protocol question D.VI.B4.

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- DHCS Test call worksheet;
- Policy and Procedures: CARES line 24/7 Access Line; Authorization Process, and Contract Log and Communication Form;
- Test call scripts;
- MHP test call results;
- Staff training log regarding test calls; and
- CARES line staff meeting agendas and minutes.

While the MHP submitted evidence to demonstrate compliance with this requirement, the MHP's toll-free telephone number did not provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(d) and 1810.410(e)(1). Protocol requirement D.VI.B.4 is deemed out of compliance. The MHP must complete a POC addressing these finding of non-compliance.

Corrective Action Description

The department is in the process of completely re-designing the 24/7 Access Line. This includes additional staffing and training/re-training on responding to requests for services, accessing risk factors, screening for substance abuse, recording of requests, referrals, and providing information about the county's services and problem resolution process. Calls will be randomly monitored for quality assurance purposes by the new supervisor with follow- up training as indicated.

Implementation Timeline: December 31, 2020

Requirement

D.VI.C1-The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, title 9, chapter 11, section 1810.405(f)).

DHCS Finding-6 (D.VI.C1)

The MHP did not furnish evidence of its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance:

- MH Contact Logs 4-1-18 to 3-18-19. However, the access log did not contain five (5) DHCS test calls.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP did not maintain a written log of initial requests for SMHS that includes requests made by phone, in person, or in writing.

The MHP must come into compliance with the provisions of CCR, title 9, chapter 11, section 1810.405(f). Protocol requirement D.VI.C1 is deemed OOC. The MHP must complete a POC addressing these finding of non-compliance.

Corrective Action Description

The department has moved to a new form in the EHR to record request for services. Instructions have gone out department-wide on the new enrollment process multiple times and the older form is no longer accessible. Staff must now utilize the new process of recording the request and disposition.

Implementation Timeline: August 31, 2020

Requirement

D.VII.C- The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

DHCS Finding-7 (D.VII.C)

The MHP did not furnish evidence to demonstrate it complies with CCR title 9, section 1810.410. The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

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

- PP #162 Cultural Competence; and
- Cultural Competence Plan.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the CCC completes its annual report of CCC activities as required in the CCPR.

DHCS deems the MHP out-of-compliance with the terms of CCR title 9, section 1810.410. The MHP must complete a POC addressing this finding of non-compliance

Corrective Action Description

The Cultural Competency Plan now includes the status of the previous year's activities

Implementation Timeline: January 24, 2020

Requirement

E.I.E-Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e).)

DHCS Finding -8 (E1.E)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e). Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e).).

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

- No policy # CARES Line-TAR Processing Protocol;
- Policy 109 conflict of Interest and/or outside employment;
- Policy 101 Compliance Plan;
- Sample of TARs; and
- Inpatient Provider Manual.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(e). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

Verbiage on non-compensation/no incentives for denying, limiting, discontinuing medically necessary services to any beneficiary will be added to the IHBS policy (this is the only service still requiring authorization).

Verbiage on non-compensation/no incentives for denying, limiting, discontinuing medically necessary services to any beneficiary has been added to the IHBS policy (this is the only service still requiring authorization). Staff responsible for creating authorizations were involved in developing the procedures.

Implementation Timeline: June 10, 2020

Requirement

E.I.H3- For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. The MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.210(d)(2)).

DHCS Finding -9 (E1.H3)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.210(d)(2). For cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. The MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.210(d)(2)).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Sample of Authorization Requests;
- Service Authorization Instructions;
- Inpatient Provider Manual; and
- Incoming Documents Log Audit September 2018.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate for cases in which a provider indicates, or the MHP determines, that following the standard timeframe could jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. The MHP shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.210(d)(2). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This verbiage has been added to the authorization manual and has been shared with all staff responsible for creating authorizations.

Implementation Timeline: June 10, 2020

Requirement

E.I.H4-The MHP may extend the 72- hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary. (42 C.F.R. § 438.210(d)(2)).

DHCS Finding-10 (E1. H4)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.210(d)(2). The MHP may extend the 72- hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary. (42 C.F.R. § 438.210(d)(2)).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Sample of Authorization Requests;
- Service Authorization Instructions;
- Inpatient Provider Manual; and
- Incoming Documents Log Audit September 2018

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the MHP justifies

(to DHCS upon request) a need for additional information and how the extension is in the interest of the beneficiary.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.210(d)(2). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This verbiage has been added to the authorization manual and has been shared with all staff responsible for creating authorizations.

Implementation Timeline: June 10, 2020

Requirement

E.I.I-The MHP shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility. (MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225).

DHCS Finding-11 (E.1.I)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225. The MHP shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility. (MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Service Authorization Instructions; and
- Inpatient Provider Manual.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall not require prior authorization for

an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary, or to a psychiatric health facility.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This specific language has been added to the Inpatient Provider Manual and has been shared in staff meetings.

Implementation Timeline: June 10, 2020

Requirement

E.I.J-The MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

DHCS Finding-12 (E.1.J)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225. The MHP that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

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

- No policy # CARES Line-TAR Processing Protocol;
- CARES Line-Authorization Process;
- Service Authorization Instructions; and
- Inpatient Provider Manual.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP of the beneficiary being admitted on an

emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing.
DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att 6; Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This specific language will be added to the Inpatient Provider Manual. This specific language has been added to the Inpatient Provider Manual and has been shared in staff meetings.

Implementation Timeline: June 10, 2020

Requirement

E.III.G- 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).

DHCS Finding- 13(E111.G)

The MHP did not furnish evidence to demonstrate it complies with MHSUDS IN No., 18-027. 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).

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

- Policy #351 Presumptive Transfer.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that 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.

DHCS deems the MHP out-of-compliance with the terms of MHSUDS IN No., 18-027. The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This verbiage will be added to the current policy on Presumptive Transfer. This verbiage will be added to the current policy on Presumptive Transfer. New and revised policies are sent via e-mail to all staff department wide by the Compliance Officer.

Implementation Timeline: August 30, 2020

Requirement

E.IV.B1- The MHP includes the following information in the NOABD:
The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1)).

DHCS Finding-14 (EIV.B1)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(1). The adverse benefit determination of the MHP has made or intends to make. (42 C.F.R. § 438.404(b)(1)).

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

- No policy #-NOABD Procedures.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP includes the adverse benefit determination of the MHP has made or intends to make in the NOABD. DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(1). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This verbiage will be added to the current policy on Problem Resolution. This verbiage will be added to the current policy on Problem Resolution. New and revised policies are sent via e-mail to all staff department wide by the Compliance Officer.

Implementation Timeline: August 30, 2020

Requirement

E.IV.B3- The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information

relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2)).

DHCS Finding – (EIV.B3)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(2). The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2)).

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

- No policy #-NOABD Procedures

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(2). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

See Finding 14

Implementation Timeline: August 30, 2020

Requirement

E.IV.B5- The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)).

DHCS Finding -16 (EIV.B5)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(5). The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)).
The MHP submitted the following documentation as evidence of compliance with this requirement:

- No policy #-NOABD Procedures

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the circumstances under which an appeal process can be expedited and how to request it.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(5). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

See Finding 14

Implementation Timeline: August 30, 2020

Requirement

E.IV.B6- The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6)).

DHCS Finding-17 (EIV.B6)

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.404(b)(6). The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6)).

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

- No policy #-NOABD Procedures

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate the beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services.

DHCS deems the MHP out-of-compliance with the terms of 42 C.F.R. § 438.404(b)(6). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

See Finding 14

Implementation Timeline: August 30, 2020

Requirement

E.V.A- The MHP provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

DHCS Finding -18 (EV.A)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b). The MHP provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

The MHP did not submit evidence of compliance that it provides a second opinion from a network provider, or arranges for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

A departmental policy will be developed to include second opinions. A departmental policy will be developed to include second opinions. New and revised policies are sent via e-mail to all staff department wide by the Compliance Officer.

Implementation Timeline: August 30, 2020

Requirement

E.V.B- At the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).

DHCS Finding -19 (EV.B)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e). At the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).

The MHP did not submit evidence of compliance that at the request of the beneficiary, when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse).

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

See Finding 18

Implementation Timeline: August 30, 2020

Requirement

F.I.D-The MHP shall have only one level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).).

DHCS Finding-20 (F.1.D)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a). The MHP shall have only one

level of appeal for beneficiaries. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).).

The MHP did not submit evidence of compliance that it shall have only one level of appeal for beneficiaries.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This verbiage will be added to the current procedures on Grievances and Appeals. This verbiage has been added to the current procedures on Grievances and Appeals. All QI Clinicians assigned to Grievances and Appeals review the procedures and receive real time training from the supervisor on all the requirements/steps involved in resolving a Grievance.

Implementation Timeline: March 31, 2020

Requirement

F.I.L-The MHP shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations have the appropriate clinical expertise as determined by DHCS in treating the beneficiary's condition or disease. If the decision involves an appeal based on a denial of medical necessity; a grievance regarding denial of a request for an expedited appeal; or if the grievance or appeal involves clinical issues. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).).

DHCS Finding -21 (F.1.L)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a). The MHP shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations have the appropriate clinical expertise as determined by DHCS, in treating the beneficiary's condition or disease. If the decision involves an appeal based on a denial of medical necessity; a grievance regarding denial of a request for an expedited appeal; or if the grievance or appeal involves clinical issues. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).).

The MHP did not submit evidence of compliance that it shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations have the appropriate clinical expertise as determined by DHCS in treating the beneficiary's condition or disease. If the decision involves an appeal based on a denial of medical necessity; a grievance regarding denial of a request for an expedited appeal; or if the grievance or appeal involves clinical issues.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

The updated Grievance and Appeal procedures (Finding 17) will include verbiage that only licensed clinicians from the QI program will make decisions on Grievances and Appeals. The updated Grievance and Appeal procedures (Finding 20) now include verbiage that only licensed clinicians from the QI program will make decisions on Grievances and Appeals. In addition, Grievances and Appeals within the QI program are only assigned to Clinical Therapists. All QI CTs are required to be licensed (only licensed clinicians are recruited).

Implementation Timeline: March 31, 2020

Requirement

F.I.N-The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).).

DHCS Finding -22 (F.1.N)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).). The MHP shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).).

The MHP did not submit as evidence of compliance that it shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This verbiage will be added to the current procedures on Grievances and Appeals. This verbiage was added to the current procedures on Grievances and Appeals. Grievances and Appeals all must go through the QI Supervisor for approval during which time any additional information submitted and/or verbalized by the beneficiary or their representative are discussed to resolve any issues. Procedures are one of the items discussed during weekly meetings with the clinical staff when new situations present themselves so that all staff have the same information/training.

Implementation Timeline: March 31, 2020

Requirement

H.B2- The MHP shall allow such inspection, evaluation and audit of its records, documents and facilities and those of its subcontractors for 10 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 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) .

DHCS Finding-23 (H.B.2)

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. E; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii). The MHP shall allow such inspection, evaluation and audit of its records, documents and facilities and those of its subcontractors for 10 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 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).).

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

- Exhibit C-Reimbursement & Payment.

While the MHP submitted evidence to demonstrate its compliance with this requirement, the evidence did not substantiate that the MHP shall allow such inspection, evaluation and audit of its records, documents and facilities and those of its subcontractors for 10 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.

DHCS deems the MHP out-of-compliance with the terms of MHP Contract, Ex. E; 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

This language has been added to the contract. This language is in both the provider contract boilerplate agreement (Section IV. Program Supervision, Monitoring and Review) and the Exhibit C (Section L. Audits). During the first year of a contract the provider receives technical assistance starting on a weekly basis with TA reduced to monthly/bi-monthly as needed. TA includes regular chart reviews and discussion of contract requirements between RUHS-BH staff and the provider throughout the process. MHP requirements are included in the Contract Monitoring

Manual that is one of the items discussed during monthly Contract Monitoring Team meetings.

Implementation Timeline: June 1, 2020

Chart Review

Requirement

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

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

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

1. A significant impairment in an important area of functioning.
2. A probability of significant deterioration in an important area of life functioning.
3. A probability that the child will not progress developmentally as individually appropriate
4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate. (CCR, title 9, § 1830.205 (b)(2)(A-C).)

DHCS Finding-1A Medical Necessity

The MHP did not submit documentation substantiating the beneficiary met the medical necessity criteria for SMHS and their need for services was established by an assessment.

- **Line number 1:** The diagnosis was recorded on 6/1/2017, prior to completion of the Assessment.
    - The MHP submitted a progress note with service date 6/12/2017, with the statement, "Staff completed the assessment, care plan and diagnosis on this day." However, there was not a completed assessment submitted. There were no assessment elements described in the progress note.

    The MHP submitted a progress note with Service Date 5/31/2018, with the statement, "Writer completed assessment this day." However, the Assessment the MHP submitted was submitted to the medical record after the review dates on 12/11/2018. There were no assessment elements described in the progress note. **RR2, refer to Recoupment Summary for details.**

- **Line number 13.** There was no initial assessment found in the medical record. *The MHP staff were provided the opportunity, but were not able to locate the missing Assessment.*

  - In lieu of the Assessment, the MHP provided a Face Sheet with diagnoses and an Assessment progress note with service date 12/20/2017 noting the Presenting Concern. All of the required elements for an Assessment were not addressed; therefore, the Assessment was not completed. **RR2, refer to Recoupment Summary for details.**

The MHP shall submit a POC that describes how the MHP will ensure that beneficiaries meet medical necessity criteria for SMHS services and their need for services is established by an assessment.

Corrective Action Description

The MHP has implemented and/or is implementing the following actions to address all findings from the chart reviews:

1) Mandating program supervisors meet with a Quality Improvement supervisor to review the QI utilization review of that program to answer questions/increase awareness of any challenges staff within that program may be having with documentation.

2) Developing recorded tutorials staff/contractors can voluntarily (or be mandated to) access for assistance with various requirements contained within assessments, client care plans, and progress notes

3) Revising Policy 122 Monitoring and Auditing Staff for Compliance. The revised policy will include new procedures on submitting peer reviews to the Quality Improvement Department

4) Developing a more intensive onboarding training/technical assistance plan for new contracted providers

5) Added component to Contract Monitoring Reports that mandates a written Plan of Correction for any “Needs Improvement”/”Non –Compliant” findings, and evidence of corrections made

6) Developing a new system with varying levels of access that will streamline access to various reports that will assist Supervisors/Administrators with obtaining reports that will assist in significantly improving the ability to monitor their programs for documentation and other requirements (eg. Identifying services claimed with no progress note attached, due dates for assessments/CCPs)

7) Revising Documentation Manual with new and/or added components for clarification of timelines, service codes, and other documentation standards

The MHP has implemented and/or is implementing the following actions to address all findings from the chart reviews:

1) Mandating program supervisors meet with a Quality Improvement supervisor to review the QI utilization review of that program to answer questions/increase awareness of any challenges staff within that program may be having with documentation. This is communicated to the supervisor in an e-mail that goes out together with the report for the program.

2) Developing recorded tutorials staff/contractors can voluntarily (or be mandated to) access for assistance with various requirements contained within assessments, client care plans, and progress notes. The site to access the tutorials is communicated to the attendees and supervisors via e-mail at the time new staff are scheduled for training.

3) Revising Policy 122 Monitoring and Auditing Staff for Compliance. The revised policy will include new procedures on submitting peer reviews to the Quality Improvement Department. The revised policy will be e-mailed to all program supervisors and administrators with specific instructions on how to complete the reviews, where to submit the findings, and the feedback process.

4) Developing a more intensive onboarding training/technical assistance plan for new contracted providers. The TA is being provided via phone and in-person to all new providers.

5) Added component to Contract Monitoring Reports that mandates a written Plan of Correction for any “Needs Improvement”/”Non – Compliant” findings, and evidence of corrections made

6) Developing a new system with varying levels of access that will streamline access to various reports that will assist Supervisors/Administrators with obtaining reports that will assist in significantly improving the ability to monitor their programs for documentation and other requirements (eg. Identifying services claimed with no progress note attached, due dates for assessments/CCPs)

7) Revising Documentation Manual with new and/or added components for clarification of timelines, service codes, and other documentation standards

Implementation Timeline: October 2020

Requirement

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

DHCS Finding-2A Assessment

Assessments were not completed in accordance with regulatory and contractual Requirements. Specifically, one or more assessments were not completed within the timeliness and/or frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample:

- **Line numbers 1, 6, 12 and 15.** The updated assessments were completed late, according to the MHP policy standards for annual updates.
    - **Line number 1:** The assessment was due 6/1/2018; however, it was signed by the ACSW and entered into the medical record on 12/11/2018.
    - **Line number 6:** The updated assessment was due on 9/22/2017; however, it was signed by the LMFT and entered into the medical record on 1/08/2018.
    - **Line number 12:** The updated assessment was due on 5/12/2017; however, it was signed by the MFTI and entered into the medical record on 4/9/2018. The next updated assessment was signed by the MFTI and entered into the medical record on 4/18/2018.
    - **Line number 15:** There were two Assessments covering the review period. The assessment signed by the MSW and entered into the medical record on 3/23/2017 and the Assessment signed by the ACSW and entered into the medical record on on 4/2/2018. The Assessment entered into the medical record on 4/2/2018 was late by the MHP's timeliness and frequency standards.

The MHP shall submit a POC that 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.

Corrective Action Description

See Finding 1

Implementation Timeline: June 10, 2020

Requirement

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

a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;

b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;

c) 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;

d) 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;

e) 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;

f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over- the-counter, and illicit drugs;

g) Client Strengths. Documentation of the beneficiary's strengths in achieving

h) client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

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

j) A mental status examination;

k) 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, Additional clarifying formulation information, as needed.

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

DHCS Finding -2B Assessment

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

- Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health, including history of trauma: **Line number 5.**
    - **Line number 5:** The following statement "None recorded at the time of the Assessment," under the section "Psychosocial History" does not address relevant conditions and psychosocial factors which affect the beneficiary's physical health, including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.

- History of trauma or exposure to trauma: **Line number(s) 5 and 11.**
    - **Line number 5:** There is no documentation with regard to trauma or exposure to trauma in the 11/30/2017 assessment.
        - The statement "None recorded at the time of the Assessment," is recorded under the section "History of Abuse (Include physical, sexual, emotional, neglect, domestic violence).
        - The Harm Assessment section, including Current Harm Assessment (Within the past 30 days) is blank under the area "Describe Past History of Harm."
    - **Line number 11:** The 4/5/2018 assessment documented "No" after the statement "New/updated client history of trauma information needed?"
- Substance Exposure/Substance Use: **Line number(s) 11 and 15.**
    - **Line number 11:** Past and present use of substances is not addressed.
    - **Line number 15:** Multiple substances are noted in the Diagnosis section; however, past and present use of substances is not addressed in body of Assessment

4/2/2018.

- Client Strengths: **Line number(s) 2, 7, 8 and 9.**
    - **Line number 2:** There is no documentation in the 7/28/2017 assessment of the beneficiary's strengths in achieving their goals related to their mental health needs and functional impairment(s).
    - **Line number 7:** There is no documentation in the 1/8/2018 assessment of the beneficiary's strengths in achieving their goals related to their mental health needs and functional impairment(s).
    - **Line number 8:** There is no documentation in the 1/19/2018 assessment of the beneficiary's strengths in achieving their goals related to their mental health needs and functional impairment(s).
    - **Line number 9:** There is no documentation in the 12/15/2017 assessment of the beneficiary's strengths in achieving their goals related to their mental health needs and functional impairment(s).

The MHP shall submit a POC that describes how the MHP will ensure that every assessment thouroughly addresses all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description

See Finding 1

Implementation Timeline: June 10, 2020

Requirement

Medication consent for psychiatric medications shall include the following required elements:

1) The reasons for (taking such medications.
2) Reasonable alternative treatments available, if any.
3) Type of medication.
4) Range of frequency (of administration).

5) Dosage.
6) Method of administration.
7) Duration of taking the medication.
8) Probable side effects.
9) Possible side effects if taken longer than 3 months.
10) Consent once given may be withdrawn at any time.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding- 3B: Medication Consent

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

- Reasonable alternative treatments available, if any: **Line number(s) 2, 5, 6, 7, 8, 9, 10, 11, 19 and 20.**
- Range of Frequency: **Line number(s) 9 and 10.**
- Dosage: **Line number 9.**
- Method of administration (oral or injection): **Line number(s) 9 and 17.**
- Duration of taking each medication: **Line number(s) 2, 5, 6, 7, 8, 9, 10, 11, 19 and 20.**
- Possible side effects if taken longer than 3 months: **Line number(s) 2, 5, 6, 7, 8, 9, 10, 11, 17, 19 and 20.**
- Consent once given may be withdrawn <u>at any time:</u> **Line number(s) 2, 5, 6, 7, 8, 9, 10, 11, 19 and 20.**

The MHP shall submit a POC that describes how the MHP will ensure that every medication consent process addresses all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description

The Medication Consent in the department's EHR now has all the required elements.

Implementation Timeline: June 18, 2020

Requirement

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-3C: Medication Consent

Medication Consent(s) in the chart sample did not include the signature of the person providing the service (or electronic equivalent) that includes the provider's professional degree, licensure, job title. **Line number(s) 2, 5, 6, 7, 8, 9, 10, 11, 19 and 20.**

The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes the signature of the qualified person (or electronic equivalent) with the professional degree licensure or title of the person providing the service.

Corrective Action Description

Revised report in electronic health record to include staff electronic signature and title on all printed documents

Implementation Timeline: January 17, 2020

Requirement

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

DHCS Finding 4A-2: Client Care Plan

Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary. The Client Plan did not clearly document the service intervention and the scope of the service based on the beneficiary's need for services:

- **Line number 20.** The10/12/2017 Clinical Assessment and the 11/9/2017 Psychiatric Assessment documented the need for Therapeutic Behavioral Support services. The 10/12/2017 Client Plan referred for TBS services and the 11/9/2017 Client Plan included TBS as a service intervention; however, there were no claims for TBS services during the review period.

The MHP shall submit a POC that describes how the MHP will ensure that services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

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)

DHCS Finding-4B: Client Care Plan

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(s) 1, 12 and 15:** There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period.
    - **Line number 1:** The Client Plan expired 6/2/2017, and the next

Client Plan was not in effect until 6/12/2017.

- **Line number 12:** The Client Plan expired 5/11/2017, and the next Client Plan was not in effect until 6/19/2017.
- **Line number 15:** The Client Plan expired 3/5/2018, and the next Client Plan was not in effect until 3/13/2018.

- **Line number(s) 10, and 16:** There was no evidence found in the medical record that the client plan was reviewed and/or updated in response to the change in the beneficiary's mental health condition, impairments, and need for Specialty Mental Health Services.
  - .....**Line number 10:** The progress note dated 5/4/2018 documented, "Client was referred to writer to update client treatment plan .....writer encouraged client to attend the recovery management group writer reviewed client chart and updated client CCP [client care plan]." A second progress note, also on 5/4/2018, documented that client had been attending the "Mastering Anxiety group." The Client Plan was signed 5/4/2018, and is ***identical*** to the Client Plan signed 5/5/2017. Neither plan includes groups/therapy as service interventions.
  - **Line number 16:** Following the referral for a Psychiatric Evaluation, the Client . Plan was not updated to reflect the medication support services goal. The beneficiary received medication during the review period.
- **Line number(s) 6, 8, 10, 12, 13 and 17:** There was **no** Client Plan for one or more type of service being claimed. *During the review, MHP staff was given the opportunity to locate the service(s) in question on* a *Client Plan but could not find written evidence of it.* **RR4c, refer to Recoupment Summary for details**
  - **Line number 6:** Individual Therapy was provided; however, this service intervention was not covered by the 2/9/2018 Client Plan (specifically, claim dated 4/12/2018).
  - **Line number 8:** Group Therapy and Individual therapy were provided; however, these service interventions were not covered by the 1/19/2018Client Plan.
  - **Line number 10:** Group Rehabilitation services were provided; however, these services were not covered by the 5/4/2018 Client Plan and the 5/5/2017 Client Plan.
  - **Line number 12:** Individual Therapy was provided; however, this service intervention was not covered by the 6/19/2017 Client Plan and the 4/11/2018 Client Plan.

- **Line number 13:** The 12/20/2017 Student Treatment Plan provided for the review by the MHP was in Draft form, without interventions and without the provider and beneficiary signatures.

- **Line number 15.** There were Intensive Care Coordination (ICC) and In Home Based Services (IHBS) provided during the review period; however, ICC services were not covered by the Client Plan signed 3/13/2018.

- **Line number 17:** In Home Based Services (IHBS), Intensive Care Coordination (ICC) and Family Team meeting (CFT) and Individual Therapy services were provided; however, these service interventions were not covered by the 2/13/2018 Client Plan. The Client Plan consisted of Mental Health Case Management (MHCM), consultation, and linkage to Mental Health Services.

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that client plans are completed prior to planned services being provided.
2) Ensure that client plans are updated at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
3) Ensure that planned services are not claimed when the service provided is not included in the current client plan.
4) Ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

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) Be consistent with the qualifying diagnoses.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding- 4C: Client Care Plan

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 proposed interventions did not include a detailed description. In some cases, only a "type" or "category" of intervention was recorded on the client plan. **Line number(s) 1, 2, 3, 4 ,5, 6, 10, 12, 14, 15, 16, 18 and 19.**

  Examples:
  - **Line number 1, 2, 4 and 5:** A list of services that will or may be offered to the beneficiary was documented under each goal. Specifically (Line 1), "Staff will provide case management, groups, therapy, resources, peer support, regular visits, and encouragement to promote mental health stability." A detailed description of the planned interventions was not provided.
  - **Line number 3:** The plan portion of the 4/4/2018 Assessment/Plan document did not provide a description of the service interventions.
  - **Line number 6:** The Client Plan signed 2/9/2018, did not provide detail regarding the group rehabilitation activities that were planned.
  - **Line number 10:** The Client Plan signed 5/4/2018, listed "Provide assessment, linkage to community resources, triage services, case management, monitor progress, family engagement, referral to support groups/therapy. " A detailed description of the planned interventions was not provided.
  - **Line number 14:** The Intervention statement under each goal on the 12/19/2017 Client Plan, is ***identical*** in verbiage and not individualized.

    For example, the intervention statement under each goal (italics and underscore added) read: "Providers will engage client in mental health

services *such as* Individual therapy, collateral services, and/or family therapy *as deemed appropriate by clinician* to assist client in processing client's past history and developing self- control skills to improve compliance with directives and decreased depressed mood. Providers will also provide *necessary* case management, coordination of service, behavioral management strategies, and linkage to outside resources *as applicable*. "

- **Line number 16:**
  - TCM, ICC and IHBS are listed on the Client Plan signed 3/8/2018, without detail. The statement *"may be offered"* was used with interventions; therefore, it was not clear whether or not the intervention *will be offered* as part of the Client Plan.

  - The TCM goal included a description that is consistent with a Rehabilitation activity. Specifically, "Case management may be used 1-4 times per month as needed to provide client additional support in demonstrating appropriate boundaries with others."

- One or more of the proposed interventions did not indicate an expected frequency. **Line number(s) 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19 and 20.**
  - For example, **Line number 2:** The frequency for services was documented "as needed", and did not indicate that there was a plan in place for how frequently a service intervention would be utilized.
  - For example, **Line number 19:** The frequency of the medication support intervention on the 3/15/2018 Client Plan, was documented "on a regular basis."

- One or more of the proposed interventions did not indicate an expected duration. **Line number(s) 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 17, 18, 19 and 20.**
  - For example, **Line number 6:** The Rehabilitation services and Medication Support services on the 2/9/2018 Client Plan did not include the intervention duration .

- One or more of the proposed interventions did not address the mental health needs and functional impairments identified as a result of the mental health condition. **Line number 2.**
  - **Line number 2:** The purpose for utilizing medication support services (i.e. the mental health need) was not written into the goal statement on the 10/18/2017 Client Plan. The goal read as follows, "[Name] will attend 10 out of 10 psychiatric appointments in the next 12 months."

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

1) 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.
2) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management ", etc.).
3) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.
4) All mental health interventions proposed on client plans are consistent with client plan goals/treatment objectives.
5) All mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the beneficiary as a result of the mental disorder.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

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

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

b) A person representing a team or program providing the service(s) or,

c) A person representing the MHP providing service(s). (CCR , title 9, 1810.440(c).)

Services (i.e.,Plan Development) shall be provided within the scope of practice of the person delivering service , if professional licensure is required for the service. Services shall be provided under the direction of one or more of the following:

A. Physician
B. Psychologist
C. Licensed Clinical Social Worker
D. Licensed Marriage and Family Therapist

E. Licensed Professional Clinical Counselor
F. Registered Nurse, including but not limited to nurse practitioners, and clinical nurse specialists
G. Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.

(CCR, title 9, § 1840.314(e); 1810.440(c); State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040)
The Client Plan must be co-signed by the LMHP directing services, within their scope of practice under State law, if the individual providing services must be under the direction of an LMHP (from the categories above).

(CCR, title 9, § 1840.314(e); 1810.440(c); State Plan, Supplement 3, Attachment 3.1-A, pp. 2m-p; MHSUDS IN No. 17-040)

DHCS Finding-4D: Client Care Plan

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

- **Line number 13:** The client plan was not signed (or electronic equivalent) by the person providing the services, the person representing the team or program providing the services, or the person representing the MHP providing services. **RR4c, refer to Recoupment Summary for details.**

The MHP shall submit a POC that describes how the MHP will ensure that the signature and· co-signature (if applicable) of an approved category of staff is obtained when required as specified in the MHP Contract and/or MHPs own policy.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

The MHP shall ensure that Client Plans include documentation of the beneficiary's participation in and agreement with the Client Plan. (MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).)

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

a) The beneficiary is expected to be in long-term treatment , as determined by the MHP,

and,

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

When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan includes a written explanation of the refusal or unavailability of the signature. (CCR, title 9, § 181·0.440(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- 4E: Client Care Plan

There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the client plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, if the signature was required by the MHP Contract with the Department and/or by the MHP's written documentation standards:

- **Line number(s) 11 and 20:** The beneficiary or legal representative was required to sign the Client Plan per the MHP Contract with the Department (i.e., the beneficiary · is in "long-term" treatment and receiving more than one type of SMHS), and/or per the MHP's written documentation standards; however, the signature was missing.

  Furthermore, the MHP did not have a written definition of what constitutes a "long- term" care beneficiary.

  - **Line number 11:** On the 11/9/2017 Client Plan, which extends into the review period, there was a note near to where the client/legal representative signature would go that stated, "See client care plan scanned into ELMR on 11.9.17." *This signature document was requested; however, the MHP was not able to locate the requested document.*

- **Line number 20:** The Client Plan signed by the LCSW and entered into the medical record on 10/12/17, was missing the beneficiary/legal guardian signature.

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that the beneficiary's signature is obtained on the Client Plan, as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2)(A)(B).
2) Ensure that services are not claimed when the beneficiary's:
   a) Participation in and agreement with the client plan is not obtained and the reason for refusal is not documented.
   b) Signature is not obtained when required or not obtained and the reason for refusal is not documented.
3) Establish a written definition of what constitutes a "long-term" care beneficiary as part of the MHP's written documentation standards.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

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

DHCS Finding-4G: Client Care Plan

There was no documentation that the beneficiary or legal guardian was offered a copy of the. Client Plan for the following: Line number(s): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 17, 19 and 20.

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that there is documentation substantiating that the beneficiary was offered a copy of the Client Plan.
2) Submit evidence that the MHP has an established process to ensure that the beneficiary is offered a copy of the Client Plan.

Corrective Action Description

The Client Care Plan in the EHR does document if the client was offered a copy of the client plan.

Implementation Timeline: January 17, 2020

Requirement

All entries in the beneficiary record (i.e., Client Plans) include:

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

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

DHCS Finding- 4H: Client Care Plan

The Client Plan 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.

- **Line number 18.** The 11/9/2017 Client Plan.

The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes the signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

Corrective Action Description

Revised report in electronic health record to include staff electronic signature and title on all printed documents.

Implementation Timeline: January 17, 2020

Requirement

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;

b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

d) The date the services were provided;

e) Documentation of referrals to community resources and other agencies, when appropriate;

f) Documentation of follow-up care, or as appropriate, a discharge summary; and

g) The amount of time taken to provide services; and

h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding- 5A-1: Progress Notes

The progress note does not describe how services provided to the beneficiary reduced impairment , restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition.

- **Line number 15.** The progress note(s) documentation did not substantiate that the focus of the intervention was to address the beneficiary's included

mental health condition and related functional impairment. **RRSa, refer to Recoupment Summary for details.**

- **Line number 8.** The progress note did not describe how the intervention provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning. RR7, refer to Recoupment Summary for details.

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition, as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

2) Ensure each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

DHCS Finding-5B: Progress Notes

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:

- **Line number(s) 1, 2, 3, 4, 6, 8, 9, 10, 13, 14, 15, 18, 19 and 20.** Progress notes associated with the line numbers did not include timely documentation of relevant aspects of beneficiary care, with provider signature required within 5 business days of the date of service, as specified by the MHP's Documentation Manual, October 1, 2014 provided for the review period.
- **Line number(s) 8, 15 and 19.** The amount of time taken to provide services. There was a progress note in the medical record for the date of service claimed. However, the amount of time documented on the progress note to provide the service was less than the time claimed, or was missing

on the progress note. **RR8b3, refer to Recoupment Summary for details.**

- **Line number 8:**
  - One progress note documented a Group Therapy service, and indicated that some of the group time was used to conduct the DHCS Adult Survey (not considered a SMHS activity, RR15b) with the group members. The total units of time claimed included the time taken to perform the DHCS Adult Survey.
  - One progress note documented part of the service included speaking to beneficiary regarding their mental health goal and another part of the service included speaking to beneficiary about the beneficiary's boyfriend's travel arrangements and coordinating on his behalf (not considered a SMHS activity, RR15b).
- **Line number 15:** One progress note documented services from two separate service categories. The progress note documented IHBS service activities and. case management activities. The units of time did not appear to be allocated to each service category. The total units of time were claimed to IHBS.
- **Line number 19:** The time claimed for one of the services provided exceeded the units of time documented on the progress note. Also, the documentation indicated the beneficiary "struggled to focus during the session and left multiple times."

- **Line number 3.** The progress note document provided to support claims for services was formatted with unit of time options (i.e. check boxes), limited to 30 minutes or 60 minutes. The documentation did not allow for a write in option for units of time, or for selection of units of time other than 30 minutes or 60 minutes, and thus may not have captured the exact number of minutes.
- **Line number(s) 4, 8 and 15.** The provider's (and co-signer, if applicable) professional degree, licensure or job title.

1) The MHP shall submit a POC that describes how the MHP will ensure that progress notes document:
   - Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
   - The claim must accurately reflect the units of time taken to provide services. The exact number of minutes used by persons providing a reimbursable service shall be reported and billed.
   - The provider's/providers' professional degree, licensure or job title.
2) Documentation is individualized for each service provided.

3) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning.

4) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).

5) Specialty Mental Health Services claimedare actually provided to the beneficiary.

Corrective Action Description

The EHR was modified to require a client plan goal be selected for each service provided and recorded on a progress note to ensure the service recorded is consistent with the goal selected, or a non- billable code be used.

Implementation Timeline: December 31, 2019

Requirement

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

a) Every Service Contact:
   1. Mental Health Services;
   ii. Medication Support Services;
   111. Crisis Intervention;
   iv. Targeted Case Management;

b) Daily:
   i. Crisis Residential;
   11. Crisis Stabilization (1x/23hr);
   iii. Day Treatment Intensive;

c) Weekly:
   i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who iseither staff

to the day treatment intensive program or the person directing the service;

ii. Day Rehabilitation;

iii. Adult Residential.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding-5D: Progress Notes

Progress notes were not documented according the frequency requirements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

- **Line number(s) 1, 6, 9 and 11:** There was no progress note in the medical record for the service(s) claimed. **RR8a, refer to Recoupment Summary for details.**

The MHP was given the opportunity to locate the documents in question but did not provide written evidence of them in the medical record.

- **Line number(s) 1, 6, 8, 12, 14, 15, 16, 17 and 19:** The type of Specialty Mental Health Service (SMHS) (e.g., Medication Support, Targeted Case Management) documented on the progress note was not the same type of SMHS claimed. **RR8b-1, refer to Recoupment Summary for details.**
- **Line number(s) 16 and 19:** For Specialty Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehabilitation) identified on the progress note was not consistent with the specific service activity documented in the body of the progress note.

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that all SMHS claimed are:

a) Documented in the medical record.

b) Claimed for the correct service modality billing code, and units of time.

2) Ensure the Specialty Mental Health Service acitivity identified on the progress note is consistent with the service activity documented in the body of the progress note.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

All entries in the beneficiary record (i.e., Progress Notes) include:

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

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

DHCS Finding-5E: Progress Notes

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

- **Line number 8.** The progress note was not signed by a provider whose scope of practice includes the provision of the service documented on the progress note(s); i.e., the provider's SCQpe of practice did not include delivering psychotherapy.
  RR16a, refer to Recoupment Summary for details.

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

1) All services claimed are provided by the appropriate and qualified staff withintheir scope of practice, if professional licensure is required for the service.
2) Staff adheres to the MHP's written documentation standards and policies and procedures for providing services within the staff's scope of practice.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020

Requirement

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

DHCS Finding-6A: ICC/IHBS

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, and that if appropriate, such services were included in their Client Plan:

- **Line number 15.** Assessments 3/23/2017 and 4/2/2018 were reviewed. There was no documentation available to ascertain that a determination of eligibility and need had been performed.

- **Line number 18.** The 10/31/2017 Assessment documented that the beneficiary had involvement with multiple child serving systems (i.e., Legal/ Child Protective Services, Individual Education Plan with placement in classroom for emotional behavioral challenges, School based counseling and community counseling, group home placement, etc.), indicating the beneficiary met eligibility criteria for ICC services and IHBS; however, these services were not included in the 11/09/2017 Client Plan.

The MHP shall submit a POC that describes how it will ensure that 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, and that if appropriate, such services are included in their Client Plan.

Corrective Action Description

Developing document to identify workflow for identification of client's that may benefit from ICC/IHBS services

Using California Medi-Cal Guidelines (3rd Edition)- youth under 22 identified as eligible for a CFTM would be considered for ICC/IHBS services. A CFTM Behavioral Health Treatment Planning form would be completed highlighting identified needs and what type of ICC and/or IHBS services are being recommended/offered. If IHBS is recommended and the program cannot accommodate the request then an IBHS referral form is to be completed so that TRAC can assist in meeting the need for IHBS services.

Implementation Timeline: August 30, 2020

Requirement

The MHP shall make oral interpretation, available and free of charge for any language. (42 C.F.R. § 438.10(d)(2), (4)-(5).)

Items that shall be contained in the client record (i.e., progress notes) related to the beneficiary's progress in treatment include:

a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;

b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

DHCS Finding -7A: Cultural and Linguistic Services

The medical record did not include evidence that oral interpretation services were made available to the beneficiary and/or the beneficiary's parent(s)/legal guardian(s). Progress notes lacked relevant aspects of beneficiary care. Below are the specific findings pertaining to the charts in the review sample:

- **Line number 7:** Four progress notes indicated language other than English preferred by · the beneficiary; however, there was no documentation to support how the beneficiary's language needs were accommodated.

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

1) All beneficiaries and their parents/legal guardians are offered oral interpretation services, when applicable.
2) There is documentation substantiating that beneficiaries and their parents/legal guardians are offered mental health interpreter services, when applicable.

Corrective Action Description

See Finding 1A

Implementation Timeline: June 10, 2020